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**Who gets to speak next: The patient  
with intellectual disabilities, her  
mother and her nurse**

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# Who gets to speak next?

## The patient with intellectual disabilities, her mother and her nurse

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### Abstract

People with intellectual disabilities experience marked health inequalities and inadequate healthcare is a major contributing factor. Nurses and other clinicians are urged to address this and adjust their communication to maximize the engagement of the patient with intellectual disabilities. However, there is limited research that examines how they are managing this in practice. So the aim of this study was to explore how clinicians manage the communicative challenges involved in triadic health consultations involving patients with intellectual disabilities and a companion by examining video recordings of naturally occurring health consultations. Selected as a 'telling case', the data presented here offers important theoretical insights about triadic health interactions. Detailed interactional analysis was undertaken using Conversation Analysis of a case drawn from a data set of 34 videos of patients with intellectual disabilities attending their NHS health check, recorded between July 2016 and July 2017. Analysis focused on how the allocation of speakership was organized in the interaction, and it revealed the micro-practices in play, particularly the mechanism of gaze, that contributed to the exclusion of the patient with intellectual disabilities as the key informant on her own health. The interactional behaviour of all three participants contributed to the distribution of speakership within the interaction. The study illustrates how the category of 'intellectual disabilities' is dynamically constituted in healthcare settings. Micro-analysis of real-life health interactions can highlight avoidable pitfalls for clinicians who are committed to promoting the participation of patients with intellectual disabilities in healthcare.

*Keywords:* Intellectual disabilities, nurses, primary care, health checks, conversation analysis, family carers, health communication

### Background

Over the last couple of decades there has been growing evidence that people with intellectual disabilities experience marked health inequalities (Emerson & Hatton, 2013; Ouellette-Kuntz, 2005), and have a life expectancy that is 15 -20 years shorter than the rest of the population (Heslop, Blair, Fleming, Hoghton, & Russ, 2013). Research and investigations have concluded that many of these premature deaths are preventable (Krahn, Hammond, & Turner, 2006) and linked to poor communication between people with intellectual disabilities, their family and paid carers, and health staff (Krahn et al., 2006).

In the UK recent policies, procedures and legislation have been introduced to address these disparities, including the NHS Accessible Information Standard (NHS England, 2015) and guidance for nurses (Royal College of Nursing, 2013) and doctors (Hoghton, 2010). These documents reflect an ideological commitment for health services to involve people with intellectual disabilities as much as possible as autonomous agents in their own healthcare, and to the impact on health outcomes of engaging people with intellectual disabilities as informants on their symptoms, as decision makers and as self-managers of their health conditions (Walsh & McConkey, 2009; Wullink, Widdershoven, Van Schroyenstein Lantman-de Valk, Metsemakers, & Dinant, 2009).

These tasks may present interactive challenges when there are questions about the patient's competence to verbalise their embodiment and their healthcare preferences. Many of us may struggle to produce clear, 'doctorable' accounts of our medical troubles when we are distressed or in pain, and we may choose to enlist a supporter when we present in medical settings, whom we can also turn to for emotional support and communicative assistance. There are clearly important contributions that the third party can make during the consultation, especially if the patient with intellectual disabilities has problems with remembering, with describing bodily sensations or with making sense of the doctor's questions (Mastebroek, Naaldenberg, van den Driessen Mareeuw, Lagro-Janssen, & van Schrojenstein Lantman-de Valk, 2016), when they are unable or reluctant to speak, or when they provide only short and unelaborated answers to questions.

However, there are also risks that the third party will 'overstep the mark' and will suppress the contribution of the patient with intellectual disabilities by answering questions on their behalf (Hutcheon, Noshin, & Lashewicz, 2017; Mastebroek et al., 2016), even when the patient is selected as a respondent. As well as effecting the 'communicative disenfranchisement' (Coupland & Coupland, 2001) of the patient with intellectual disabilities and undermining their authority, autonomy and adult status, the supporter runs the risk of misrepresenting them (since presumably it is the patient him- or herself who is the authority on their own embodiment) and of providing incomplete or inaccurate information.

Medical staff have also been accused of colluding in this exclusion of the patient's voice by failing to adjust their talk in line with the patient's individual communication needs, or by directing their questions at the supporter who is placed in the position of key informant (Murphy, 2006; Ziviani, Lennox, Allison, Lyons, & Mar, 2004). However, these accounts of medical exclusion have been drawn almost exclusively from post-hoc interviews with medical staff, people with intellectual disabilities and their supporters (Ali et al., 2013; Jones, McLafferty, Walley, Toland, & Melson, 2008; Ziviani et al., 2004). There is no need to doubt the abiding impression that participants in medical encounters with intellectual disabilities are left with: that these consultations are often not run of the mill and require particular thought and careful planning (Wullink, Veldhuijzen, van Schrojenstein Lantman-de, Metsemakers, & Dinant, 2009). However, we do not yet have a body of evidence drawn from observations of people with intellectual disabilities talking with nurses and doctors which helps us identify the embodied interactional practices that result in the perceived exclusion of these patients from healthcare interactions. This sort of detail is required in order to go beyond the rather vague and idealized guidance given to practitioners that clearly they find difficult to implement (Perakyla & Vehvilinen, 2003).

### *Conversation analysis and people with intellectual disabilities*

Focusing on what actually happens in healthcare communication using Conversation Analysis (CA) has proved extremely illuminating in revealing the unspoken interactional rules that structure the conduct of clinician-patient encounters (Barnes, 2005; Maynard & Heritage, 2005). CA involves analysis of naturally occurring talk in order to understand how individuals use speech and aspects of bodily conduct such as gesture, gaze and posture, to accomplish social actions (Hutchby & Wooffitt, 2008). Particular attention is paid to the sequential organization of talk and what this can tell us about how social relationships are managed through the dynamic negotiation in interaction of claims to authority and knowledge, of demonstrations of affiliation or resistance, and the constitution of social identities (Antaki & Widdicombe, 1998).

Instead of assuming that a category such as ‘intellectual disability’ can account *a priori* for the way that interaction involving individuals with this label is organized, CA studies have traced how this identity is worked up within ‘talk-in-interaction’, highlighting situations in which the usual interactional preferences in conversations between competent adults, such as face-saving and being allowed to ‘speak for oneself’ (Lerner, 1996) are overridden (Antaki, Walton, & Finlay, 2007; Finlay, Antaki, & Walton, 2008; Jingree, Finlay, & Antaki, 2006).

### *Speaker selection in multi-person health interactions*

The interactional practice in focus here is that of speaker selection; the orderly way that participants effect a transition from one speaker to the next. In their foundational paper on turn-taking in conversation, Sacks, Schegloff and Jefferson (1974) outlined normative conversational practices for coordinating turns at talk. Once a speaker has completed his/her turn at talk (usually having accomplished some social action, such as greeting, requesting information, inviting, offering etc.), the determination of who speaks next follows three possible options:

- a) the person selected by the speaker takes the next turn.
- b) any other party self-selects, if the first speaker did not select someone to talk next
- c) the current speaker has the option to continue in the absence of making a selection for next speaker, or someone else self-selecting.

Selecting someone to speak next involves composing a turn-at-talk that constitutes the ‘first pair part’ of a sequence that expects some sort of response (such as a question) and addressing it to a specific co-participant. The addressing is commonly accomplished either through the first speaker directing their gaze at the addressee or using an address term (often the person’s name) (Lerner, 2003). There are also less overt ways of addressing, for instance making it clear when there is more than one other person present, that only one person is eligible to speak next, either by virtue of an invoked social identity, or because they possess unique knowledge or experience that is relevant to the response.

These resources are particularly important in multi-party interactions, when use only of a second person address term (‘you’) would indicate a single recipient is being addressed without designating specifically who is being referred to (Lerner, 2003). However, there are circumstances in multi-party interactions when someone other than the obvious addressee might select themselves to take the next turn. Stivers and Robinson (2006) note that there is a preference for progressivity in conversation that can trump allocated next speakership. If no response is forthcoming from the allocated next speaker, it seems that participants orient to the need to keep the interaction on track, and other speaker will jump in.

There is a growing literature on ‘triadic interactions’ in healthcare that involve a clinician, a patient and another (or other) supporting individual(s), who may be relatives, staff, or friends. Work in paediatric settings has unpicked the relational dynamics between doctors, their young patients and the mothers and fathers who accompanied their children to the doctors (Silverman, 1987; Stivers, 2001, 2012). Other studies have examined how roles in talk are distributed in triadic consultations involving older adults (Coupland & Coupland, 2001), patients with aphasia (Barnes & Ferguson, 2015) or in the audiology clinic (Ekberg, Meyer, Scarinci, Grenness, & Hickson, 2015).

These studies reveal a great deal of variability in the involvement of third parties in medical contexts. They also show that the variability can be shaped by different factors: not only the characteristics of the participants such as patient’s age, and presenting problems (Laidsaar-

Powell et al., 2013; Stivers, 2001), but also the local context of the talk itself, such as the phase of the consultation (opening, examination or diagnosis and treatment recommendations), how participants are addressed, and whether clinicians manage third party incursions into talk with resistance or acquiescence (Ekberg et al., 2015; Karnieli-Miller, Werner, Neufeld-Kroszynski, & Eidelman, 2012; Solomon, Heritage, Yin, Maynard, & Bauman, 2016) .

## **Current Study**

The aim of this study was to explore how clinicians manage the communicative challenges that arise in triadic health consultations that involve patients with intellectual disabilities and a family carer. The focus of the study is how all participants negotiate who gets to speak next when the nurse asks a question about the patient's health or healthcare.

### *Design*

The data presented here is drawn from a qualitative CA exploration of healthcare communication in single case study, selected as a 'telling case' (Mitchell, 1984) that does not claim to be typical or representative, but offers new theoretical insights into the challenges of promoting the participation of patients with intellectual disabilities. Focusing on one case, where multiple examples of the same phenomenon are presented within a single interaction is not an uncommon procedure in CA research, especially with 'atypical' communication groups where initial detailed exploratory work is required (Garcia, 2012).

### *Participants*

The wider data set consists of 34 audio and video recordings of people with intellectual disabilities attending an annual health check at their general practitioners. These annual health checks were introduced in England and Wales in 2008 as a 'reasonable adjustment' to primary healthcare services as required by UK equalities legislation. GPs are incentivized via an additional payment to complete annual health checks with their registered patients who are identified as having intellectual disabilities. The programme has been a qualified success. Around half of registered patients receive a health check each year, with beneficial results for the detection of previously unreported health conditions, provision of health promotion and referrals on to secondary care services (Buszewicz et al., 2014; Robertson, Roberts, Emerson, Turner, & Greig, 2011).

GP practices across London were recruited to this research through National Institute for Health Research (NIHR) primary care clinical research networks and were eligible for inclusion if they had undertaken at least 5 learning disability health checks during the previous 12 month reporting period. GP practices who participated in the study were asked to contact registered patients with intellectual disabilities who were over the age of 18 and did not require support from an interpreter, to invite them to take part in the research. Interested patients who gave their permission to share their contact details received a follow up phone call from the researcher. Any GP staff (doctors, practice nurses, healthcare assistants) who conducted learning disability health checks were eligible to take part. Sampling was opportunistic, though efforts were made to include a range of staff and of patients of different ages with a variety of support needs.

The 34 health checks were conducted by 14 clinicians from 10 GP practices. Four (29%) of the clinicians were practice nurses, the others were doctors and one physician associate. Four patients (18%) attended on their own. The others were accompanied by a family member (n=9) and/or at least one paid carer or supporter (n=23).

*Data collection*

Video recording of the health checks took place over a 12 month period between July 2016 and July 2017. To avoid unnecessary distractions the researcher was not present during the recording.

*Ethical considerations*

After the initial phone contact, patients (and/or their family or paid carers) who expressed an interest received a visit from the researcher who shared information about the research in Easy Read and accessible formats, including a DVD about the project. Where patients were deemed unable to give informed consent on their own behalf, a family member or paid carer was engaged as a research consultee, who agreed to advise the research team on what they understood to be the patient’s preferences regarding involvement, according to the UK Mental Capacity Act (2007) guidance. Ethical approval for the study was granted by the London (Camden and King’s Cross) NHS Research Ethics Committee (16/LO/0455).

*Data analysis*

All the recordings were transcribed verbatim. Passages of particular interest were transcribed in more detail using the system developed by Jefferson (Hepburn & Bolden, 2013) (see Table 1). Analysis involved identifying all the instances during the health check where the nurse asked a question requesting information and then examining in each instance who responded, and how selection of the next speaker was accomplished through use of words, prosody, gaps and pauses in speech, and non-vocal resources including gesture, posture and gaze.

**Table 1:** Transcription Conventions

↑	Upward pitch shift
↓	Downward pitch shift
=	No discernable gap between utterances
.	Falling, end-of-sentence intonation at the end of a turn
?	Strongly rising tone
,	Continuing or slightly rising intonation at the end of a turn
<u>a</u>	Raise in volume or emphasis
:	Prolonging of the sound; multiple colons denote a longer continuation.
° °	Quieter speech
[ ]	Sections of overlapping speech.
(0.7)	Pauses in the talk, measured in tenths of a second
(.)	Pause of less than one tenth of a second.
–	‘Cut off’ or unfinished delivery
pt	Lip smacking sound
( )	Unclear section

## Findings

In this case study, the 49 year old patient, Helen (all names are pseudonyms) is attending her annual health check with her mother, Pat, who is in her 70s. The nurse conducting the health check has not met Helen before, though she has seen Pat in the surgery on a couple of prior occasions. The nurse has a checklist on her computer that lists the topics to be addressed during the health check and she also has access to the patient's electronic record. The business of the health check involves the nurse soliciting information about a fairly comprehensive range of health issues, taking some biometric measurements (blood pressure, pulse, weight and height), offering relevant health advice, proposing new treatments and recording the proceedings in a patient health plan.

*The clinician selects the patient as next speaker and the patient takes the next turn*

**Table 2:** The clinician selects the patient as next speaker and the patient takes the next turn

<b>Example 1</b>	
5	Nurse: Helen Smith?
6	Helen: °Yeah°
<b>Example 2</b>	
84	Nurse: Cause I'm always washing my ↓hands, my hands
85	are a bit cold I <u>do</u> apologize.
86	Helen: It's all right.
<b>Example 3</b>	
498	Nurse: What do you do for work?
499	(1.2)
500	Helen: ( ) (1.8) <u>S:ainsbury's</u> .
501	Nurse: Pt o[ <u>kay:</u> ]
502	Helen: [( ) ]
<b>Example 4</b>	
560	Nurse: You said your- it gets you down a bit so there
561	must be an <u>i</u> ssue there.
562	(0.8)
564	Helen: Hm um <u>s:ometimes</u> , yeah.
565	(0.4)
566	Pat: Is it? (.) Oh=
567	Nurse: =Is that the same manager?
568	Helen: Mm
<b>Example 5</b>	
736	Nurse: No? (0.2) Do you know what a smear test ↑is

737		(0.6)
738	Helen:	Hm ((nodding))
739	Pat:	I've <u>explained</u> it to her
<b>Example 6</b>		
814	Nurse:	Any problems with your hearing?
815	Helen:	No.
<b>Example 7</b>		
974	Nurse:	How do you feel about (.) starting some ta-
975		some medication for cholesterol
976	Helen:	Hm ((nods))
977		(0.9)
978	Nurse	[Yes?

In these examples, the patient, Helen is unambiguously selected by the nurse as the recipient of the first pair part of an interactional sequence that requires a response. The nurse performs a variety of actions in her talk, including confirming information (Example 1), asking questions that seek a yes/no response (Examples 5 and 6), apologizing (Example 2), seeking information (Example 4). In all of these exchanges, according to the video recording, the nurse is looking directly at Helen. There are no first pair parts that are unambiguously addressed by the nurse to Helen that do not receive a response from her. Helen's responses have the following characteristics:

- i) they could involve an embodied response, such as Helen nodding in response to a yes-no inquiry (Examples 6 and 8)
- ii) Helen's verbal responses were generally short and unelaborated, often a single word or vocalization.
- iii) in Examples 3,4 and 5 there was a delay in Helen's responding. However, these delays were not overtly treated as problematic. They did not trigger an entry into the exchange by Pat, Helen's mother, to supply the second pair part of the exchange on Helen's behalf. Nor were the delays followed by operations of self-repair of the first pair part by the nurse.

*The clinician selects the patient as the next speaker and the patient's mother takes the next turn*

**Table 3:** The clinician selects the patient as the next speaker and the patient's mother takes the next turn

<b>Example 8</b>		
40	Nurse:	Did you bring me a <u>urine</u> sample today?
41	Pat:	O::h sh-
<b>Example 9</b>		
125	Nurse:	Pulse are a little bit irregular. Have you
126		had an ee cee gee recently at all
127	Pat:	No [no she hasn't
128	Nurse:	[Okay. And it would be wise to probably

129		just um check(0.2) send her for a routine ee
130		cee gee because the pulse is a little bit
131		(1.1) m- <u>irregular</u> .
<b>Example 10</b>		
357	Nurse:	So would you say your appetite is fairly
358		goo[d
359	Pat:	[It's good
360	Helen:	Hm
<b>Example 11</b>		
442	Nurse:	When was the last time you had your eye test
443		(0.3)
444	Nurse:	done
445		(0.3)
446	Pat:	Pt er:::m last year? (0.7) Yeah last year I
447		think she'll be due for an eye test soon
<b>Example 12</b>		
730	Nurse:	What about your smear tests: you don't seem to
731		have had one
733	Pat:	No

On the other hand there are a number of exchanges where the clinician appears to be selecting Helen as the next speaker, but her mother, Pat, is the one who responds (see Table 3). In all of these examples the nurse uses the second person reference as the address term and is, moreover, asking Helen questions about her direct experiences of healthcare. Nevertheless, her mother Pat appears to usurp Helen's opportunity to produce the second pair parts to the nurse's questions.

One hypothesized difference between Examples 1 – 7 and Examples 8 – 12 is that the first group of exchanges requires a second pair part that Helen is hearably the most eligible party to produce or has obvious epistemic authority to supply the information requested, whereas the second set of exchanges resonate with Pat's understanding of her role as Helen's carer and an authority on her daughter's engagement with institutions of healthcare. So along these lines, there is logically only one person who could accept the nurse's apology for having cold hands (Example 4) or report their feelings about starting a new medication (Example 7). Furthermore, Helen is likely to be recognized well able to name her workplace (we learn she has been working there for nearly 30 years) and to be the expert on her own feelings about work (Example 5). In Examples 5 and 7, securing Helen's response is important for the actions initiated by the nurse – confirming Helen's understanding of a medical procedure and gaining her consent for a new treatment.

The second group of examples relate more to medical routines (supplying a urine sample in Example 8) or whether and when Helen has had medical investigations such as ECG (Example

9), an eye test (Example 11) or a smear test (Example 12). Pat's responding in these cases might be seen as part of her identity work as a parent-carer. By displaying her rights and responsibilities to respond to the nurse's inquiries she consolidates the impression of being an involved and proactive guardian of her daughter's health and healthcare.

Research on triadic medical consultations in other settings suggests that third party 'speaking for' the identified patient is not unusual (Mazer, Cameron, DeLuca, Mohile, & Epstein, 2014). In Stivers' (2001) investigation of who responds to the paediatrician's initial elicitation of the child's medical problem, she found that even when the child was unambiguously selected to respond by the doctor, in 44% of cases the parent presented the problem. Coupland and Coupland (2001) also give examples of family members responding when the doctors select their elderly relatives as next speaker, and similar incursions have been noted in the audiology clinic (Ekberg et al., 2015). However, it does appear to be the case that the immediate context has a role in eliciting the third party involvement. Relatives provide 'uninvited' responses when they note that the patient is struggling to answer, giving rise to long gaps in the discourse, or when the patient offers responses that are inadequate, incomplete (Stivers, 2001) or vague (Coupland & Coupland, 2001). Thus the relevance of the patient's own accountability to respond when selected to do so by the doctor is maintained.

In addition the clinician's own behavior has an impact on the involvement of the third party. Stivers (2001) noted that doctors are often ambiguous in their selection of the next speaker. They might fail to make it clear who they are addressing because they are facing away from the patient and third party. This is frequently the case when a computer constitutes a 'fourth party' and commands the clinician's attention (Swinglehurst, Roberts, Li, Weber, & Singy, 2014). Stivers (2001) found that parents responded in 83% of occasions when the doctor's selection of next speaker was ambiguous.

However, Stivers also found that the management of ambiguity in next speaker selection was a collaborative venture between parent and child and the outcome of interactional negotiation. This negotiation was conducted through vocal and non-vocal resources, particularly mutual gaze between child and parent, gestures such as shrugs and eyebrow raises, and parental displays of 'holding off' their turn through in breaths and tokens such 'um' and 'er'.

Pat does not seem to be orienting in these sorts of ways to Helen's rights to take up next speakership when addressed by the clinician. There is a slight gap after the nurse's incremental addition to her turn in Example 12, but in the other fragments Pat responds at the appropriate Transition Relevance Point (TRP) or in overlap with the end of the nurse's turn (Example 10).

### *The importance of gaze*

However, a more detailed examination of the nurse's behavior suggests that she might be introducing a slight ambiguity in matter of speaking selection that Pat exploits to take up speakership instead of her daughter. In Examples 8 and 10 the nurse uses both a second person address term, looks directly at Helen and maintains her gaze in Helen's direction throughout her turn. In Examples 9, 11 and 12 she uses the second person address term, begins her turn by looking at Helen, but glances at Pat before completing her turn. We can see how this plays out in Example 9. For this analysis I have used Charles Goodwin's notation system for transcribing gaze (Goodwin 1981). Speaker's gaze is marked with a line above ( ——— ) the transcribed utterance. Recipient's gaze is marked with a line below ( \_\_\_\_\_ ) the utterance. Dots ( . . . ) indicate a movement that brings the participant's gaze to another interlocutor and commas ( , , , ) indicate a shift of gaze away from another interlocutor. In multi-party interactions the name of

the person gazed at appears above the line that indicates gaze and each recipient is shown on a separate line below the speaker. I have included the computer as a gazed at participant, though it has not been given its own line. (see Table 4).

**Table 4:** Multi-modal transcription of Example 9

125	Nurse:	<u>Computer</u> ..... <u>Helen</u> Pulse are a little bit irregul a r.
	Helen:	<u>Computer</u>
	Pat:	<u>Nurse</u>
126	Nurse:	<u>Helen</u> .... <u>Pat</u> .... <u>Helen</u> .. <u>Pat</u> Have you had an ee cee gee recently at all?
	Helen:	<u>Computer</u> ... <u>Nurse</u>
127	Pat:	<u>Nurse</u> No [no she hasn't
		<u>Pat</u>
128	Nurse:	[Okay. And er it would wise to probably
	Helen:	,, ((looks into middle distance))
	Pat:	<u>Nurse</u>
129	Nurse:	<u>Pat</u> just um check
	Helen:	
	Pat:	<u>Nurse</u>

The nurse is taking Helen's pulse. She and Helen are looking at the computer screen. This is the position participants are in as the nurse starts to report on the measurement of Helen's pulse as seen in Figure 1.

**Figure 1**



The nurse starts her turn at line 125 by looking at the computer and turns to Helen by the end of her turn. When she starts asking her question (line 126) she is looking directly at Helen, but glances twice at Pat during her turn (during the production of 'ECG' and at the end of the turn). These glances may be seen to introduce enough ambiguity about the selection of next speaker to offer a warrant to Pat's responding in line 127. We might also consider Helen's non-vocal orientation to speakership. Unlike her mother, whose gaze is fixed on the nurse as soon as she starts to speak in line 125, Helen does not turn her gaze from the computer to the nurse until half way through the nurse's question in line 126. Helen is not displaying the same preparedness to respond as her mother, and is delaying her alignment to the role of recipient, which might explain why the nurse seeks out an additional potential respondent by glancing at Pat.

Pat not only takes on the task of 'speaking for' Helen by answering the nurse's inquiry on her daughter's behalf. She also launches a sequence in which Helen is 'spoken about' in the third person with the nurse. This is an example of the bias in multi-party turn-taking that favours the "just prior to current [speaker] to be next speaker" (Sacks et al. 1974: 712). In the following 20 lines of talk, Pat continues as the nurse's interlocutor and both continue to refer to Helen as 'she'. In maintaining a mutual third party referring practice for Helen, Pat and the nurse articulate a shared stance as individuals concerned with Helen's healthcare, and relegate Helen to the status of 'overhearer' (Goffman, 1981), or non-addressed observer of the interaction. Coupland and Coupland (Coupland & Coupland, 2001) suggest that this use of third party referencing is potentially silencing and repressive of the speaking rights and autonomy of the talked-about patient.

## **Discussion**

The analysis demonstrates some of the difficulties faced by clinicians in consultations where a patient with intellectual disabilities attends a visit with a family member, particularly when, as in this case, the patient's relative is keen to take an active rather than supporting role. The nurse seems to orient to the patient as key respondent by making her the primary addressee. Nevertheless she finds it hard to resist including the patient's mother as a recipient of her questions, however minimally. Although in this case study the nurse does reinstate Helen as addressee each time she introduces a new health topic for discussion, she seems to respond acquiescently to Pat's takeovers and engages with her in extended sequences that exclude Helen's participation. We can see enacted here the nurse's dilemma: on the one hand, how to strike a balance between involving the patient's family member or carer as a valued participant in the consultation, who is moreover willing and able to progress the institutional goals of providing relevant clinical information, whilst on the other, maintaining a focus on the person with intellectual disabilities as the expert on their own health and healthcare. The detailed interactional analysis illustrates the challenges of realizing normative models of 'patient involvement' in real life settings (Perakyla & Vehvilfinen, 2003).

Compared to the data from paediatric visits (Stivers, 2001; Stivers, 2012), it seemed that in this case, the patient's mother was less inclined to make her bid for speakership following a question that was directed at her daughter contingent on some process of negotiation, or on a jointly recognized difficulty with responding manifested by the patient herself. This may be because the cultural expectation that children should be socialized into the role of independent health care user does not hold for patients with intellectual disabilities, who are frequently in

life-long care relationships where there are often low expectations that the individual will continue to learn and develop through their lifespan because of assumptions about the fixed and unvarying nature of intellectual disabilities (Rapley, 2004). Moreover, Helen and Pat's relationship as 'cared for' and 'carer' goes back nearly 50 years, and what appears to be Helen's tendency to take the back seat in interactions in her mother's presence is likely to be long established.

### *Limitations*

Data from a single health consultation cannot tell us how common are the sorts communicative dilemmas encountered by the nurse in this analysis, and how widespread are the communicative practices described here. Nevertheless scrutiny of this single case allows for a fine-grained multi-modal analysis that suggests patterns in the data that are regular and meaningful and capable of yielding insights for practice.

### **Conclusions**

This study contributes to our understanding of the dynamics of participation in triadic healthcare settings. It also reveals how healthcare settings are a space where disabled identities are constituted and reinforced. The analysis does not regard 'communicative impairment' as an intrinsic characteristic of the individual that can be assumed *a priori* to impact on health communication, despite the dominance of this assumption in the social construction of intellectual disabilities (Rapley, 2004). We can see how 'being intellectually disabled' is a position constituted through micro-practices involving glances, tiny pauses and use of one word rather than another. Although just a snapshot of the ongoing relationships between our participants, the analysis hints at how such micro-practices can become sedimented into habits of exclusion and silencing, with implications for the persistence of health inequalities among people with intellectual disabilities.

Moreover, the analysis reveals how all parties in the triadic health consultation contribute to the exclusion of the patient with intellectual disabilities, and it suggests some of the 'missing links' (Perakyla & Vehvilfinen, 2003) between ideals of inclusion and interactional practices. Specifically, this case study illustrates the power of the machinery of gaze for speaker selection; it follows that encouraging staff to keep their gaze settled on the patient with learning disabilities is likely to maximize their involvement. Research in other sorts of triadic consultations, such as audiology clinics (Ekberg et al., 2015), suggests that clinicians can resist being waylaid in this way by quickly reinstating the patient as the interactional recipient following an incursion from an accompanying family member. We can also see how the patient with intellectual disabilities plays a role in how speakership is allocated in this consultation through her use of very minimal (in some cases non-verbal) responses and her delay in using gaze as a resource to display her readiness to respond. At present, there is only a small body of research detailing interventions to support the health communication and self-advocacy of people with intellectual disabilities (Chinn, 2017). More research is needed to determine how such initiatives can be realized in practice, and how the autonomy and self-determination of the patient with intellectual disability can be negotiated within lifelong care relationships.

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