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“D’yuh like porridge”: Social talk as a relational, interactional, and clinical component of surgical consultations

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ABSTRACT

Background: Small talk and social talk are often recommended to doctors as rapport building strategies for consultations. These types of talk occur across different activities in clinical consultations. **Aim**: To explore how small talk and social talk are used in surgical consultations. **Methods**: Using conversation analysis, we examined the sequential positioning and action ascription of small talk and social talk in a sample of video-recorded surgeon-patient consultations from New Zealand and Australia. **Results**: Small talk and social talk sequences almost always do more than build rapport in surgical interactions. Rather, they contribute in complex ways to all three institutional agendas of a consultation – clinical, interactional, and relational. **Discussion**: This study broadens previous topic-based analyses and binary or linear conceptualisations. We show that small talk and social talk provide a rich resource for enabling different actions within consultations as well as managing relationships (e.g. managing transitions between activities, facilitating sensitive discussions or examinations, and supporting treatment planning). **Conclusion**: This study has provided a basis for further research to more fully understand the complexities of small talk and social talk in clinical consultations, as well as considerations of how such evidence might best be applied within training and assessment for clinicians.

KEYWORDS

Consultation, conversation analysis, small talk, surgeon

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Introduction

Building rapport in medical consultations is considered a key skill in effective communication, taught to medical students through models such as the Calgary-Cambridge Guide (Silverman, Kurtz, & Draper, 2013), which specifically foregrounds the relational component of communication. Small talk and social talk are considered a rapport-building (or relational) technique in medicine, with clinical students and clinicians advised to use it to improve the clinician-patient relationship (Mauksch, Dugdale, Dodson, & Epstein, 2008). However, there is a diffuse evidence base upon which to build such advice and training, with only some consideration of the implications of different clinical environments for the relevance and utility of small talk and social talk.

Consultations involve three intersecting institutional agendas – clinical, relational, and interactional. The clinical agenda relates to the biopsychosocial content of the consultation; that is, the content and activities that form the presentation, diagnosis, and management of health concerns. The relational agenda refers to how affiliation is managed to build and maintain an interpersonal relationship between participants. The interactional agenda relates to how the consultation is managed as a social and institutional activity, from its overall sequential progression and structural organisation down to the more granular level of localised turns. These interwoven agendas influence (and are influenced by) what occurs in a consultation and how it is managed, including small talk and social talk. In this exploratory analysis we consider the role of small talk and social talk in the clinical, relational, and interactional components of surgical consultations, with the aim of developing a more defined conceptualisation of small talk and social talk and the actions they perform in practice.

Literature Review

Small talk and social talk are terms that are often used interchangeably. In particular, much of the healthcare communication literature uses the term “small talk”, grouping together differing aspects of “non-clinical” talk into the same category with different inclusion criteria depending on the study. While the body of literature we review here captures the breadth of this work, we make a distinction between small talk and social talk. We define “small talk” as talk that tends toward phatic communion or is about a (usually neutral) topic that provides interlocutors with a common reference point and equal access to knowledge (e.g. the weather). We define “social talk” as talk that is focused topically on aspects of social life and where participants share an epistemic domain, but may have differential epistemic authority or rights (e.g. music, family).

Small talk in healthcare consultations has received some attention in interactional research, though it is quite minimal when considering the importance assigned to its role in rapport-building more broadly within the clinical and professional communication literatures (Cole & Bird, 2013; Fortin, Smith, Frankel, & Dwamena, 2018; Silverman et al., 2013). This may speak to assumptions that small talk is considered peripheral “chit chat” rather than serving more strictly clinical functions within a medical encounter.

Since the late 2000s, interactional sociolinguistic and conversation analytic research into small talk in clinical interactions has considered interactions in nursing (Defibaugh, 2017; Macdonald, 2016; Plumridge, Goodyear-Smith, & Ross, 2009), speech-language pathology (Walsh, 2007), traditional Chinese medicine (Jin, 2018), and surgical care (Hudak & Maynard, 2011; Maynard & Hudak, 2008). These studies have examined naturally occurring interactions, frequently focusing on topicality and rapport-building in their definitions and analyses. For example, Maynard and Hudak (2008) identify small talk as a strategy used by both surgeons and patients to either disattend to a physical task occurring simultaneously, e.g. examination, or to resist an interactional task that is currently in train, e.g. a treatment recommendation. The authors suggest that small talk "because of its prosocial quality, can mask the resistance and disattention that it helps accomplish" (2008, p. 685).

In their analysis of small talk in surgeon-patient consultations, Hudak and Maynard (2011) identify three types of small talk: topicalised small talk, brief small talk, and co-topical talk. Topicalised small talk refers to a new sequence of talk on a topic that is "referentially independent from their institutional identities as patients or surgeons" (2011, p. 638). Brief small talk starts in a similar way but has no or limited uptake from the interlocutor while co-topical talk is small talk that is clinically relevant to the ongoing interaction. All of these instances were identified through topic; however, the local sequential environment, particularly how initiations of small talk were responded to, formed the distinguishing features of each type.

Jin (2018) formulates small talk along a continuum, adapted from Holmes (2000). This continuum starts with "core medical talk" at one end then moves to "medical-related talk" then to "social talk" and finishes with "phatic communion" (2018, p. 32). While Jin references Hudak and Maynard's critique of such a model (2011) as lacking contextual specificity, this continuum still relies on topic-based definitions of small talk within different sequential environments of the consultation. Neither model provides much commentary on the actions performed by the small talk beyond the broad consideration of prosociality, and whether or not it is designed to resist or disattend. Hudak and Maynard state that their work on small talk "will enable subsequent analyses of its distribution, and of the different social actions which it can accomplish" (2011, p. 635).

Building on the work of Hudak and Maynard, in this project we have extended the focus of previous research to an action-based analysis that considers how sequences of topical small talk and social talk are designed and responded to by interlocutors in surgical interactions to perform more than just the relational actions assumed in the conventional definitions. We show that, in the context of asymmetric institutional interactions such as these, the potential "relationality" and relative epistemic neutrality inherent in small talk and social talk provides a rich interactional resource for progressing one or more of the three intertwined agendas of the surgical consultation – interactional, clinical, and relational.

Methods

Conversation analysis is concerned with the structural and sequential organisation of naturally occurring interactions. It allows the analyst to build an understanding of how intersubjectivity is achieved through an examination of the normative expectations displayed by participants in their unfolding talk. As an inductive approach, it is ideally suited to exploring clinical

interactions because it considers all aspects of how talk is co-constructed by participants within the local context, as well as the broader organisational structure of the interaction, in order to talk the institution into being (Heritage & Clayman, 2010). In a recent review, Barnes (2019) identified three approaches in using applied CA to investigate medical encounters: descriptive studies, observational-relational studies, and causal studies. This exploratory study is in the first category – a descriptive study designed to better understand how small talk and social talk are used in surgeon-patient consultations.

When considering the concept of "action", conversation analysis focuses on participant understanding and recognition of actions achieved through talk. This also allows for what is called the "next turn proof procedure" whereby we can prove the action of one turn at talk through the response that follows (Peräkylä, 2011). The focus is then on the primary action (or "main job") that the turn is ascribed by the participants themselves (Levinson, 2012). This is not to say that turns of talk have only one action; indeed, they can have multiple actions and these are clearer when looking at the broader sequence within which they occur (Levinson, 2012).

The data for this secondary analysis is drawn from two existing video consultation archives that each include a variety of surgical specialties, visit types, and genders and ages of participants. These are the ARCH Corpus in New Zealand (ARCH website, 2021) (73 video-recorded surgeon-patient consultations), and a clinical interactions database in Australia (48 surgical consultations). The two authors engaged in independent creation of an initial collection, then shared data to refine the definitions and analyses of small talk and social talk in the surgeon-patient consultations presented below.

When considering how wide to cast our analytic net in collection building, we developed an initially broad topical characterisation of small talk and social talk, using member knowledge to identify candidate examples. These included conventional phatic talk, personal experience and opinion, humour, and any other mundane talk sequences invoking topical domains that could potentially occur in everyday talk, and were not demonstrably institutional or clinical talk. We collected both clear and ambiguous examples of small talk and social talk in order to understand the impact of sequential placement and the unfolding context on action ascription. This resulted in a broad collection of possible small talk and social talk.

Following collection building, conversation analysis involves close analysis of the local sequential and structural organisation of the interaction. This is done through detailed transcription, repeated observation, and focusing on participant understandings of talk as evidenced in the data. Our analysis of the actions ascribed to candidate instances of small talk and social talk by the participants during different activities and in different sequential positions within the consultation allowed us to further refine and categorise the collection.

We examined our candidate collection at different levels of granularity. This included where small talk and social talk occurred in the overall structural organisation of a consultation, whether it occurred at the boundaries of or embedded within a consultation or consultation activity, and what actions the participants ascribed to the small talk or social talk, as determined by an analysis of the local sequential organization, including the next turn proof procedure. These levels of analysis highlighted that topically defined small talk and social talk were often doing more than just relationship building and were typically also deployed in the service of interactional management and/or progressing clinical business. We examine how each of these agendas was achieved through small talk and social talk in the following section.

Results

Interactional agenda

The overall structure of medical consultations follows an institutional project of activities with aspects such as establishing the reason for the visit, gathering information (history taking and examination), delivering diagnosis, and discussing next steps (e.g. treatment recommendation) (Robinson, 2003; White et al., 2013). In the data we examined, small talk and social talk sequences that occurred at the boundaries of the consultation overall, as is typical of small talk in institutional interaction (Holmes, 2003), were used to manage the transition between the everyday world and the business of the consultation. Small talk and social talk were also used within the consultation to manage potential interactional awkwardness, for instance due to a gap in the progress of the consultation while waiting for something to happen.

Overall consultation boundaries

It was notable that, by comparison with primary care consultations in a broader database (Stubbe, 2017), when surgeons initiated small talk prior to commencing the formal business of the consultation it was often very minimal and most commonly consisted of very brief introductions and greetings to mark the start of engagement between doctor and patient.[i] Any small talk prior to or embedded into the opening activity is often quite brief, consistent with the time constraints typical of busy outpatient settings. Extract 1 is from a consultation involving a senior gynaecologist in a high-risk antenatal clinic. Here it is used very ‘economically’ in pursuit of several interwoven actions: the primary interactional tasks of launching and then rapidly transitioning the consultation to the first item on the clinical agenda, whilst at the same time attending to the norms of social interaction and the need to establish rapport with a potentially anxious new patient and her partner.

Extract 1: ARCH-ANSP27-02 – congratulations

```
[PA = patient's partner]
 1   DR:    so ((NAME-DR))'s my name (.)
 2   DR:    nice to meet yo[u:]=
 3   PT:                   [nice to meet you]
 4   DR:    good [da:y how's it] going
 5   PA:         [hi ((NAME-PA))]
 6   PA:    >°good to meet you°<
 7   DR:    um (.) alright so i've got a (.) referral for you from the
 8          midwife just te:lling [me  ]=
 9   PT:                          [mhm?]
10   DR:    = a wee bit about u::m you know why you're here?
11          [obviously] you guys=
12   PT:    [mhm]
13   DR:    =are pregnant¿ con[gratulations]
14   PT:                      [mhm]
15   PT:    thank you
16   DR:    u:m (.) but (.) yeah do you wanna sort of tell me in your own
17          words) wha:t's sort of what's been happening and where you're at
18          and (.) why you're here
19   PT:    u:m so we are (.) well we're twenty weeks) o:n (1) sunday?
20          monday? (.)ish
```

The interaction begins with an archetypal reciprocal greeting sequence (lines 1–6) as the doctor enters the room, sits down and introduces himself to the patient and her partner in turn, making eye contact and smiling throughout. In line 7 he swiftly transitions to a referral recognition sequence (White et al., 2014) prefaced with a shift-implicative 'um (.) alright'. However, before proceeding with his elicitation of the problem presentation in lines 16-18 the doctor embeds a further brief small talk sequence (lines 11-14). Whilst fitted to his clinical agenda (namely to find out about what is going on with this pregnancy), this primarily 'does rapport' by acknowledging the social norm that a wanted pregnancy warrants congratulations, and it is responded to as such by the patient.

Boundary talk also happens at the end of the consultation in the transition out of the clinical business. In the consultation from which Extract 2 is drawn, the patient is seeing a plastic surgeon about removal of a melanoma. Earlier in the consultation the patient had brought a written list of questions. The surgeon, commenting that the patient is organised, asked what work the patient did do, as this patient is in their 90s, and uses this to explain why the patient is well-organised. The consultation then continues. At the end of the consultation, this topic is picked up again (line 15).

Extract 2: MQ-VL17-22 – what sort of engineer were you

```
1    DR:   i'll sort this out for you in a  (.) in a [few weeks' time.=
2    PT:                                             [alright.
3    DR:   =alright?
4    FF:   (excellent ta)
5    DR:   no worries i'll [(do it)
6    FF:                   [(         ) excellent tha[nks.
7    DR:                                             [heh heh heh
8          (4.9)
9    PT:   ahhhh
10         (1.5)
11   PT:   this
12         (2.6)
13   PT:   °ahhh°
14         (5.1)
15   DR:   what sort of engineer were you,
16         (0.2)
17   PT:   mechanical.
18   DR:   a:h. what did you build,
19         (0.9)
20   PT:   ah::: (0.3) i was in: production mostly¿ >um (0.8) with an
21         american multinational?
22   DR:   oka:y
23         (0.4)
24   PT:   making uh (1.0) (my specialty was          ) for the automotive
25         [industry.
26   FF:   [ah::
27   DR:   ah::, gee well that's gone through a lotta changes now hasn't it,
28   PT:   aw:: yeah.
29   DR:   eh:. 'ere's no m- no more car:s manu[factured in australia_=
30   PT:                                       [eh heh
31   PT:   =that's right.
32   FF:   [°mm hmm°
33   DR:   [you would a seen a lotta changes [going through your career.
34   PT:                                     [that's right,
35   PT:   yeah_
36   DR:   bit sad, isn't it,
37   PT:   (     )
```

A closing sequence (White, 2015) occurs (lines 1-7) and the participants start to leave the room. The surgeon then asks for further information about the patient's previous work as an engineer (line 15). The surgeon and patient discuss the industry in which the patient worked, with the surgeon providing assessments (lines 27, 33, 36) that are met with affirmative responses by the patient. As this sequence occurs following the conclusion of clinical business, after the formal closing of the consultation (line 8), it is not potentially hearable as being clinical, but rather marks the boundary between the clinical and the everyday social world.

Managing waiting

More extended sequences of social talk also occurred when transition to a new activity was delayed. Extract 3 provides an example of this type of boundary social talk. Here, the patient has been referred to a colorectal surgeon for a screening colonoscopy. Prior to this part of the consultation, the patient has mentioned to the surgeon, who is running late, that she needs

to be home for her children after school and for music lessons. The surgeon notes that they will be quick. The excerpt below is near the start of the clinical component.

Extract 3: MQ-CARM12-12 – how many children?

```
1   DR:  i'm (.) i'm [gonna (.) hear from you what's going on?
2   PT:              [oh okay,
3        (0.7)
4        °i'll j'st (.) get you up on the computer.°
5        (6.7)
6   DR:  °(i hope)°
7        (4.8)
8   DR:  it might or mightn't come up_ (0.7) so (0.4) tell me what's been
9        ah here we go (.) that's good, (0.5) so i c'n i li- i prefer to
10       type (0.2) as you talk_
11       (0.3)
12  PT:  okay¿
13       (1.1)
14  DR:  how many children do you have.
15  PT:  five.
16       (0.7)
17  DR:  °fair dinkum° (0.3) how old [are they.
18  PT:                              [yeah.
19       (0.4)
20  PT:  uh:: *eh* (0.7) near:ly seventeen and my twin boys are eight
21       (0.2)
22  DR:  okay.
23  PT:  (yeh) yih saw my husband (.) not long ago >steve johnson.
24       (0.5)
25  DR:  yes: okay¿ (0.6) um::
26       (1.2)
27  PT:  an- and jane sends us off for preventative stuff
28  DR:  o[kay
29  PT:   [coz she knows we won't go and do (0.2) you know a=
30  DR:  =[unless yih
31  PT:  =[(test with you) without you or anything [she has to really=
32  DR:                                            [okay
33  PT:  =(0.5) hit us with a great big stick,
34  DR:  okay_
```

The surgeon starts this part of the consultation with a referral recognition sequence by noting to the patient that he will not read the letter, but instead would like to hear from her what is going on (line 1). The patient does not provide a problem presentation in response to this and the surgeon does not pursue one. Instead, he works to open the patient notes on his computer. This stops the problem presentation activity, with almost 12 seconds of silence while waiting. The surgeon starts to abandon waiting as he begins formulating an opening elicitor (line 8).[ii] Interrupted by the computer starting to open the notes, he comments that he prefers to take notes as the patient talks (line 10). However, the notes are still loading and the surgeon pursues a different line of questioning by asking about the patient's children in line 14. While this kind of question might be relevant to the patient's social history, its position before the activity of problem presentation rather than in its more usual and logical positioning after that indicates that it is social talk designed to build rapport while the participants wait for the required technology. This interpretation is supported by the patient's

aligning and type-conforming responses to the surgeon's questions (lines 15 and 20). The patient begins to redirect the consultation back to the business at hand in line 23 by referring to her husband's consultation with the same surgeon. In the context of the previous question-answer sequence about her children, the action here is ambiguous. This turn is potentially hearable as a continuation of the social talk, as indicated by the surgeon's repair initiation (line 25) and subsequent silence, which indicate he is unsure why the patient has mentioned her husband. In line 27, the patient clarifies by commenting that the referring doctor 'sends us off for preventative stuff'. The social talk here is an opportunistic approach to rapport building, filling the space created by the technological issues that have arisen. This serves the interactional agenda as it maintains a connection to the ongoing activity.

In Extracts 2 and 3, we argue that the social talk is deployed in the service of both the interactional and relational agendas: it can be seen as building rapport between the participants through an increased knowledge of the patient's life beyond the reason for the visit, while at the same time assisting in managing the flow of the consultation. This speaks to the multiple actions that such talk can perform.

Clinical agenda

We identified a number of turns or sequences that were potentially classifiable as small talk or social talk on the basis of topic, but were demonstrably produced in the service of the clinical project (i.e. they occurred in certain sequential positions such as social history taking, and were not observably designed or responded to as social talk by the participants). For example, in Extract 4, the surgeon is asking the patient general history taking questions, mostly related directly to the patient's health.

Extract 4: MQ-CARM12-04 – what do you study?

```
1    DR:   have you had babies?
2    PT:   no_
3          (2.6)
4    DR:   what work do you do:¿
5    PT:   i'm a student at the moment.
6    DR:   what do you studying?
7    PT:   accounting¿
8          (0.6)
9    DR:   °where at¿°
10   PT:   (0.2) uh:m (0.7) parkview tafe.
11   DR:   °yup°
12         (5.6)((DR typing then looks to patient and taps on table))
13   DR:   family history of bowel cancer [or polyps=
14   PT:                                  [nuh
15   DR:   =[or anything like that_
16   PT:   =[not that i'm aware of no=
17   DR:   =okay and you're otherwise we:ll¿
18   PT:   yup
```

After a 2.6 second pause (where the surgeon is making notes on the computer), the surgeon initiates a new sub-sequence in history taking: asking about the patient's social history. This

starts with a question about her work (line 4). The patient comments that she is studying, and further detail about what she is studying and where is pursued by the surgeon. This sequence ends and is followed by another long pause. As this brief sequence occurs within history taking, it can be understood as acting within that local context. That is, the question about the patient's work is important information for the doctor in considering aspects of diagnosis and, in particular, treatment of the presenting problem. Pursuing further information about the patient's course of study also could possibly be an opportunity for the doctor to gauge the patient's probable health literacy level.

In our analysis, we also found sequences that were clearly oriented to as small talk or social talk, but were nonetheless primarily serving the clinical agenda - in other words, doing 'double duty' in terms of action formation and ascription (Levinson, 2012; Steensig & Drew, 2008). This type of small talk or social talk tends to be embedded within an ongoing activity of the consultation such as treatment recommendations. Data-internal evidence suggested a range of different clinical reasons for deploying small talk in this way, such as distraction from an uncomfortable procedure or supporting treatment planning.

Distraction

Embedded small talk can be used to distract from and/or normalise unpleasant or socially awkward examinations or procedures (Macdonald, 2016). In Extract 5, the surgeon has just commenced an endoscopic rectal examination (lines 2-3). In other types of examination, doctors often produce 'online commentary' (Heritage & Stivers, 1999) to explain what they are doing and seeing, and perhaps to fill the silences. Here the only online commentary occurs in line 7 just as the doctor is ready to start: 'I've got to look inside,' to which the patient responds with laughter and an acquiescent 'yeah'.

Extract 5: ARCH-ISSP03-04 - not a bad day out there

```
1    DR:   yeah perfect yeah that's that's great that's fine that's (.)
2          wonderful okay yep (.) what i want to do is just examine you
3          first and then put a little (.) tube in with a light and a
4    PT:   that's [that's] what doctor ling said
5    DR:          [yeah  ]
6    DR:   yeah [(        )] i've got to look inside (  all about)
7    PT:        [((laughs))]
8    PT:   yeah
9          (2)
10   DR:   okay
11         (7)
12   DR:   it's not a bad day out there is it?
13   PT:   it's a lovely day (we've had a) good run of weather
14   DR:   yeah
15         (3)
16   DR:   (   ) do you get er did you feel that jolt last night?
17   PT:   i felt (.) the first one [i didn't feel] the second one
18   DR:                            [yeah   yeah  ]
19   DR:   yeah yep
20         (11)
21   PT:   ((coughs))
22         (27)
23   DR:   ((mutters quietly))
24         (11)
25   DR:   all right there
26   PT:   yes
27   DR:   just you let me know if i'm hurting you and i'll just (.) stop
28         okay?
```

After 7 seconds of silence, the doctor initiates a stereotypical small talk sequence about the weather, and, after another 3 second pause, mentions a recent spate of earthquakes (lines 16-19). The procedure was not videorecorded, but it is inferrable from the audio data that these short bursts of canonical small talk coincide with the insertion of the endoscope and/or the early stages of the examination. It is unlikely that the small talk is simply filling an interactional gap in this case, as there are much longer unfilled pauses later in the procedure (e.g. lines 20, 22, 24). This suggests that the small talk occurring here is primarily in service of the clinical agenda, serving to distract the patient from an unpleasant examination. Both topics (the weather and recent earthquakes) sit within a shared epistemic domain where doctor and patient have equal epistemic rights, so the small talk does not require the patient to provide new knowledge to the surgeon, as other questions about their personal life might do. We cannot be certain of the doctor's purpose in choosing to initiate small talk here, but we can see that the patient provides full responses to the doctor's two topic initiations, thus indicating it is treated as small talk. It is also plausible that by invoking a completely neutral topic that sits within an epistemic middle ground, this exchange indeed serves to distract the patient to some extent, and perhaps also serves to minimise social distance and any sense of awkwardness induced by the sensitive nature of the procedure.

Supporting treatment planning – doctor-initiated

Social talk can also support the doctor's decision making in terms of treatment planning. This can be achieved where the doctor asks about a social aspect of the patient's life within an activity that is not history taking, as in Extract 6. Here the patient is seeing the plastic surgeon

about removal of lesions from her face. This sequence occurs following examination, diagnosis, and explanation of the procedure.

Extract 6: MQ-VL17-21 – what sort of work do you do?

```
 1    DR:   ah: the procedure itself takes about twenty minutes so it’s
 2          not [that it’s not a particularly big procedure, >risks are=
 3    PT:       [okay,
 4    DR:   =small infection: .hhh bleeding obviously if we get-um
 5          something unusual in the pathology we might have to (0.3)
 6    PT:   yep
 7          (0.2)
 8    DR:   do [a wider excision yeah] exactly,
 9    PT:      [(do a wider ex-) yeh]
10          (1.1)
11    DR:   what sort of work do you do?
12          (0.4)
13    PT:   ah:o office_ (0.2) (m[ainly) (0.2) yep
14    DR:                        [ah::¿
15    DR:   .hhh *so::: (good let me) um* (2.1) °°(       )°° (0.6) .hh all
16          the um skin item numbers have changed >°(no area one beni:gn)°
17          (1.7)
```

The surgeon finishes his explanation of the procedure (lines 1-9), which is followed by a 1.1 second pause. The surgeon starts to fill in forms to book in the procedure on his computer and, in conjunction with this administrative activity, asks the patient what work she does (line 11). The surgeon uses a sequence closing third ‘good’ (lines 14-15) rather than pursuing more information, and the patient does not attempt to continue discussing it beyond that, so the sequence is treated as complete by both participants. While this brief single question-answer sequence could in theory be topically coded simply as social talk, in this context it appears to be serving the dual purposes of maintaining the continuity of the face-to-face interaction as the doctor turns his attention to the computer (Dowell, Stubbe, Scott-Dowell, Macdonald, & Dew, 2013) (as in Extract 3 above), while at the same time eliciting potentially relevant clinical information – as it is a facial procedure, if the patient worked outside or somewhere that required facial covering, then the treatment might be altered. In other words, this sequence appears to be understood as being primarily in the service of the clinical and interactional agendas of the doctor as a small social history taking sequence rather than being designed to build rapport.

Supporting treatment planning – patient-initiated

Social talk for supporting treatment planning can also be initiated by the patient during an activity that is not history taking, as in Extract 7. In this extract, the surgeon has just proposed carrying out a planned operation in May and explained there would be a recovery time of at least four or five weeks. The patient (a farmer) responds with what topically appears to be social talk – ‘cos I start lambing in June see’, before going on to explain why this presents an obstacle to the surgeon’s proposed timing for the procedure.

Extract 7: ARCH-ISSP04-02 – 'cos I start lambing in June

```
[W = patient's wife]
1    PT:   cos i start lambing in june see
2    DR:   oh i see yeah
3    PT:   that's what's worrying me cos if um (.) i'd like to get it
4          done as quick as i can so i can
5    DR:   yeah okay all right well (.) suppose you can't stop them
6          [((laughs))]
7    PT:   [((laughs))]
8    W:    [no((laughs))] no you can't stop them from [lambing] no
9    PT:                                               [no  no ]
10   W:    no i can't tip them up now if we have any problems
11   DR:   oh i see well [yeah] so
12   W:                  [mm  ]
13   W:    so (      )
14   DR:   (oh yeah) early june or late june or any time in june
15   PT:   yeah i start pretty early in june cos i get (in) away early (.)
16         while the money's right you know
17   DR:   oh yeah
           ((lines omitted))
18   DR:   okay well um (.) well we'll try we'll try and do it as soon as we
19         can for you i mean just left to the normal sequence of events
20         from now would probably be in the (P) about the m- middle of may
21         which doesn't give you much time i spose
22   PT:   no
23   DR:   does it (.) um (.) but i'll have a look there and see what we can
24         organise [for you yeah yeah yeah]
25   PT:            [oh it'd be very good  ] thank you
26   DR:   yeah okay
```

The surgeon produces an aligning response, then initiates a brief humour sequence (lines 5-8) but does not offer an earlier date. This triggers a lengthy narrative (not shown) collaboratively produced by the patient and his wife to justify the need for the surgery date to be brought forward. In line 18, the surgeon acquiesces, and undertakes to try for an earlier date, which brings the sequence to a close. While coding for "non-clinical talk", this was captured as a patient talking about work. However, the action it achieves through its sequential location within the treatment recommendation activity of the consultation and, more specifically, prior to the patient *accepting* a treatment recommendation by the surgeon, means that it is understood by the participants as being in the service of the clinical agenda, as evidenced by line 18.

That is not to say there is no relational aspect to this sequence, in addition to its primary contribution to the clinical agenda. In theory, the patient could simply have stated straightforwardly that he needed to be fit to return to normal work by June, and the surgeon did not need to extend the social talk with a humorous comment. So why was this sequence constructed in this way? Arguably, it serves to 'soften' the patient's resistance to the surgeon's treatment proposal by framing it indirectly, and flattens the epistemic and deontic gradients (Heritage, 2012; Landmark, Gulbrandsen, & Svennevig, 2015) by invoking the patient's lifeworld, an interpretation that is supported by the surgeon's joke and laughter (lines 5-6) which align with these relational actions.

Through these examples we can see that social talk can be treated by participants as being primarily in the service of a clinical agenda, whilst at the same time often performing double duties. Surgeons and patients do discuss topics that might be considered “non-clinical”, but they do so in sequential environments that mean they are understood in relation to the ongoing activity, either to distract from it or to contribute to the co-constructed action occurring.

Relational agenda

There are very few examples in our data set that could confidently be analysed as *only* doing relational work – that is, small talk or social talk to which the participants did not ascribe any additional action, as determined through our analysis. In this data, relational social talk tended to be embedded in an ongoing activity such as discussing management. Embedded social talk is usually bounded by other discrete action sequences and so is tangential to the activity-in-progress, though it may also be topically designed to be integral to the construction of an ongoing action sequence (see Extract 1 above).

Doctor-initiated

Doctors in our data are more often the initiators of small talk and social talk in general, including that which can be considered primarily relational. In Extract 8, which is from the same consultation as Extract 3, the surgeon has asked the patient some history taking questions and then reads the referral letter (lines 1-2).

Extract 8: MQ-CARM12-12 – what are the musical instruments?

```
1     DR:    °i should read anne's letter° >have you had any operations on
2            your tummy?
3     PT:    no.
4            (5.6)
5     DR:    what are the (.) musical instruments.
6     PT:    .hh we h've hh tubas and french horns and sax[ophones an:d
7     DR:                                                 [aw:: so its all
8            (0.2)
9     PT:    [trumpets,
10    DR:    [wind.  okay
11    PT:    yeah the- well they're school bands primary school [bands=
12    DR:                                                       [yep
13    PT:    =are always wi:nd_
14    DR:    =yeah
15    PT:    except my elder daughter now plays piano and does voice lessons
16           as well so (0.4) yeah
17           (1.3)
18    PT:    it's ah::
19    DR:    oh i remember the trumpet i just (.) loved the trumpet_
20    PT:    yeah [it's it's great i love it.
21    DR:         [and uh:m
22    DR:    but i couldn't (.) play it i uh:m (0.9) eh eh are you into
23           baroque trumpet or: [or
24    PT:                        [actually we are going to see (.)
25           performance shortly in saint basil's cathedral.
             ((58 seconds talking on same topic))
26    DR:    are they good at it.
27           (0.8)
28    PT:    they're getting better
29    DR:    yeah
30    PT:    yeah.
31           (1.0)
32    DR:    now (0.4) um: the whole idea behind (1.5) um: (0.5) <looking
33           f:uh cancer>¿
34    PT:    mhm
```

The surgeon refers back to the patient's earlier comment about needing to get home for her children's music lessons by asking about the instruments they play. The patient responds, and this could have been the end of the sequence. Instead, the surgeon expands the topic, which is not clinically relevant,[iii] with both participants discussing wind instruments and performance for more than 60 seconds (not all shown). The sequence returns to a question about the patient's children specifically (line 26) and, following the answer to that, the surgeon returns to clinical business, moving to a new activity of explaining the screening procedure (starting in line 32).

In this extract we can see a shift from a doctor's question about something within the patient's epistemic domain (line 5) to a shared epistemic domain about wind instruments more generally (line 10). This creates an epistemic middle ground that enables both parties to engage on equal footing in terms of epistemic rights, thus reducing the asymmetry inherent in a surgeon-patient encounter. This asymmetry can be observed, for example, in question-answer sequences where the doctor asks and the patient answers without the doctor

providing information about their own life or an opinion from their perspective regarding the topic.

In Extract 9, the patient is seeing a colorectal surgeon as a follow up for inflammatory bowel disease as she recently had a flare up. The patient is attending the consultation with her mother as a support person. They have been discussing what foods the patient can re-introduce into her diet, with a focus on the foods she misses the most. In line 4, the patient introduces a new food.

Extract 9: MQ-CARM12-01 - do you like porridge?

```
1    DR:   you're gonna always have that (0.3) in the back of your mind that
2          possibility of a of a blockage,
3          (1.0)
4    PT:   wha about porridge_
5    DR:   (0.4) should be fine_
6    PT:   o[kay]
7    DR:    [d]'yuh like porridge?
8    PT:   yeah
9          (0.4)
10   DR:   okay. (0.4) brown sugar? >are you a brown sugar (.) porridge
11         person?
12   PT:   °>(no not eaten it with)< brown sugar° (0.6) jam?
13         (0.5)
14   DR:   ↑really.
15   PT:   (0.2) yeah
16         (1.0)
17   DR:   ↑okay.
18   ?:    nfhh heh
19         (0.3)
20   DR:   na 'at's weird. .hh coz (0.3) no just porridge is: um (1.6) y:eah
21         no: >i find out a lot about< (.) somebody. (0.2) by how they have
22         their porridge,
23   PT:   nfhh [°huh huh°
24   DR:        [like if you put salt in it or:
25   PT:   °huhf°
26         (0.3)
27   ?:    huh (.) heh heh
28   DR:   do you cook it in the microwave ↓or do you cook it on the st[ove.
29   PT:                                                               [oh
30         microwave,
31         (0.7)
32   DR:   (°you see that°) (1.2) yeah.
33   MO:   uhhehh
           ((32 seconds omitted))
34   DR:   [i reckon] you can eat if you like porridge you should eat it.
35   PT:   m'kay
36   DR:   yeah it's really good food (0.2) [and, and] =
37                                          [wha' abou'] grai:ns and all
           that,
```

Following the surgeon's assessment in line 5 that porridge 'should be fine' and a sequence closing third (line 6) from the patient, the surgeon or patient could have moved on to discuss additional foods. Instead, the surgeon continues the porridge sequence, asking further questions about how the patient eats her porridge (lines 10-11). This line of questioning could

be analysed as relational social talk or alternatively, it could be understood as part of the more clinical components of the consultation – is what the patient adding into her porridge problematic for her condition, for example. It is more likely the former however, as the surgeon offers no assessment as to whether the additions to the porridge are problematic, only expressing surprise at the choice.

At line 20 however, the surgeon shifts from this more ambiguous social talk to offering his view of porridge as an indicator of a person's personality. This is met with laughter and smiles from the patient and her mother. The surgeon extends this with a question about how it is cooked, eliciting more smiles from the patient and laughter from her mother (line 33). The sequence continues beyond this (not shown, for brevity) with the surgeon, patient, and mother discussing stovetop versus microwave cooking of porridge. As mentioned, the patient was asked to identify foods she would like to eat again, and the surgeon closes this side sequence (Jefferson, 1972) by moving back to an assessment of whether porridge is safe for the patient to eat (line 34). The patient then moves on to the next part of the activity by introducing a new food to be assessed by the surgeon (line 37). The social talk sequence is embedded within the overall activity of discussing management of the patient's condition through diet. The surgeon moves away from the medical business of giving and eliciting clinically relevant information, demonstrating that he is attentively listening to the patient by building from what she is saying into a relational and tangential side sequence. This is similar to the previous extract in that the surgeon, who is the same in both extracts, introduces his own opinions and knowledge about a topic to which both he and the patient have equal epistemic access.

Patient-initiated

Patients initiated small talk or social talk much less frequently than doctors in this data set. When patient-initiated small talk did occur, it also tended to be relatively brief. In Extract 10, the patient and surgeon have discussed the patient's surgery and are making arrangements. The surgeon is signing off on a form for the patient to also sign.

Extract 10: MQ-VL17-19 – when's your birthday?

```
1    DR:   thirtieth (.) my goodness.
2    PT:   i know:
3          (1.4)
4    PT:   when's your birthday,
5          (0.6)
6    DR:   october.
7          (1.0)
8    DR:   fifty one this ye:ar¿
9          (0.5)
10   DR:   [hehh
11   PT:   [you don't look a day over sixty (let me tell you.)
12   DR:   ah hah hah hah hah thanks mate,=
13   PT:   =[heh heh heh
14   DR:   =[huh huh huh .hhh autograph here for me,=
15   PT:   =thank you¿
16   DR:   *there you are*
17   PT:   i just turned forty so i'm not [far off you
18   DR:                                  [(          )
```

While writing the date, the surgeon comments on the date being ‘already’ the end of the month (line 1). The patient agrees with this assessment and then, following a pause, asks the surgeon when his birthday is. There is no clinical relevance to this question as it is about the surgeon rather than the patient, and, as such, we can analyse it as a relational action initiated by the patient. The surgeon responds with the month and also a comment about his age. This comment within the context of the initial turn lamenting about the date might be heard as another such lamentation. This appears to be the patient’s interpretation, as he responds with a joke that the surgeon does not look ‘a day over 60’, when the surgeon is clearly under 60.

Patient-initiated small talk and social talk, particularly that which is initiated outside the context of other already occurring small talk (e.g. reciprocal enquiries), is uncommon in this data set. This may indicate that the normative responsibility for relationship-building through small talk and social talk and for the management of the overall structure of the consultation (Stevanovic & Svennevig, 2015) both sit with the surgeon.

Discussion

Existing conceptualisations of small talk focus on topic and on its off-task, non-instrumental nature. Holmes (2003) and Jin (2018) consider small talk to be either more or less “small” in workplace interactions, with Jin formulating that this is dependent on how relevant the talk is to the core business of the medical agenda. Our analysis of the actions ascribed to the small talk and social talk in a sample of surgical consultations highlighted the often multifunctional nature of this talk, with binary or linear conceptualisations insufficient to capture what can be done through small talk and social talk.

Small talk and social talk are more than “chit chat” and, in the surgeon-patient consultations analysed in this research, such talk is frequently designed to achieve actions beyond off-task rapport building. In considering the sequential positioning of small talk and social talk and its action formation and ascription, we can see the significance of interactional context and participant understanding when describing small talk and social talk in clinical interactions.

Across the data, we found that surgeons were the main initiators of small talk and social talk sequences, regardless of what action they performed. This suggests that, for the most part, surgeons appear to exert deontic authority over whether small talk and social talk is relevantly part of the consultation. This aligns with the findings of Weidner that show clinicians have “deontic authority to initiate a trajectory of action that the recipient should relevantly comply with” (2015, p. 81).

Taking these aspects together, we can see the complexity in defining small talk and social talk in consultations. In Extracts 4 and 6, for example, we can see that the different sequential environments for questions relating to a patient’s work (within social history taking and within treatment planning, respectively), influence the action that can be ascribed to the turn. If these were identified via a topical coding scheme, for example, that nuance in the analysis would be lost. This inductive close analysis of actual interactions adds a necessary richness to formulating the role of small talk and social talk in surgeon-patient consultations.

Small talk and social talk are often considered “neutral territory” in conversation, with Jin (2018) and Walsh (2007), for example, suggesting that small talk is more symmetrical than clinical talk in consultations. We posit that this may be because primacy within the epistemic

domains in small talk and social talk is not as inherently fixed as compared to other aspects of the consultation. The ability to create a middle ground through designing an action as small talk or social talk results in less chance of encroachment on (or need to invoke) a participant's epistemic primacy. In other words, it is a way to temporarily set aside or downplay the institutional asymmetry within these consultations.

The omnirelevance of the clinical agenda in a consultation (cf. Hudak, Clark, & Raymond, 2012) also impacts on the action ascription of small talk and social talk – unless it is clearly formulated or responded to as performing a non-clinically relevant action, there may be a tendency to ascribe an institutionally relevant action to an utterance that could otherwise be classified as small talk or social talk. This might especially be the case in surgical consultations which, by comparison with other types of consultation (e.g. primary care), are often higher stakes. They are also more likely to be one off or less frequent and undertaken in pursuit of diagnosis and ruling treatment in/out rather than incremental care. Because participants may orient to this clinical omnirelevance, adding in small or social talk in an effort to build rapport may not be understood as such by the patient. This then raises the analytic question of why turns might be designed in this way. We would argue that participants in clinical consultations can exploit the potential ambiguity of turns that are hearable topically as small talk and social talk as a resource for achieving their interactional objectives and progressing the multiple institutional agendas of the consultation.

Conclusions

We have demonstrated that binary conceptualisations of small talk (on-task versus off-task, or clinical versus non-clinical) do not adequately capture what can be done through small talk and social talk in surgeon-patient consultations. We show that the use of small talk and social talk in clinical settings almost always extends beyond the simply relational role it is usually assigned. Instead such talk is frequently used to perform multiple actions at once. In surgeon-patient consultations, the focus is usually on one specific problem or aspect of the patient's health, so small talk and social talk may be more hearable or expected to be in the service of the clinical work.

What is normatively expected to occur in a consultation will likely differ between visit and clinician types, as well as being influenced by the relationship between the doctor and patient. While we have distinguished between small talk and social talk in our analyses, we have not explored differences between the use and function of each. This is an exploratory study focused on small talk and social talk in surgeon-patient consultations from Australia and New Zealand. As such, we do not make claims to generalisability of our observations on the distribution of the particular actions and sequential organisation identified above. We do, however, suggest that the conceptualisations arising from our analyses are theoretically transferable – namely, that small talk and social talk are almost always doing more than 'being relational' in clinical interactions, and that the omnirelevance of the clinical influences the actions ascribed to small talk and social talk. While we used topic to initially identify possible small talk and social talk, our subsequent analysis focused on action and the relationship between action and sequentiality, exposing how small talk and social talk can contribute to all three agendas of the consultation.

Small talk and social talk are generally considered to be simply a relational tool in medical consultations, imperative for the rapport building between participants. Given rapport building is considered an important process skill in consultations, small talk and social talk arguably form part of the interactional project of the consultation, to the extent that building and maintenance of rapport (and, therefore, trust and therapeutic alliance) are inseparable from the more overtly clinical and institutional aspects. Small talk and social talk sequences can be used to perform one or more relational, interactional and clinical actions in surgical consultations. Positioning small talk and social talk as just a relational tool misses the richness and utility of such talk as a resource for accomplishing actions that contribute to and cut across all three core institutional agendas.

Accordingly, advising medical students or practitioners to do "small talk" simply as rapport building is overly simplistic, and may lead to problematic outcomes such as breaching expected norms for all participants, particularly in surgeon-patient consultations. This study has provided a basis for further research to more fully understand the complexities and relational implications of small talk and social talk in clinical consultations, as well as considering how such evidence might best be applied within training and assessment for clinicians.

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Endnotes

[i] It was not possible to reliably determine in all cases whether or not small talk had taken place at the beginning of a consultation, as recordings were not always started immediately after all participants had entered the room.

[ii] With reference to Jefferson on side sequences (1972), we argue that the activity is not delayed by a side sequence (i.e. the small talk) but that the initial activity was stopped by the technological issue and the small talk was included opportunistically. This is particularly evidenced by the long pauses at the start of Extract 3.

[iii] We use the term "clinically relevant" to mean interaction influencing diagnostic decisions and treatment recommendations by the doctor. We do acknowledge that while small talk may or may not be directly or even indirectly in the service of these activities, the act of small talk as a relational strategy in order to build rapport and trust with a patient is important in itself to the provision of clinical care.

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