Take Care of Yourself: Negotiating Moral and Professional Face in Stroke Rehabilitation

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Introduction

Politeness as facework can provide a useful lens through which to analyse the interactions that take place in medical institutions. As Heritage and Clayman (2010) observe, it is talk itself that "instantiates" the institutional ethos as "sequences of talk … are aligned with, and embody, some of the basic imperatives of the institutions in which they are found." (Heritage and Clayman 2010:32). Recent theoretical developments in discursive politeness and interpersonal pragmatics (Haugh et al. 2013) have shown a politeness analysis to be highly relevant to showing how professional and institutional roles and relationships are constructed and reproduced in therapeutic encounters. This is not least because politeness concerns not only the moral order *of* interaction (Goffman 1983) but also the moral order *in* interaction (Heritage and Lindstrom 1998). That is to say, there is a moral order "constructed of institutionalised rights and obligations" as well as "the moral worlds evoked and made actionable in talk." (Heritage and Lindstrom

1998: 397). It is therefore appropriate and timely that politeness theory, broadly defined as face-work and relational work (Locher and Watts 2005) should be applied to the study of health care interactions.

It is the purpose of this chapter to discuss the ways in which the ideology and morality of modern health care are played out in the day-to-day practice of stroke rehabilitation and is concerned with the way institutional roles and identities are managed through talk between patient and health professional in this specific context. I take the Goffmanian view that face, defined as "the positive social value a person effectively claims for himself by the line others assume he has taken during a particular contact" (Goffman 1967:5), and face-work is necessarily involved in all social interaction. Such a framework can be instructive in analysing relationship and identity management in any situation. However, face management in the medical context is subject to particular institutional and professional influences; the interactional stance of the professionals and the patient is affected by the approach to care taken. In stroke care in particular, the emphasis for recovery is on the effort and motivation of the patient; the patient has a moral responsibility to make efforts to become well (Michailakis and Schirmer 2010). These moral issues, as well as professional identity are rehearsed and managed in interaction between health professionals and patients (Bergmann 1998). As part of my analysis, I will invoke the notion of "professional face" that has been noted in other studies of workplace politeness (see Grainger 1990; Orthaber and Marquez-Reiter 2011; Jagodzinski and Archer 2018) and that somewhat extends Goffman's (1967)

and Brown and Levinson's (1978/1987) idea of personal face. Professional face can be conceived of as that in which the speaker takes on the values of the organisational or institutional role that they are representing. Since this chapter deals with interactions between professional and non-professionals (i.e. patients), I will also be taking into account the institutional definition of the patient role in this context.

The data I focus on for the chapter is from a series of conversations about progress in recovery that took place between a stroke patient, a doctor and one of her occupational therapists (OT hereafter). I reveal the processes and mechanisms whereby an underlying ethos is negotiated between individuals in real time and real situations with a view to "gain[ing] access to the actual practices in which morality comes to life" (Jolanki, 2004: 486). In the analysis, I look at the negotiation of professional and patient face wants in the specific institutional context of rehabilitative health care and discuss the ways in which OT and patient each manage their professional and institutional faces. In particular, I will discuss the impact of "hope work" (Perakyla 1991) on interactional management. Instilling hope and optimism in the patient is part of the central philosophy of stroke rehabilitation (Becker and Kaufman 1995; Hafsteinsdottir and Grypdonck 1997) and the interactional strategy of "hope work" has been identified as a characteristic of the discourse of health professionals who work in therapeutic capacity with patients with long-term illnesses. Perakyla (1991: 417) defines it as "an interactional process whereby the medical identities of the patient and the staff are explicated and specified in terms of the hopefulness of the

situation". Hope work, he asserts, is an important part of the professional identity of those working with seriously ill patients. However, other scholars ask whether the professional goals of hope work can sometimes be foregrounded at the expense of enabling the patient to voice fears and concerns about their illness. Wiles et al (1998), for example, argue that over-optimism in those caring for stroke patients can give false hope. This is one of the issues addressed in this chapter. In the interactions analysed below, we see how the patient and health professionals collaborate interactionally to construct the treatment regime as worthwhile, and the patient as morally worthy of such treatment. All three participants engage in hope work and we will see how the OT in particular seeks to maintain this as a moral "line" (Goffman 1959), even when the patient orients to what is arguably a more realistic projection of her future abilities.

Face, politeness and morality in health care discourse

Bergmann (1998) notes that many professions are engaged on a daily basis with moral issues:

> "whenever respect and approval …for an individual are communicated, a moral discourse takes place …. Morality is constructed in and through social interaction, and the analysis of morality has to focus, accordingly, on the intricacies of everyday discourse." (Bergmann 1998:286)

Health care settings, in particular, are often prime sites where morality is "made actionable in talk." (Heritage and Lindstrom 1998:397). Furthermore, morality is subject to the goals and requirements of the community in question (Eelen 2001). In health care contexts, appropriately moral behaviour is constrained by the medical ethos and the institutional requirements at play. In interactions between health care providers and patients, the interlocutors will orient to institutional identity needs such as the maintenance of medical professional face and the face needs of the "good" patient (Parsons 1951). In contemporary Western medicine these institutional identities are, in turn, set within an ideology of neoliberalism. According to Harvey (2005), neoliberalism is "a theory of political economic practices that proposes that human well-being can best be advanced by liberating the individual entrepreneurial freedoms and skills within an institutional framework characterised by strong private property rights, free markets and free trade." (Harvey 2005: 2). The marketisation of society is believed to have an impact on all human behaviour, involving, among other things, a cultural move towards individualisation (Block 2014) and the "responsibilisation" of the individual for her/his own wellbeing (Sarangi and Roberts 1999; Gwyn 2002). In the sphere of medicine, recovery from illness therefore becomes very much a moral matter. In connection with this, Jolanki (2004) coined the term "healthism" in which "failure to recover or to resist the adverse effects of illnesses may be attributed to either lack of motivation or a defective will." (Pollock 1993, in Jolanki 2004: 484).

Studies into the sociology of interaction (Goffman 1959), politeness (e.g. Brown and Levinson 1978, 1987; Terkourafi 2011) and the discourse of health and illness (Sarangi 2016; Heritage and Lindstrom 1998; Bergmann 1998) teach us that moral norms are regularly negotiated between social actors as part of their orientation to face needs. Thus, talking about health becomes a question of the presentation of one's self as a responsible member of society.

For patients, this seems to involve both legitimizing the need for care as well as demonstrating that one is a worthy patient. Heritage and Clayman's (2010) account of the way patients talk about their ailments with doctors confirms that patients are concerned to present their problems as "legitimate" areas for medical attention. Jolanki (2004), also found that elderly people's health care talk consists partly of explaining and justifying their health care choices such that they present themselves as being worthy of respect and approval. The specific interactional resources invoked include appealing to an outside opinion (getting a witness to "testify"), "balancing" good with bad (e.g. being careful vs. being lazy) in order to prove one is morally accountable and rational, rhetorically conceding to the interviewer and comparing the current "self" with a previous version (Jolanki 2004: 493-496). These behaviours all have a moral orientation to do with establishing responsibility (Sarangi 2016).

Similarly, in the work of Coupland and Coupland (1999), such moral accountability on the part of elderly patients can be found in the form of

using age as a face-saving rationale for their illness. That is, implicitly, they cannot be held accountable for their condition as they cannot help being old. In this setting, however (a geriatric out-patients clinic), doctors explicitly espouse ideologies of self-care and anti-ageism and so find themselves in the position of attempting to refute such self-disenfranchising statements whilst not damaging the patient's face by contradicting them. Such interactional tensions also appear in my data wherein the patient's own evaluation of her condition is at odds with the professional ethos.

For their part, doctors are increasingly encouraged to listen to patient narratives and to afford credibility to lay perspectives on health care. Sarangi (2001) notes that some patients present themselves as "play doctors", diagnosing themselves and recruiting into their talk "relevant medical labels" and "medical reasoning" (Sarangi 2001: 4). This can lead to a need to balance the medical and moral discourses that can exist alongside one another in interaction (Maseide 2003). In Heritage and Lindstrom's (1998) data on new mothers' interactions with health visitors, health visitors walk a tricky interactional line between "expert" and "friend", but their professional stance is maintained by subordinating moral evaluation (of mothering skills) to the discourse of practical and technical reasoning. This type of scenario, then, is potentially a far cry from the "asymmetrical medical encounter" previously described by Mishler (1984) as patients appear to consult the doctor, not as an expert, but as a second opinion. As Cheek (1997:6) observes, it is not a question of who has power and who is powerless, but about which viewpoint is "afforded main frame and why".

Some doctors may welcome the resourceful, well-informed patient, but there is evidence to suggest that many regard this type of patient as demanding, costly and time-consuming (Shaw and Baker 2004).

Studies that micro-analyse interactions with the allied health professions are relatively rare (Spiers 1998; Mullany 2009; Harvey and Koteyo 2013) but those that do find the application of politeness theory useful. In my own previous work, I have found the judicious application of concepts from Brown and Levinson's (1978; 1987) politeness framework to be enlightening for the analysis of nurse-nurse, nurse-patient and occupational therapist talk. For example, Grainger et al. (1990) show how nurses walk a fine interactional line between responding sympathetically to patient talk about troubles and their need to complete the physical task at hand; Grainger (2004) discusses the way in which verbal play between patients and nurses during care routines can orient simultaneously to interpersonal positive face needs whilst also constructing and maintaining institutional identities. Defibaugh (2014: 69) also makes use of the idea of institutional identity in nursing talk. In a study of nurse practitioner's use of indirectness to hospital patients she says: "using indirectness…aids in the construction of the nurse practitioner identity, by conforming to "nurse speak". Her status as a competent nurse practitioner is constructed, in part, by her use of indirectness." Zayts and Kang (2009), on the other hand, find that institutional goals can sometimes present interactional tension for health care providers. Using the notion of "politic" behaviour (from Locher and Watts, 2005) to genetic counselling encounters, they show that different

norms of relationship management/interaction are negotiated depending on the professional and institutional goals of the speakers. In the Hong Kong context, they argue, the need for clarity of information is in tension with the professional ethos of non-directiveness (i.e. allowing the patient to make up their own mind about genetic testing).

It is clear from the literature, then, that institutional norms and identities are inextricably linked with the management of interaction in health care encounters. In the following section I outline the specific ideology of care that is reflected and constructed in conversations with stroke patients.

The institutional ethos of stroke rehabilitation

Stroke is an illness which most commonly affects older people, and as with many afflictions of old age, there is no cure, although significant improvements can be made after the initial stroke event. The extent of these improvements are, however, notoriously difficult to predict in any one patient and this uncertain trajectory of the illness leads to difficulties in communicating the prognosis to the patient. Becker and Kaufman (1995) report that this uncertainty tends to be managed by professionals by remaining optimistic about recovery. This, it is argued, helps the patient to remain motivated to participate in therapy. Such emphasis on motivation can be explained in part as a way that the patient can demonstrate their personal competence as a worthy patient, even in the face of physical

incompetence (Parry 2004). Rehabilitation therapy (involving occupational therapy, physiotherapy and speech therapy) is effectively the only treatment for stroke. There are no drugs or technological procedures which can help patients regain use of bodily functions (Becker and Kaufman 1995). The reality is that neurological function may or may not recover spontaneously and that rehabilitation therapy can only maximise these functions or teach patients how to substitute for lost functions. Wiles et al. (1998) claim that the effectiveness of much stroke rehabilitation is unproven and yet, patients commonly believe there is a direct link between participation in rehabilitation programmes and full recovery (Wiles et al. 1998; Becker and Hoffman 1995). Parry (2004) claims that patients and therapists tend to collude in perpetuating this belief by avoiding the topic of physical incompetence. Instead, physiotherapists and occupational therapists tend to focus on functional recovery (rather than a return to the pre-stroke condition). This may have the desired effect of maintaining hope and optimism, but can also contribute to false optimism which Grainger et al. (2005) have shown may have to be dealt with unexpectedly by therapists on other occasions, such as when discussing discharge from hospital.

The lack of any medical treatment and the reliance on rehabilitation as the only treatment places stroke care within the neoliberal conception of health care (Osborne, 1997), discussed above, in which the patient takes increased responsibility for getting and remaining well. Maclean and Pound (2000) argue that contemporary stroke care has echoes of Parson's (1951) notion of the "good patient". Motivation is viewed as "within" the personality of the

individual patient and effectively puts the responsibility for recovery onto her/him. Becker and Kaufman explain that the moral component in stroke rehabilitation is very much foregrounded:

> A characteristic of rehabilitation is that the patient must carry out the therapeutic work. He or she must want to recover. This perspective, requiring involvement of the patient in his or her own treatment and care, places the onus for recovery first and foremost on the patient...the importance ascribed to patient motivation takes the pressure off providers to cure patients and transforms rehabilitation from a professional to a moral domain. (Becker and Kaufman 1995: 169)

As such, when the "trait" of motivation is not manifested and recovery is incomplete, the patient, rather than the health professional, can be held accountable (Maclean and Pound 2000). While this approach to treatment may have benefits in terms of giving the patient more control over their care, it can also lead to ambiguity as to where expertise lies in the patient-therapist relationship (Gwyn 2002). In stroke care, to some extent this is managed through the joint setting of therapeutic goals. However, Parry (2004) argues that collaborative goal-setting in physiotherapy sessions with stroke patients is interactionally delicate partly because patients do not have the expertise to judge their own therapeutic requirements and partly because patients do not want to assume too much knowledge for fear of de-legitimizing the need for professional help. It is precisely this management

of the therapeutic relationship, in the context of a self-help and optimistic ethos of care, that is the focus of the analysis below.

Data context and analytical approach

The interactions I analyse here are part of a set of ethnographic data gathered in a stroke rehabilitation hospital ward in the UK in 2002. The whole data set consists of four hours' worth of video recordings of interactions between two right-hemisphere stroke patients and various health professionals in the multidisciplinary team (specifically, occupational therapists, the registrar and the social worker). The interactional data were supplemented with field notes (researcher observations of the context) and audio-recorded interviews with patients. Informed written consent was obtained from each participant and the project was approved by the U.K. National Health Service ethics board of the relevant health care authority.

For the purposes of this paper I focus on conversations between the patient known as "Angela" (pseudonym), one of her occupational therapists and one of her doctors. The conversations take place on different occasions over the space of a few days. Angela is relatively young to have suffered a stroke (late 40s) which left her paralysed on the left side of her body. She has been in hospital for approximately 3 months and has recovered some movement in her left side. She can walk unaided but still with some difficulty. Earlier in her treatment she went through a period of depression

and despondency, however, at the time of recording, she is very cooperative with rehabilitation therapy and highly motivated to recover. Hence, she is well liked by the medical staff who find her rewarding to work with. In Parson's (1951) terms she is a "good" patient because she takes responsibility for her own recovery and is motivated to do so.

The definition and application of "politeness" in this chapter may be thought of as in the second order (Eelen 2001) sense of facework. In keeping with the third wave (Grainger 2011) of politeness research, it combines notions from traditional pragmatics with a constructivist approach, sometimes employing relevant concepts from conversation analysis. Thus, the analytical methodology employed here can be described as "interpersonal pragmatics" (Haugh et al. 2013) or, more recently, as integrative pragmatics (Haugh and Culpeper 2018) since it integrates discursive approaches to politeness with more traditional pragmatic ones.

A number of discourse phenomena are commented on in the interactions and these analytical concepts are taken from conversation analysis (concerning structure and sequence of turns), pragmatics (concerning speech acts and "take up"), politeness theory (concerning "face" management) and interactional sociolinguistics (concerning expressions of authority and solidarity). Such a combination of discourse analytic approaches from across the disciplines provides a healthy cross-fertilisation of techniques, resulting in a rich and "thick" description (Sarangi and Roberts 1999) of the institutional discourse.

Data Analysis

The doctor and the good patient

Patient-doctor interactions that take place during ward rounds in a hospital differ from those in a GPs consulting room in many respects. One of the main differences is that the patient has not sought out the doctor by making an appointment and may well even be unaware that s/he will see the doctor that day. Thus, the presentation and management of medical problems will necessarily take a different structure from that described in much of the doctor-patient literature. As Heritage and Clayman argue, "the norms organising social interaction…are usually mandated by institutional imperatives" (Heritage and Clayman 2010:133). In this case, additional factors concern the usual treatment of stroke patients, whose recovery is largely assisted by physiotherapists and occupational therapists. The goals and expectations of bedside conversations between doctors and stroke patients have a tendency, then, to be ambiguous in terms of expected outcomes. This ambiguity is observable in the extract I analyse here.

In this interaction between Angela and the doctor (in this case a middle-ranking hospital doctor) we see how Angela is positioned as a highly motivated, and hence "good" patient. We see how this also involves Angela being the "expert" on her own health, and the doctor's role, as constructed in his interaction with the patient, is thus somewhat ambiguous: being

somewhere between that of a medical authority and that of a friend. In particular, the way in which Angela's medical problems are presented and responded to are discursively negotiated in a way that reflects the professional and patient roles within the realm of stroke rehabilitation.

Extract 1[i]

In this situation, Angela has just received some physiotherapy to her foot and is sitting in her room when the doctors arrive on their ward rounds. Two doctors walk through the door (a junior doctor and a more senior colleague). Only the senior doctor speaks to the patient.

D = Doctor

P = Patient (Angela)

1 D	(as he is walking in the room) hello
2 P	(mildly surprised) oh (.) afternoon
3 D	haven't seen you for a bit
4 P	no (.) ((certainly not)) I've seen you (.) around
5 D	I keep missing you I'll come in here and you're burning off in the
6	other direction going to rehab
	[ ]
7 P	yes ((I know)) (.) ((that's right))
8 D	glad I caught you (.) (intake of breath) yeh erm basically all the therapists
9	keep saying very nice things about you
10 P	((oh do they))
	[ ]

11 D	um (.) that you're doing everything they are expecting you to do
12	and there's still more you will be able to do eventually
	[ ]
13 P	yes I've just had some just now
14	because I'm (.) my foot keeps swelling (.) so I'm (motions with hand)
	(2.0)
15 D	right
16 P	hobbling (.) I'm not (.) walking like that
	[ ]
18 D	need
19 P	(indicates a walking motion with her hands)
20 D	need to keep moving it then (nods emphatically)
21 P	oh ((yes)) I can move it but it's (.) always going over to the side
22 D	(looking down at P"s foot) (sympathetically) yeh
23 P	and it's heavy
24 D	lots and lots and lots of practice (1.0) but yeh erm (.) it's nice to have a patient who (laughing) the therapists like working on
25	because they think they're getting places

The first turns in this conversation consist of phatic communion and an informal style. This understates the professional relationship and defines the encounter as friendly and casual. "Hello", "haven't seen you for a bit", "I've seen you around" and "glad I caught you" are the kind of thing friends might say to one another. At lines 5 and 6, the doctor accounts for the lack

of previous contact between them as a positive thing. By using an energy metaphor: "you're burning off in the other direction", it is implied that she has an energetic approach to rehabilitation which, in this context, is a positive moral assessment, since being highly motivated in rehabilitation constructs the patient as a "good" non- malingering patient. In other words, it orients to the patients' institutional positive face needs: the need to be approved of as a good patient (Parsons 1951).

The doctor then goes on to discuss the patient's progress in explicitly moral terms. He comments that "all the therapists keep saying very nice things about you" (line 9) and "it's nice to have a patient who the therapists like working on"(lines 24 -25) which, on the surface, could be taken as personal positive politeness (i.e. expressing liking and approval of the patient as a person). This bears out Parson's observations that the sick role involves showing a commitment to getting well, which in turn involves cooperation with the medical staff. Thus, even though there is unlikely to be an expectation of a complete return to wellness in this case, the doctor still orients to the patient's role in the process towards wellness. However, notice that, at line 11, the doctor couches the patient's progress and cooperation with the rehabilitation regime in terms of "doing everything they are expecting" which simultaneously constructs the patient's role in recovery as active but under the authority and guidance of the medics. Thus, at this point, he positions himself in more of an expert role in which he is giving an assessment ("there's still more you will be able to do").

For her part, Angela agrees with the doctor's assessment of her as actively engaged in rehabilitation ("yes, I've just had some now") and her response orients to his professional identity and introduces a "medical" topic at line 14 with "my foot keeps swelling". This self-assessment is indicative of taking the "line" (Goffman 1959) of an expert on herself, although, since she mentions an unresolved problem ("it's always going over to the side") this conversational move can also function as a request for advice. However, since the doctor has not obviously come to speak to her in this capacity, there has to be some negotiation of the trouble and some ambiguity as to its status in the interaction: is she asking for advice or treatment? According to Heritage and Clayman (2010:133) "one of the things that may be put to the test during problem presentation is the patient's own moral character." Thus, by soliciting "technically competent help" (Heritage and Clayman 2010:119) in a troubles resistant (Jefferson 1988) or "stoic" (Maynard 2003) way, Angela continues to present herself as a worthy patient.

At lines 20 and 24 we see that the doctor's take-up of this move is equally ambiguous: he does indeed orient to these as requests for advice, when he says "need to keep moving it then (line 24) and "lots and lots and lots of practice" (line 24). This is effectively a recommendation to continue with the physiotherapy, rather than offering a diagnosis or any additional treatment. Furthermore, his next move is phatic talk towards closing the conversation (Maynard and Hudak 2008): at lines 24-25, there is a pause,

followed by a return to his opening initial topic of how well she is doing: "it's nice to have a patient who the therapists like working on".

The good patient and the occupational therapist

In this next extract we see how the institutional moral order that is associated with stroke rehabilitation is "made actionable" (Heritage and Lindstrom 1998), in part, by facework. In other words, the ethos of self-help, motivation and optimism that underpins stroke treatment is constructed, reinforced and managed through facework as the interaction unfolds.

Extract 2

As one of her therapy goals, Angela has just made lunch for her two sons in the OT kitchen. The following interaction takes place while the sons are eating (in the kitchen). Angela and the OT have a discussion about A's progress while they watch the sons eat.

1 P	I don't know if it's strength or confidence I don't
2	think it's confidence because (1.0) I think maybe
3	it's balance and strength
	[ ]
4 OT	(nods)
5 P	((I've got to)) (.) do it because I'm not shy of doing it (.) (pats leg)
	[ ]
6 OT	mm
7 P	because the thing it's actually ((building that foot))

	[ ]
8 OT	it it
9	definitely tires after a long (.) after you've been walking around
10	a bit
11 P	but I'm not I'm not putting any stress on my er
12 OT	no
13 P	back now by (.) tensing up (.) which I used to do
	[ ]
14 OT	you're doing ec you're doing
15	extremely well with your walking I mean when we walked
16	down (.) your walking was very very good
17 P	well the nurses have been taking me in fact it got to
	[ ]
18OT	mm
19 P	the stage where (.) they'd say what do you want (.)
20	((I was going to say)) toilet and they didn't ask
21	((or)) offer me a chair they just went (sticks elbow out to demonstrate nurse offering an arm for support)

(at this point they are briefly interrupted by another OT who enters the room to see if it is free. She leaves and Angela carries on)

22 P	so I mean you and Sharon ((convinced me)) that I could
23	do it because I convinced myself I couldn't (laughs)
	[ ]
24 OT	mm
25 OT	but I think it's a mixture of confidence strength (.) and

	[ ]
26 P	mm it (.) yeh
27	because I wa- I was going to
	[ ]
28	and wait until this one's strong enough I thought
	[ ]
29 OT	Mm
30 P	what if it's going to take months I can't wait that long
31 OT	it's better to keep trying
32 P	yes
33 OT	definitely

At the outset, this conversation is framed in terms of both morality and technical medical knowledge (Heritage and Lindstrom 1998), and these themes are sustained throughout the extract. At line one the patient contrasts physical recovery with state of mind ("strength or confidence") as an explanation for her good progress. At the same time, the patient presents herself as an "expert" on herself. Her assertions express opinion, self-reflexivity and self-analysis ("I don't think its confidence"). She attributes her recent success in rehabilitation to both physical and moral virtues: "I think maybe it's balance and strength" (lines 2-3); "I'm not shy of doing it" (line 5); "I'm not putting any stress on my back now" (line 11). Thus, both her physical and moral attributes are brought to bear on presenting herself as that of a "good" patient. The OT similarly gives her assessment in terms of a mixture of physical and moral strength; she gives a technical

assessment of Angela's performance through the objectivisation of her body ("it definitely tires") as well as giving a face-enhancing praise of Angela as a person ("you're doing extremely well…your walking was very very good").

The moral strand of this interaction necessitates some facework. Overtly presenting oneself as "morally good" risks promoting one's own positive face at the expense of the addressee's face needs (Brown and Levinson 1987:66). In this case, Angela invokes a comparison with past performance and attributes her current motivated self to the efforts of the OTs: “you and Sharon convinced me I could do it because I convinced myself I couldn't” (lines 22-23). Thus, by enhancing the therapists' professional face wants she also positions herself as a worthy (motivated) person without boasting.

Similarly, Angela's strategy of comparing previous thoughts ("I was going to wait until this one's strong enough") with current ones (“I can't wait that long”) mitigates the potential for face loss. Furthermore, these utterances reflect a view that effort in rehab can supersede natural recovery to which both patient and OT seem to subscribe. At line 31 the OT agrees that “it's better to keep trying” and at lines 32 and 33 they confirm their absolute alignment with one another: “yes”, “definitely”

Thus, in the extract we see how OT and patient manage a collaborative relationship in which the moral order of interaction (Goffman 1983) helps to maintain the institutional moral order. They both take part in a face-oriented and expert (technical) discourse on the patient's progress. They are aligned with one another on both the construction of the patient as highly

motivated as well as on the construction of motivation and effort as the keys to recovery.

The good patient in question

This patient has not always been as optimistic about her ability to recover as Extracts 1 and 2 suggest. It emerges that she has been distressed by something the social worker wrote in support of her housing application, putting a negative slant on her process of recovery and, from Angela's perspective at least, reporting things about her recovery which militate against an optimistic outlook. Angela, the patient, at this stage has been in hospital almost 3 months. She is getting ready for discharge soon but is anxious about the housing situation she will return to. She is worried that the social worker, who is attempting to get her re-housed, is not dealing with her case effectively.

Extract 3

The OT has just entered P's room and tells her that she will be having a bath and some therapy to her right arm after lunch. She then introduces the topic of a letter written by P's social worker to the housing office.

1 P	yes well (.) it said I wasn't responding to therapy
2	because I couldn't concentrate but then the reason
3	then was because I was upset because I didn't have

	[ ] [ ]
4 OT	yeh yeh
5 P	anyone to help me
	[ ]
6 OT	sure
7 P	and and I do now
	[ ]
8 OT	and (.) what we're trying to do at the
9	moment Angela is re-contact your social worker
	[ ]
10 P	mm
11 OT	well (.) we wh-what we said is that you you y- (.)
12	initially you responded very well
	[ ]
13 P	yeh mmhm
14 OT	but when you got very (.) upset and anxious
15	and had all those things on your mind (.) then
	[ ] [ ]
16 P	oh yes yes I did yes mm
17 OT	y-your therapy (3.0) sort of (.) your improvements
18	(.) slowed down (.) quite a lot and you s-because
	[ ]
19 P	yes
20 OT	you y- y- you seemed as if you were very (.)

21	pre-occupied by what was on your mind
	[ ]
22 P	that's how I felt I
23	don't think she put that across very well in the letter
24 OT	yeh
25 P	I think she put it across
	[ ]
26 OT	but but now you're feeling
27	better about yourself (.) you you appear to feel
	[ ]
28 P	well
29 OT	better about yourself
30 P	you've expressed
	[ ]
31 OT	and are more focussed and can
	[ ]
32 P	yes
33 OT	concentrate better (.) you're improving in leaps and
34	bounds with your therapy
35 P	well you've just told me the impression I got from
36	you at the time (.) she did not put that in the
	[ ]
37 OT	yeh
38 P	letter at all

	[ ]
39 OT	right

The social worker's assessment and Angela's lack of progress is framed in moral terms. It is attributable to her state of mind ("I wasn't responding to therapy because I couldn't concentrate") and a rationale is found in terms of her emotional state and lack of support ("I didn't have anyone to help me"). This chimes with Jolanki's (2004) assertion that health talk is about explaining and justifying one's behaviour so that you can present yourself as a "worthy" person (Jolanki 2004: 488). Initially, the OT aligns with the patient, providing minimal responses of agreement. She continues then by re-orienting the professional perspective to be more optimistic than that presented by the patient; that is, in response to Angela's doubts about her progress, she engages in hope work (Perakyla 1991). In line with the conventional wisdom on the treatment of stroke (Becker and Kaufman 1995), the OT's discourse is one of optimism and moral support. Thus, like Heritage and Lindstrom's (1998) study on health visitors and mothers, OTs working in stroke rehabilitation arguably adopt the role of both expert (giving advice and direction) and befriender (sharing experiences and affiliating).

At lines 11-12 the OT takes up the moral stance; her utterance orients to the assumption that non-response to recovery is a moral matter. It pays attention to Angela's positive face needs and can be heard as praise ("you responded very well"). She also mirrors -and thus aligns with- Angela's rationalisation

that failure to respond was down to state of mind ("you got very upset and anxious and had all those things on your mind"). This can be seen as a mitigating or face-saving strategy which orients to Angela's (positive) face needs (Brown and Levinson 1987). In this case it is the need to be seen as a "good patient". She then explicitly links recovery with attitude and improved morale: "but now you're feeling better about yourself…and are more focussed and can concentrate better (.) you're improving in leaps and bounds with your therapy".

This link between therapy and state of mind is underscored further in the extract below where the element of hope for further improvement is introduced.

Doing hope work

Extract 4

1 OT	so (2.0) just tell me again cos I don't want you to get
2	the negative end of the stick I want you to get the
3	positive end of the stick (1.0) what what (.)what have I
4	just (.) told you
5 P	well that I've improved quite a lot (.) and (.)
	[ ]
6 OT	yes
7 P	that (.) if I was more positive from what you've said
8	(.) that I'd probably respond even better to therapy
9 OT	yeh (.) and what abou=

10 P	=I've been delighted that (.) there's a chance
11 OT	yeh
12 P	I mean (.) I really really didn't think stroke
13	patients could get (1.0) even (.) to my stage
14	(laughs)
15 OT	smiles and nods) oh they they can they can get even
16	better than you as well
17 P	mm cos I'm
18 OT	you're gonna improve even more
19 P	been stressing myself out worrying about the children
20	which I don't think I should
21 OT	that doesn't (.) that doesn't help matters Angela I
22	mean I know (1.0) you can't help worrying about your
23	children (1.0) but the worries and anxieties that you
24	have
25 P	(begins to cry) yeh
26 OT	they do affect your therapy
27 P	(looking down and crying) well you can tell it's
28	affecting my children as well as me
29 OT	(softly) yeh
30 P	and I was worried (.) about the fact (.) that in
31	actually I really was beginning to think that because
32	of her letter that you thought I couldn't get better
33	(1.0) but now I realise that you've got a lot of hope

34	in me (.) and I've got faith in you ((3 syllables))
35 OT	(laughing) we wouldn't be bothering with you Angela
36	if we didn't feel ((that))
	[ ]
37 P	(laughs)
38	well I've always had faith in you
39OT	you've had faith in you or faith in us?
40 P	(crying) faith in you
41 OT	well we've always had faith in you
42 P	(crying) occupational and physio very much
43 OT	alright?
44 P	yes
45 OT	you'll make me cry in a minute

The patient presents herself at line 5 as a "good patient" by claiming to have a positive state of mind saying "I've improved quite a lot" and "I've been delighted that there's a chance". The utterance "if I was more positive…I'd probably respond even better to therapy" simultaneously expresses the view that she is morally responsible for her own recovery and introduces an element of hope for future improvements. She promotes her own moral, "good patient" face by comparing her former hopeless attitude with her current one: "I really didn't think stroke patients could get even to my stage" (lines 12-13). The OT takes up the optimistic theme and states with certainty that "they can get even better than that" and "you're gonna improve even more". Angela's next utterance relieves her of accountability

for any previous failure to improve (and thereby is face-saving), but simultaneously acknowledges her moral responsibility to maintain a positive attitude: "I'm been stressing myself out worrying about the children which I don't think I should". The OT gently confirms this perspective at line 21: "that doesn't help matters Angela" and "the worries and anxieties that you have they do affect your therapy", which is a potential threat to her face in the role of "good patient". However, she mitigates it with "I know you can't help worrying", explicitly removing some of the responsibility from the patient. In this way, a shared perspective is constructed where Angela is a good and responsible patient whose failures are excusable.

As A becomes visibly upset, the interaction takes on a more charged atmosphere. At lines 33-34 Angela invokes the almost religious virtues of faith and hope, as reasons to be optimistic about recovery. This is a highly moral discourse in which both patient and health professional express their belief in the other. Therapist and patient align closely with one another as they construct P's recovery as a joint enterprise in which they are both equally involved. That they are on the same footing is evidenced by the joint laughter at lines 35 and 37, and the almost identical utterances from Angela: "I've always had faith in you" and the OT "we've always had faith in you". Notice, however, that the OT maintains a professional, rather than personal face, with the use of "we". Angela reflects this back when she tearfully says "occupational and physio very much". Thus, both OT and patient attribute the moral qualities of hope and faith to the professional

roles of physiotherapy and occupational therapy. It is constructed as a professional, not a personal quality.

In the next extract from the interaction (a few moments later) patient and therapist alignment (Goffman 1981) shifts, as the patient reveals her innermost fears about recovery. She displays a perspective (Maynard 1992) which is not completely in line with the professional ideology of optimism. It is interesting to see how this is responded to by the OT and I suggest that perhaps the professional ethos of optimism is maintained at the expense of supporting the patient in her realistic assessment of her situation.

Hope work threatened.

Extract 5

1OT	what matters now is what we do from now onwards isn't it?
2 P	yes (.) well the best thing to do is concentrate on
3	physical abilities I think (.) because they're not
	[ ]
4OT	yeh
5 P	going to be very good even (1.0) with recovery if
6	you see what I mean
7OT	who says?
8 P	(thinks about it) (1.0) well compared to a normal person
9	it shouldn't it doesn't bother me actually being disabled
10	(1.0) I don't know why it's it's just not go- it's just the

11	idea of going back there that (.) really disables me
12OT	(1.0) this course that I was on over the weekend Angela
13	that I was telling you about
	[ ]
14 P	oh yes yeh
15OT	they were telling me (.) right (.) that (.) people
16	who've had a stroke can make recovery up to two years
17	(.) post event
	[ ]
18 P	(nodding) that's what the doctor told me (.) the week
19	I had it (.) soon as I was sitting up (1.0)
20	after he told me that (.) yes
	[ ]
21OT	so what is it now? it's been
22 P	three months
23OT	three months? four months?
24 P	he said you will be out of here within 3 to 4 month which
25	may sound a long time to you and I thought it didn't but
26	(nodding) it does now (.) now I'm going through it yes
27OT	but your recovery can still continue
28 P	Yes
29OT	two years after you've had that stroke
30 P	(nods slightly)
31OT	so what in what? 2004 (.) you'll be coming to the

32	end of your recovery
	[ ]
33 P	Mmhm
34OT	that is when you can say (1.0) I'm gonna be disabled or
35	(.) whatever
	[ ]
36 P	Yes
37OT	for the rest of my life (.) you might not be
38 P	yeh
39OT	you might not be disabled
40 P	(1.0) mmhm
41OT	alright? (.) but what is it (.) even now Angela at this
42	point in time what is it (.) what can't you do now
43 P	I want to be able to hold my baby (meaning grandchild)
	(The OT then demonstrates how P might manage to hold a baby in her good arm. They then go through Angela"s list of recovery goals, e.g. "bake a cake".)

The OT's utterance at line 1 (what matters now…") is very much in line with the institutional ethos hitherto discussed, whereby recovery is presented as a joint activity that looks to the future. Initially Angela is aligned with this view and she presents herself as knowledgeable ("the best thing to do…", line 2) but then she says something which, deviates from the professional line of hope: "they're not going to be very good even with

recovery" (lines 3 and 5). Even though Angela says "it doesn't bother me actually", the OT challenges P"s perspective that she will be permanently disabled by invoking her professional knowledge: "they were telling me that people who've had a stroke can make recovery up to two years post event" (lines 15-16) and later, "that is when you can say I'm gonna be disabled". Thus, when the institutional line is deviated from, the OT challenges, contradicts and directs the patient, all of which are face-threatening in terms of interpersonal politeness. However, the institutional moral order is re-instantiated via the interaction in which the OT now foregrounds her professional expertise, and authority. In response, the patient re-aligns herself with this point of view, first through confirming "that's what the doctor told me" (line 18) but then with only minimal agreements at lines 28, 30, 33, 36 and 38. The slight pause and then minimal response "mmhm" at line 40 could be interpreted as a sign of only partial alignment and possibly as a withheld disagreement. The OT then demonstrates how a baby might be held in one arm and then goes through Angela's list of recovery goals, such as baking a cake. Interestingly, even though this is said in an encouraging manner, it also somewhat confirms Angela's perspective that her recovery will consist of learning to manage, rather than being back to "normal", as she acknowledged in line 8. Nevertheless, Angela's mention of being disabled seemed to threaten the OT's professional face and motivated her to contradict the patient's assessment of her future abilities.

Conclusion

In the encounters studied in this paper, there is clear evidence of the orientation to the moral order of stroke rehabilitation. In particular, we find that face-work is oriented to both personal and professional face; that is to the negotiation of both an institutional expert/authoritative role as well as a "friendly", more solidary one. I have also shown how the ethos of optimism and self-help for stroke care is enacted through the talk of the medical professionals as well as the patient, all of whom seem at pains to reinforce the professional construct of the highly motivated and expert "good" patient .At the same time, the role of the medical professionals is often constructed as that of "friend", or "friendly expert". In particular, the OT engages in "hope work" which is closely allied to the rehabilitation ethos and is necessary for the projection of a professional image. In the interactions discussed here, the dominance of these institutional faces is brought into relief when the patient momentarily departs from the seemingly required optimism to discuss her fears and expectations of recovery. Even though the patient expresses what may be realistic projections of limited mobility, the OT risks misalignment, and thus personal face threat, with the patient in order to re-establish the discourse of hope.

[1]Key to transcription conventions (adapted from Jefferson 1984)

(.) pause of less than one second

(1.0) length of pause in seconds

(laughs) non-verbal activity

((3 syllables)) unclear speech

[ ] overlapping speech

underlining emphasis

: extra long syllable

= contiguous utterances

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