Title: The pivot-point between problem presentation and advice in a health-helpline service

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Abstract

This paper examines interactions between callers to a health helpline and specialist nurses. Helpline call-takers must judge the appropriate moment to move from listening to the caller's problem to offering them the appropriate service. In a study of Parkinson's UK nurse call-takers, we find that the pivot is the point at which the caller reports the upshot of their trouble in terms of an impact on their daily life. Indeed, if the caller seems likely not to produce this upshot report, it is generated by the call-taker. Using the methods of Conversation Analysis we analyse how these upshot formulations are reached, and how the call-taker subsequently edits them to deliver a service that stays within their institutional guidelines. The findings contribute to sociological and clinical understandings about how health problems are framed and managed interactionally in order to reach a deliverable outcome for both participants in a helpline environment.

Introduction

Soliciting help from a health professional is not a simple matter; interaction researchers have shown that it is a highly organised process, characterised by a number of activities or phases (for a review, see Robinson 2003). Of these phases, the patient problem presentation (Robinson and Heritage 2005) is obviously crucial: for the physician to make a diagnosis, for example, they need (amongst other things)

accurate information about what the patient thinks is wrong with them. From the patient's point of view, this phase of the consultation will feel equally vital: it is the only phase in a medical encounter, Heritage and Robinson (2006) observe, in which patients have the right to describe their concerns in their own words.

Significant as that phase is, it has to be left behind so that diagnosis and dispensation be given. The question, then, is how the participants in the scene come to a tacit agreement that enough has been said, and that the phase can be closed in favour of the next one. In their very useful guide to the problem presentation phase, Robinson and Heritage (2005) suggest that there are rather conventional and explicit "exit devices" (as they call them, following Jefferson's (1988/2015) work on "boundarying off" troubles talk) with which the patient can signal that their account is over: "*... patients' talk that explicitly indexed completion (e.g., And that's why I'm here today). We found that such units tend to be 'exit devices' that are employed after the presentation of current symptoms; such exit devices are designed to communicate completion and to prompt transition into information gathering...*"' (p. 491). The boundaries between one topic and another can be difficult to identify in more mundane environments, due to various features of turn taking designed to link one turn with another (Button and Casey 1985). Topic change may be disjunctive/boundaried (Sacks, 1992) or progress in a more step-wise fashion (Jefferson, 1984a). Typically, transitions are clearer in institutional environments, but this remains an under-researched area. This motivates enquiry as to what other possible devices there may be - particularly in non-present encounters, in which (unlike primary care or other medical consultations, where the physician has the option of physical examination) the next phase is the delivery of the particular service at issue (e.g. advice or support).

Exit devices may also warrant further investigation with reference to their interactional operation. Jefferson (1984a) refers to pivotal[1] turns in non-institutional trouble tellings. These are produced by a trouble's recipient, which can be preceded by '*summing up the heart of the trouble*' (p.202). In that context a pivot refers to a turn that connects to the prior turn but makes talk about other matters relevant, or one that, in Jefferson's words '*has independent topical potential*' (p.203). With further specificity Holt and Drew (2005) present figurative summaries as pivots. In their analysis a turn including or comprising a figurative expression is used to summarise talk about a prior issue. These summaries are not followed by a disjunctive shift to a new topic but one the participants find something related to talk about. How such pivots operate within institutional talk remains unexplored.

Health/medical helpline calls

Hepburn *et al*. (2014) provide a useful overview of supportive non-medical helplines (offering services such as child protection, telephone counseling, mental health support, and so on). Some of these do involve advice giving (though many do not) and have some points of contact with the medical calls that are our focus here. There is increasing interest in such calls, which have covered support for cancer sufferers and their families (Leydon *et al*. 2013) and, with a sharper edge of possible immediate action, calls to the UK's "NHS Direct" triaging service (Pooler 2010).

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[1] It is important to acknowledge that pivots have also been explored by Schegloff (1979) with reference to syntax and Walker (2007) in terms of phonetic design such as where a possible end of one TCU can act as the possible beginning of another.

Of particular interest here is what makes medically-oriented helpline calls different from face-to-face, physically co-present consultations. Obviously, direct physical examination is not possible, but there are many other differences. The purpose of the interaction is less well defined, and there may not be a definitive diagnosis, unlike the primary-care visit, where, as Robinson (2003) reports from his data, diagnosis is almost always delivered. Here, though, a medical diagnosis is not the call taker's role or responsibility, nor is direct medical treatment or referral for medical treatment (as defined by Robinson 2003). In sum, for primary care consultations '*the project has, as its ultimate objective, the solution of patients' problems, which is treatment*' (Robinson 2003: 47). The helpline service's objective is different: to address callers' health related concerns relating to either themselves or in many cases a relative or significant other.

That difference may sometimes prompt awkwardness in the call, as the caller's expectations come up against limits within which the call-taker must operate. An example of when this may be an issue is when callers request specific medical advice but when the provision of medical advice is outside the helpline's remit. Butler, Danby, Emmison and Thorpe (2009) identify three ways that nurses on a child health helpline handled such occasions. They reminded callers of their professional identity as a nurse, and emphasised the epistemic limitations of that role– using statements such as "I'm just a nurse" – or they invoked the boundaries imposed upon them as employees of the helpline. This is the kind of strategy that a call-taker must employ when the nature of the problem established in the problem presentation phase is outside the call-taker's remit, and the caller must be diverted onto a different track.

The problem(s)

The first problem then, is to find how it is, in these helpline calls, that the caller and the call-taker come to a point at which there is an agreement that the problem has been stated, and that the call-taker can move to the next phase. The subsequent problem for the call-taker, thereafter, is to manage the caller's concerns in such a way as to render them amenable to action that the call-taker is licensed to take.

To find at least the beginnings of an answer to those questions, we collected a corpus of data from calls to Parkinson's UK. Parkinson's UK, a national charity, provides a free and confidential telephone helpline offering support and advice to individuals affected by Parkinson's disease and to health professionals working with this client group. Parkinson's disease is an increasingly common degenerative neurological condition that can cause a range of physical, cognitive and social problems. The Parkinson's UK helpline is not designed to offer medical diagnoses or prescribe interventions for health issues. Callers contact the telephone line and disclose to the helpline operator their reason for calling e.g. a medication query, a benefits query or a general Parkinson's health related question. The helpline operator provides advice if it is within their remit or will request an appropriate specialist in the team to provide a call-back" to the caller. Typically the call-back is made within 24-48 hours of the original enquiry. The data accessible to this study comes from a set of telephone calls where a Parkinson's disease specialist nurse has called back an individual who contacted the helpline with a specific query.

The UK Royal College of Nursing (RCN) sets out specific guidelines for practitioners working on telephone helplines for people with long term conditions (Royal College of Nursing 2006). They state that a call should include mutual agreement between the call-operator and the caller regarding a) what the problem is, and b) what help or advice the caller is seeking. While such guidelines are certainly

useful to some degree, they are far from comprehensive. There are few studies that specifically address the telling of the caller's problem and give a detailed analysis of how this complex process works.

In this paper we seek to examine the organisational relationship between two phases, the problem presentation phase and what we see here as the problem explanatory phase. How do the caller and the call-taker arrive at a point where the presentation is hearably over, and what does the call taker do thereafter?

Methodology

The dataset consists of audio-recorded telephone conversations between two specialist nurses and 30 callers to the Parkinson's UK helpline. The majority of callers are people with Parkinson's disease (n=22) with the rest being close family members (n=8). The calls were recorded in two phases: 2011 and 2013.

Calls to his helpline are initially dealt with by non-medically trained operators. This reflects the potential nature of calls that may include requests for general information as well as more specific questions about social benefits, services, housing etc. Callers who present with a non-emergency health/medical problem or query are offered a call-back from a specialist nurse within 48-hours. Basic details and a simple gloss of the reason for the call are then recorded and transferred to one of the specialist nurses for action. A two-stage consent procedure was employed for this study. The first stage requested verbal consent to record the call-back conversation, the second stage requested written consent to release the call to the research team. Requests for consent ended once 30 agreements were in place. All callers who gave initial verbal consent subsequently gave written consent. In the extracts and analysis

the people seeking advice or help are coded 'C' and described as callers, the nurses

are coded 'N'. Recording protocols and ethics procedures were approved by

Parkinson's UK and the University XXX Research Ethics Committee.

In line with conversation analytic methodology (see Atkinson and Heritage

1984) and its application to institutional interaction (see Drew and Heritage 1992 for a

review) we worked with the data inductively and on the understanding that a turn at

talk is a means to perform a social action; that to talk is always to do something

(Schegloff 1996). Our primary motivation was to see how it was that call-takers

managed the dilemma of handling the caller satisfactorily while also staying true to

the prohibition on offering direct medical advice.

Our analysis followed three phases:

1) Recordings were transcribed using CA conventions (see Jefferson 1984b and

Appendix 1 for a transcription key).

2) The data and transcripts were then examined by the authors for orderly patterns of

interaction around the pivotal points where problem-tellings gave way to advice

management. All calls featured the telling of problems and some form of nurse receipt

of these troubles. Among these we identified a considerable subset of calls (12/30) in

which the caller (or occasionally the call-taker) claimed some form of what we call

"problem impact" (that is, some effect of the problem on the caller's life).

3) The call openings, problem-tellings and post-telling uptakes were then examined in

detail drawing on conversation analytic principles of turn design and sequential

placement.

Analysis

The analysis addresses instances where some sort of impact statement arises from a caller's problems. The impact statement typically follows a description of the symptoms or difficulties encountered but, as will be shown, may not be the sole preserve of the caller. We describe two key features: the ways in which impact is delivered and the subsequent uptake of that impact by the nurse.

To introduce the data: the callers have rung the service's reception centre with an initial bid for help, and a specialist nurse then rings them back. The nurse will therefore already have a simple gloss of the caller's problem, such as 'difficulties with medication'. The pattern of these call-backs is generally for the nurse to invite the caller to state their problem or requirement in their own words, and then to deal with it and close the call. Our interest is in the latter part of the caller's account of their problem - what Heritage and Robinson (2006) have analysed in CA terms as the 'problem presentation' - as it reaches its end, and projects a response from the nurse.

Section 1: Problem-tellings and their impact

One recurrent way in which callers design their problem-tellings is to provide a description of their symptoms terminating in some sort of impact or upshot formulation (Heritage and Watson, 1979). Such a statement makes explicit the relationship between the presenting symptoms and the effects these have on the caller's day-to-day life.

The first extract is from a caller who has been experiencing hot sweats at night. We can gloss the body of his account as being the detailing of a series of physical symptoms (hot flushes, getting very hot) and what he has done so far to address them (ventilating the room, wearing only a vest at night). What we are

concerned with is how he ends the account with a statement of the *impact,* or *upshot*

of his problem, at lines 31-33 (in bold).


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Extract 1  – 098

01    N:    I believe you've been having a few problems
02          with (.) hot flushes at night is that right.
03          (0.5)
04    C:    Yes (1.0) er:m (0.8) w-w-what what it is °h(0.5)
05          I'm on medication?
06    N:    Uh-huh
07          (0.5)
08    C:    Erm and(0.8)I find I-I go to bed about half past
09          ten,
10    N:    Okay?=
11    C:    =Normally, and erm-get ta sleep fairly reasonably
12          (0.5) but round about three o'clock (.) °h I'm
13          woken up (0.5) by these hot flushes,
14          (1.0)
15    C:    And my body gets very hot (0.6) and erm now >I-I
16          sleep in a very well (.) ventilated room I must
17          say that.<
18    N:    Okay
19    C:    In fact much more th-°han I'd be sleeping in the
20          back garden put it that way. °h and erm (0.3)
21          but it ah-it takes me (0.3) almost an ↑hour or-all
22          of an hour if you like (.) to cool down,
23          (0.4)
24    N:    Hm-mm.
25    C:    I: make a point of using that opportunity to go
26          to the loo and I wear (0.3) >I only go to sleep in
27          a vest a night< (.) so that uhuh (.) that gives my
28          body a chance to cool down.=
29    N:    =Ah huh
30    C:    And (.) >I find thut this< this disturbs my sleep
31          to such an extent that (0.2) makes i:t er makes
32          me (0.2) uh it make it makes it bad fer me during
33          the day [(2 syllables)
34    N:            [That's right ((continues))
```

The nurse could, in principle, have come in at many points in the caller's account (e.g.

at lines 14 and 23); but she holds off until he has himself delivered what both parties

take as being the pivot point: the effect that the reported symptoms are having on him.

In lines 30-33, he relates the problem of hot flushes to their effect on his day-to-day

living: 'this disturbs my sleep to such an extent that it makes it bad for me during the

day'. The complaint here is framed in terms of symptom impact. One consequence of

the hot flushes is that it affects his sleep, as mentioned already (line 13), but it is the impact on his everyday life that he chooses to end with (or, more precisely, that he offers as one possible end among other possible ends, and is taken up by the nurse). There seems to be something about bringing out the effect on one's life that signals the appropriate point of hand-over from troubles-teller to troubles-recipient.

The second example suggests that the practice may be a recurring one. Here the caller is the husband of a person with Parkinson's disease. That he has called to talk about his wife is established in the initial exchange. The problem he describes is the ability to cope with a combination of his wife's depression and Parkinson's disease.

Extract 2 – 069

```
01   N:   ⌈I believe ⌉ it's regarding your ↓wife whose
02   C:   ⌊Yeah      ⌋
03   N:   bin havin⌈(.) a few problems recently.         ⌉
04   C:            ⌊That's right yeah she's yeah she's not⌋
05        yeah oh yeah she's not at all well y'know
06        °h coz she's deep-erm: s-been treated for
07        depression ya see fa-sort of depression (.) she been
08        partly treated fer depression but um °h en then
09        about °h last january y:'know they told us that er
10        she's been diagnosed with parkinson's ya see,
11        s⌈o ⌉
12   N:    ⌊uh⌋-huh
13   C:   we got the two together en it's: not °h very (.)
14        easy to handle is it °hu-huh
15   N:   No: it's ↑very difficult I mean °h sometimes um
             ((continues))
```

Following the nurse's invitation to describe his wife's problems (see Robinson 2006), the caller initiates with a summary gloss regarding his wife's health status: 'she's not at all well' (line 05). He then details the main problems in medical diagnostic terms, a combination of depression and Parkinson's disease. His initial attempted formulation describes his wife as depressed but this is reformulated to being treated for depression

and then partly treated for depression. It is at this point that the caller launches what will be the pivot point, where the nurse can take a turn: a summary of the case as having a life-impact on both his wife and himself ('it's not very easy to handle'). The nurse is given further licence to take a turn by the caller rounding it off with the tag question 'is it'; and she duly does so.

Extract 3, below, shows another example of the same kind. Here the caller's complaint is a painful toe, something that has been experienced previously. This arises early in the call but is followed by an extended trouble telling sequence featuring, as in Extract 1, a number of self-help attempts (Edwards and Stokoe 2007). Rather than show the entire account, we can now focus on the lead-up to the pivot point at which the caller reveals the impact of the complaint on her everyday life, and the nurse responds.

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Extract 3 - 121


  13   N:   Ah: how cun I help?
  14   C:   (.) Erm I've got (.) I've had this before and it
  15        passed it went, it was erm er sometime last year erm I
  16        have erm really painful (.) big toes but one's more
  17        so than the other >but it< I think it probably
  18        would be cause it's  my right side that's affected,
  19   N:   Mmm hmm
  20   C:   Erm and it's my big toe on my right foot and my
  21        husband's bless him, he's been rubbing some oils into
  22        my toe in the evenings I get waves of pain through it,
  23   N:   Right
             ((a number of turns deleted; caller eventually
             mentions going to the gym))
  50   C:   …four mornings a week cause I'm passing it on the way
  51        into work so I'm not coming out there °h like a tomato
  52   C:   sweating [but I ]am doing  erm things like legs bums
  53   N:           [Right ]
  54   C:   where it's helping with my balance?=
  55   N:    [Yes ok]
  56   C:   =[doing ] things like lunges and things erm,
  57   N:   Yep
  58   C:   So I'm doing all-I'm doing everything that I can but
  59        (.) this is erm hindering me Ha
  60   N:   Ye[ah  ]
  61   C:     [MORE] than anything >but [it's]<  erm it's really
  62   N:                               [Yes ]
```

```
63   C:   painful?
64   N:   Yep
65   C:   But erm I don't know what to do about it.
67   N:   ↓Ok and this is >jus the one toe< and does it does it
68        erm is it (.)does the toe sort of stick up (.) a bit
```

Note again the nurse's displays of incipient speakership (at lines 55, 57, 60, 62 and 64), and, again the caller's holding on to speakership until the delivery of the impact on her everyday life, ending with what can be subsequently treated by the nurse as specific entry point, as if in response to a call for help: 'I don't know what to do about it' (line 65).

The call-taker provides the upshot if the caller doesn't

So far it is reasonable to conclude that a display of impact is the preserve of the problem's teller. This makes sense given their direct experience of, and epistemic claims to, the preceding symptom(s) presentation. There are, however, some revealing cases where the caller's account seems not to be on a trajectory towards an impact, or where the nurse decides that enough of the account has been given to allow her to intervene; and then what happens is that it is *she* who provides the upshot-formulation that allows her to begin the advice phase. The point to stress is that it seems that it is this upshot (whether volunteered by the caller, or provided by the nurse) that is doing the work of marking the transition point from problem telling to problem receipt.

In the extract below it is worth showing the full development of the caller's account to reveal how it is apparently drifting in detail; note how it is the nurse, and not the caller, who comes in to provide the upshot in line 117.

Extract 4 — 116

```
            ((a number of turns deleted during which the caller
            describes the recent conformation of her diagnosis and
            then begins to list her symptoms))
97    N:    Is it is it a tr-tremor that you have.
98          (0.3)
99    C:    Well I've sort of got a tremor i:n both[arms really,]
100   N:                                           [Uh hum        ]
101   C:    but as much as anything it's my walking that worries
102         me [I'm  ] (0.2) I'm very unsure,
103   N:       [right]
104   N:    Yes [yes]
105   C:        [Erm] and ((background voice)) ah [pa ha ha     ]
106   N:                                          [What's what's]
107         he sayhing?
108   C:    He's making er funny er ah er funny er a what did you
109         er what did you say? >funny actions<.
110         ((background voice))
111         ↓oh: yes I'm finding it difficult to ↓eat I can't eat
112         with a (.) a knife and fo:rk [er          ]
113   N:                                 [↓Oh right]
114   C:    I use I can use a fork in the right hand
115   N:    [Right]
116   C:    but I can't use [(2 syllables]
117   N:                    [So the-THESE] these symptoms
118         are getting in the way of of ↓life a bit aren't they.
119   C:    Oh they are yes they definitely are
```

The details of the caller's account (tremor, the exact way she can use a fork) - and

possibly, the potentially disruptive presence of a third party in the conversation (lines

105-110) allow or prompt the nurse to offer an upshot along the same kind of

vernacular lines as we have seen above produced by the caller: these symptoms are

'getting in the way of life a bit'. It is this that forms the pivot into her own phase of

advice giving (not shown here, but to which we return when we see this case again in

section 2).

In summary, then: a recurrent feature of the calls is that the caller provides an

account, but that for the nurse to be given a clear opportunity to move into the advice

phase, a summarising impact statement is provided. This is usually done by the caller

(who is, after all, the one who 'owns' the experience - in Heritage's (2012) terms, who

is epistemically entitled), but may be done, perhaps as a short-circuit, by the nurse.

Stance and generality in the impact-pivot

What can we say about these upshot formulations, and why they might be useful as pivot-points to allow the nurse to embark on the advice phase? Two features suggest themselves:

a) *Stance*. The fact that the caller has arrived at a summarising upshot displays that they have, indeed, finished the detailed catalogue that the upshot formulation is to be taken as summarising, and works to alert the nurse that the point of hand-over has been reached. There are two features that lend themselves to this reading. One is the strongly axiomatic element in many of the pivots, reminiscent of what Holt and Drew (1988) find in idiomatic phrases being used to terminate accounts (in, as it were, an unarguable way). The other is the summary's emotional stance, the: this will work as a clear signal to the recipient of what corresponding stance to adopt in displaying her assessment of the caller's case.

b) *Generality*. By moving away from the details of the physical symptoms, the upshot protects the caller's case from being reduced to any one specific symptom (that is, it prevents the nurse focussing on just the detail of the time at which they feel hot, rather than the general problem of flushes; or on the use of the non-preferred hand for eating, rather than the general problem of tremor; and so on), and giving a broader, less specific scope for the nurse's advice. By the same token, were it to be the nurse who offers the upshot (as in Extract 4, above), then it displays that she is orienting to the caller's general concern and not to the more contingent details of the catalogue of symptoms that the caller has provided.

Section 2: Uptake of the impact

Having identified the impact as the pivot out of the caller's problem, we can move to see how the nurse deals with it. Her opportunity now is to use this summary not only as a prompt to show her understanding of the caller's life-world problem (to use Mishler's (1984) familiar term), but also an opportunity to preface her subsequent institutional, medical-world work with what we can refer to as an *uptake*.

```
Extract 5  - 098

30    C:   And (.) >I find thut this< this disturbs my sleep
31         to such an extent that (0.2) makes i:t er makes
32         me (0.2) uh it make it makes it bad fer me during
33         the day ⌈(2 syllables) ⌉
34    N:           ⌊That's right  ⌋ it does have a big impact
35         doesn't it, I I think y'know what we find
36         is °h um y'know (0.2) hot sweats um particularly
37         at night are-can be a common problem. I mean
38         you're doing everything that um you know practical
39         that you can ↓do like keeping your room well
40         ventilated (.) um an things like that but
41         ↑sometimes its t-you know having too much
42         perspiration can be a side effect of the
43         parkinson's medications
```

The uptake begins with the nurse confirming the caller's symptom impact at lines 30-33. That is the pivot-point into her response. She acknowledges the caller's problem: 'that's right' (line 34), but notice that she does so with the tag question *doesn't it*. This has the effect (Hepburn and Potter 2010) of asserting the nurse's *own*, prior, judgement of the significance of the caller's symptoms, as well as providing confirmation of the status of the caller's problem as something nurse-able. As a tag question, it also acknowledges the caller's access to this knowledge, and as a turn-medial tag question, it softens the response requirement. This allows what Jefferson (1984a) would call a step-wise topical move from the (now disarmed) unique and particular experiential nature of the caller's complaint to whatever can be said about it from, as it were, a non-news angle.

With the topic now prepared for non-particular treatment, the nurse eschews reference to specifics (hot flushes) and instead invokes the commonality of the problem: that is, a problem that is both familiar to the medical community and one that is not particularly exceptional in Parkinson's disease. The nurse concedes some recognition of the particularity of the caller's situation but only as a prelude (Author 1999) to the delivery of the salient point: the underlying physiological causes (lines 41-43). The hot sweats are now referred to as 'having too much perspiration' and are linked to the side effects of medication (first introduced by the caller –Extract 1, line 5). This physicality and medicalisation paves the way for the later disposal of the call, when the nurse offers a leaflet on 'skin, scalp and sweating problems'. It may be further noted that the nurse, aside from acknowledging the impact of the symptoms, is not directly addressing any emotional aspects associated with the caller's problem presentation.

We see again in the extract below the nurse's exploitation of the pivot-point to uptake the caller's situation in a medicalisable way. Once more, this is a continuation of an extract first seen above (Extract 2).

```
Extract 6 – 069

13   C:   we got the two together en it's: not °h very (.)
14        easy to handle is it °hu-huh
15   N:   No: it's ↑very difficult I mean °h sometimes um
16        y'know what we find with parkinson's is °h
17        ↑parkinson's is caused by this lack of this
18        chemical called dopamine in the ↓brain, °h
19   C:   ⌈Right  ⌉
20   N:   ⌊en that⌋'s produced in the area of the brain
21        ri:ght next to the area of the brain that controls
22        controls mood, so somet⌈imes parkinson⌉'s cun cun
23   C:                          ⌊Oh: right     ⌋
24   N:   y'know make the-the depression symptoms worse
25        or some peo⌈ple cun present⌉ with depression
26   C:              ⌊Oh:    right   ⌋
27        before they °h um are diag↑nosed with Parkinson's
```

In the first instance the nurse receipts the caller's impact statement through an upgraded evaluation of 'not very easy to handle' to 'very difficult' (line 15). Through this upgraded assessment the nurse is displaying an agreement with the caller (Pomerantz 1984) and validating the caller's problem as legitimate. But within the same turn she shifts talk away from the caller's ability to cope (his emotional state) and towards a physical neurochemical account of the disease. This shift to a depersonalised disease oriented position appears to ignore the caller's trouble but the hesitancy and restart (lines 15-17) is indicative of an attempt to preface subsequent talk with an explanatory account of what may appear to be two separate problems. The nurse then offers a reason for why Parkinson's disease may be associated with depression. The newsworthiness of this is evidenced by the caller at line 26.

Subsequent talk (not reproduced here) supports the claim that the nurse's shift to an explanatory account, grounded in the physical rather than emotional or psychological, is displaying her treatment of the problem as a practical issue to be addressed through practical advice, such as signposting to appropriate medical care, rather than a call for emotional help. We also note a degree of caution in the nurse's uptake. Her use of 'sometimes' (line 15) hints in part at the uncertainty of attributing reported symptoms to the underlying disease.

```
Extract 7 – 121


58   C:   So I'm doing all-I'm doing everything that I can but
59        (.) this is erm hindering me Ha
60   N:   Ye[ah  ]
61   C:     [MORE] than anything >but [it's]<  erm it's really
62   N:                                [Yes ]
63   C:   painful?
64   N:   Yep
65   C:   But erm I don't know what to do about it
67   N:   ↓Ok and this is >jus the one toe< and does it does it
68        erm is it does (.) the toe sort of stick up (.) a bit
69   C:   Yep
70   N:   Yeah ok erm it sounds as >if what they call it< it
71        it's something called dystonia and it's like a sort of
72        cramp and it's really really common
```

```
73   C:    Ok
74   N:    Erm and it can s- does it does it tie in with erm
75         doses of medication?
```

The uptake in Extract 7, above, is again at the pivot-point following the
caller's complaint upshot formulation. The nurse's first action is to seek to confirm
the exact presentation of the toe problem. This is not a direct response to the caller's
aforementioned hindrance, pain or inability to act but rather an orientation to the
physical complaint itself. The caller's confirmation enables the nurse to progress to a
medicalised label. This is carefully crafted not as a direct or formal diagnosis,
something the nurse is not entitled to do on the helpline, but rather a sympomatic
label by proxy – something 'they' call it and which 'sounds as if' rather than
categorically is. 'They' here may well be referring to medical professionals who can
legitimately confirm the diagnosis. Again, as with the uptakes in Extracts 5 and 6, the
nurse frames her uptake with reference to physicality both in terms of the question she
asks at lines 67-68, and in her subsequent explanatory account at lines 70-72. The
nurse ends her explanatory turn with reference to commonality, as with the uptake in
Extract 5. This commonality again being dual purpose as both unexceptional in
Parkinson's disease, and one that is well known to medical professionals.

In Extract 8 (as shown in Extract 4 above) is the nurse who offers an upshot of the
caller's problem presentation. This has the function of closing down the problem
telling phase and enabling the nurse to progress the talk towards advice giving.

Extract 8 — 116


```
111          ↓oh: yes I'm finding it difficult to ↓eat I can't eat
112          with a (.) a knife and fo:rk [er         ]
113   N:                                  [↓Oh right]
114   C:     I use I can use a fork in the right hand
```

```
115  N:    [Right]
116  C:    but I can't use [(2 syllables]
117  N:                    [So the-THESE] these symptoms
118        are getting in the way of of ↓life a bit aren't they.
119  C:    Oh they are [yes they definitely are]
120  N:                [Yes yes yep yes        ]
121  N:    so your your ya know it isn't unreasonable that you
123        would like to see somebody about them and if-if it is
124        parkinson's there's medication available that can
125        treat symptoms erm a-and and hopefully things would
126        would improve for you. erm what I would say there
127        there are a-other conditions that sometimes mimic
128        parkinson's as >ya know< there's things like sem
129        something called essential tremor and things like
130        that but if [it's] your if  it's your walking that's=
131  C:                [Yeah]
132  N:    =affected and it isn't just a tremor I I think you ya
133        know you really would like to see a neurologist
143        I would think.
144  C:    Yes.
```

The caller's emphatic agreement (line 119) with the nurse's upshot turn provides a next turn opportunity for the nurse to deliver post-impact advice talk. In this case it is characterised by signposting to a specialist. Notice, however, that she does not immediately and unilaterally recommend seeing the neurologist; that might perhaps have seemed too brusque. Instead, she first offers an empathic assessment that what the caller has to cope with: it *isn't unreasonable* (line 121). That is 'taking her side' as Heritage and Raymond (2005) put it, in their analysis of assessments of others' experiences of which one has no direct knowledge. Her orientation to the material that worked as a pivot, before delivering her advice, is testament to its interactional importance. As with the other Extracts in this section we note that in the nurse's uptake there is recourse to medication and physicality, despite the problem presentation being framed as a daily living activity issue. There is also an element of caution that again displays the nurse's uncertainty in categorically associating reported symptoms, such as a tremor, to Parkinson's disease itself.

Discussion

The problem we set out to address in this paper was how a caller and a call-taker reached a position where the caller's problem-presentation could be understood to be complete, entitling the call-taker to move to the next phase of the interaction. We knew that previous literature had identified such formulae as *And that's why I'm here today* as what Robinson and Heritage (2005), following Jefferson (1988/2015) call "exit devices", but we felt that there might well be other, more subtle, practices that achieved the same result. Our analysis of calls to a helpline for people with Parkinson's disease suggested that one powerful practice was for the caller to display completion by adumbrating the unhappy effect of their problem on their daily lives. That is, bringing out the personal impact of the symptoms they described. Indeed, we found that this identification of impact was so robust that it if it was not provided by the caller, it would be supplied by the call-taker.

We will now examine key features of impact / uptake work with reference to the wider functions of the helpline and the nurse's role within it. One crucial feature of the pivoting upshot formulation is that it shifts away from physical symptoms and self-management strategies, towards an experiential outcome or real-life impact. Such an impact might be presented in a variety of forms, but the impact on day-to-day life appears to be a common feature. What might such a construct be doing? On the one hand it might be a matter of the caller upgrading the completeness-sounding of their account, given that the call-taker has so far withheld uptake. Alternatively, or additionally, specifying upshot allows the caller to invoke an impact for themselves even though the original reason-for-call was trouble experienced by *other* people in their lives, making a directly empathic assessment more expectable (Heritage and Raymond 2005). In Extract 2, for example, it is the husband who describes the difficulties his wife has experienced (Parkinson's and depression) but it is an inability

to cope that is presented as the impact. This enables the husband to enter into the first-hand problem account rather than remaining in a proxy role.

The design and organisation of these impact statements is - certainly as compared to formulae such as *And that's why I'm here today* - by no means simple or straightforward. Extract 3 in particular shows the caller initiate her impact statement 'so I'm doing everything I can but this is hindering me' with no recognisable problem uptake by the nurse. She adds further impact details regarding pain before saying 'I don't know what to do about it'. It is this more marked incapacity that works as a recruitment (as Kendrick and Drew 2016 term requests for assistance) of the nurse as a provider of help. A final point can be made regarding impact. We have shown that this need not be the sole preserve of the caller. As shown in Extract 4, the nurse may also generate an impact statement suggesting that this construct is available to both participants and that whilst it may not be a necessity for progression, it does hold some currency in enabling the nurse to offer a specific type of next turn response, namely an uptake.

With reference to the nurse uptake there are several features that inform a broader consideration of the help-line remit and what the nurse is and is not enabled to offer. We note that following an initial next turn receipt of the impact the nurse highlights the physicality of the problem. There may be good reasons for this insofar as it grounds the problem in terms the nurse can then address. Maynard and Heritage (2005: 431), refer to the ways in which patients seem to justify and legitimise their reasons for seeking medical help, that is, the '*doctorability* of their problems'. What we see here may be part of this legitimisation. By framing the problem in physical terms the nurse is laying a path towards a hearably doctorable, or perhaps nursable, solution. At the same time the nurse does not attend to an emotional route of care.

Some degree of distress may feature in the caller's account but the nurse does not follow this through as distress. The problems are medicalised in next position. We see this markedly in Extract 6, in which an initial impact receipt ('no it's very difficult') is promptly followed by a neuro-anatomically grounded explanation of the aforementioned problems. There is no explicit barrier to showing empathy or exploring emotional problems on this helpline but the data reveals a strong orientation to physically framed uptakes in line with physically presented symptoms irrespective of any emotional or psychological impact.

Together with physicality we also note reference to the commonality of the problems presented, linking the caller's issues to a wider community of people with Parkinson's disease. As well as offering reassurance (a known and understood issue) this may have the function of situating the caller's problems within the professional expertise of the nurse and also showing the problem as one recognisably linked to Parkinson's disease and therefore validating it as something worthy of interest, and relevant to this particular helpline. It enables the caller to hear whatever is to follow as something to do with Parkinson's disease and therefore a legitimate line of enquiry for both participants. This commonality may also have the advantage of channelling the call towards a more generic form of advice rather than specifically tailored to the caller's individual circumstances. The nurse is not permitted to address medical issues directly through this helpline but what she can do is signpost the caller to appropriate medical services (see also Hepburn *et al*. 2014).

An additional identifiable feature of these uptake turns is one of caution. The nurses' accounts are rarely absolute; this is observed in all four of the nurses' post-uptake accounts of the symptoms. Difficulties in communicating uncertainty of risk in medical interactions is a recognised issue (Politi *et al*. 2011) but here the issue is more

aligned to the contextual constraints of the helpline. The nurse cannot physically examine the caller, has no access to medical notes, nor can she verify the accuracy of the caller's self-reported symptoms. Her uptake is therefore couched in non-absolute terms. This is further exemplified by the nurse's approach to diagnostics. A formal diagnostic classification of Parkinson's disease is explicitly not within the nurses' remit. However, more informal diagnostic work is exhibited through the nurses' uptakes. By acknowledging the impact of symptoms and moving promptly to link these symptoms to a wider classification of Parkinson's (as with reference to commonality in extract 5), the nurses are, at minimum, maintaining the relevance of the diagnosis to the current conversation. There is of course evidence of what may appear to be diagnostic talk. In extract 7, for example, the nurse labels a described problem as *dystonia* (referring to persistent or intermittent muscle contractions), albeit as a problem firmly embedded within a higher diagnostic classification. In what appears to be diagnostic talk the nurse is addressing a symptom known to be associated with neurological disorders like Parkinson's disease.

It should also be added that a clear impact-uptake practice was identified in thirteen of the thirty calls. Other practices include callers asking for advice directly or presenting a medication-based dilemma resulting in extended question-answer sequences. These other practices will be presented in subsequent publications.

Concluding remarks

Caller and call-takers face the joint problem of negotiating a problem that is solvable by the institution that the call-taker represents. In what seems (to the caller) to be a medically-oriented helpline, the premium - from the caller's perspective - may be on presenting a problem which requires, and receives, a medical solution. But the call-

taker's entitlements may stop well short of making a diagnosis, or giving clinical advice. So there are two countervailing forces at work in how the caller's presentation is dealt with: one the one hand it has to be hearably brought to full completion, so that the next phase of the call can be launched; but it also has to be hearable as the kind of problem which might be shaped by the call-taker into an institutionally-appropriate form. Perhaps that is why we see, in these Parkinson's UK helpline data, orientation by both caller and nurse to delivering the problem as being a matter of the caller's personal, life-world consequences - serious and worthy of the nurse's attention, but transformable into the kind of problem that she can deal with, well within the limited powers at her command.

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Appendix 1: Transcription key (see also Jefferson 1984b)

A.   Some aspects of the relative timing of utterances

[square brackets   Overlapping talk

= equals sign   No discernible interval between turns

(0.5) time in parentheses   Intervals within or between talk (measured in tenths of a second)

(.) period in parentheses   Discernible interval within or between talk but too short to measure

(less than 0.2 of a second)

B.   Some characteristics of speech delivery

Punctuation symbols are designed to capture intonation, not grammar, and are used to describe

intonation at the end of a word ∕ sound, at the end of a sentence or some other shorter unit:

. period   Closing intonation

, comma   Slightly rising intonation (a little hitch up on the end of the word)

? question mark   Fully rising intonation

- dash   Abrupt cut off of sound

: colon   Extension of preceding sound – the more colons the greater the extension

here underlining   Emphasised relative to surrounding talk

.tch or .t   Tongue click

hhh.   Audible outbreath (number of h's indicates length)

.hhh   Audible inbreath (number of h's indicates length)

>Talk<   Speeded up talk

Hah hah or huh huh etc.   Beats of laughter

((word)) words enclosed   Transcribers' comments in double brackets