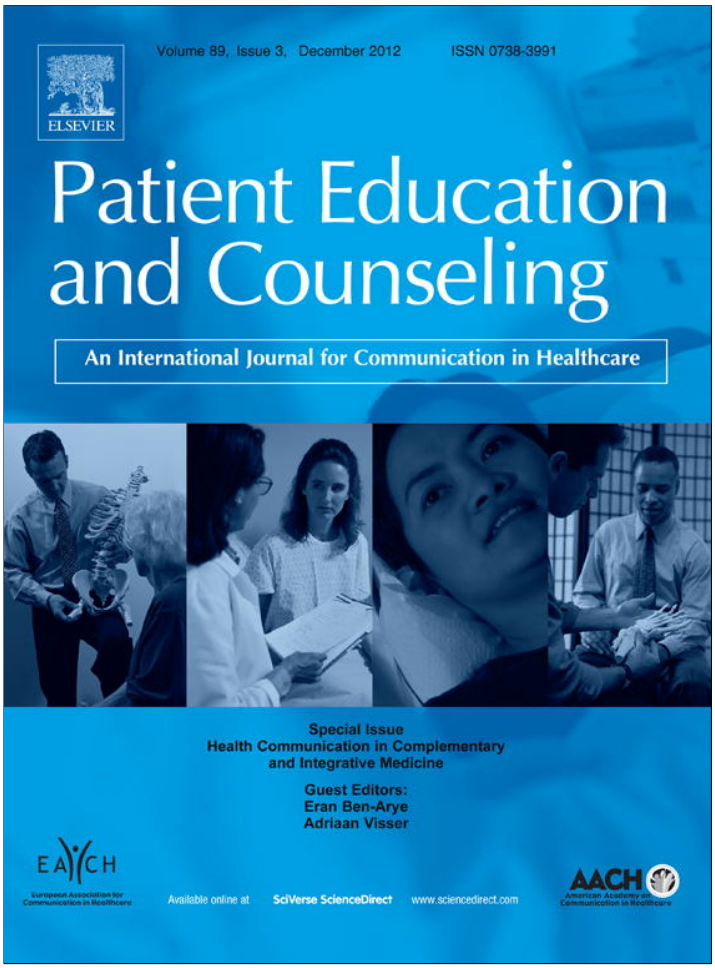

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Communication about self-care in traditional acupuncture consultations: The co-construction of individualised support and advice

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ABSTRACT

Objective: To analyse the co-construction of self-care advice in traditional acupuncture consultations.
Method: Analysis of 27 audio-recorded and transcribed consultations, involving 7 practitioners, augmented by integrating the data from 15 patient interviews and regular practitioner discussions.
Results: Self-care talk was initiated equally by practitioner and patient, and was threaded through and between acupuncture consultations. It involved interactive discussions that were interwoven with other types of talk, especially life-world and acupuncture talk. Practitioner engagement in self-care talk appeared to increase with experience. The self-care talk was co-constructed within the context of a relationship that was characterised by continuity, mutuality and trust.
Conclusion: Self-care support and advice was integral to the practice of traditional acupuncture and individualised in terms of the patient's life-world and/or the Chinese medicine diagnosis. The co-construction of self-care talk did not replicate the asymmetry of conventional medical consultations.
Practice implications: The active participation of both patients and acupuncture practitioners in self-care talk may be related to professional practice that is underpinned by a holistic theory base such as Chinese medicine and is delivered in the context of therapeutic relationships based on continuity, mutuality and trust. These findings may inform professional education and the design of multi-disciplinary care pathways.

1. Introduction

Numerous interview studies with patients and practitioners of traditional acupuncture indicate that promoting self-care and lifestyle change plays an important part in many consultations [1–10]. However, until now these accounts have not been substantiated by studies of recorded or observed acupuncture consultations. Such observational evidence is important because research into human behaviour and interaction has repeatedly demonstrated that what people say they do does not necessarily accord with their observed activity. For example, observed and recorded family practice encounters in California revealed a striking absence of health promotion talk despite its apparent importance in interviews with the same physicians [11]. Consequently, we set out to investigate communication about self-care in traditional acupuncture consultations by analysing consultation recordings. We used the UK Department of Health definition of self-care: '*Self-care is a part of daily living. It is the care taken by individuals towards their own health and wellbeing: the actions people take to stay fit and maintain good physical and mental health*' [12]

In contrast to the lack of observational research into acupuncture consultations, there are a growing number of observational studies of communication between patients and biomedical doctors. These studies have used qualitative methodologies such as conversational analysis [13], semi-quantitative methods such as the Roter interactional analysis system [14], and mixed method designs [15] to analyse the 'co-construction' of talk by health professional and doctor. Co-construction is a term that acknowledges that when two people interact, both of them inevitably play a role in determining how the talk and other action progresses [16]. These studies have highlighted a consistent and persistent asymmetry in consultation communication patterns: doctors generally dominate the talk – by initiating topics, asking the

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questions, blocking or ignoring patient agendas – whilst patients exhibit diffidence and self censorship [16–21]. Studies of self-care talk have most often demonstrated that self-care and lifestyle talk is infrequent or is severely limited in extent: typically, doctors and patients co-construct patient behaviours as unproblematic and doctors are reluctant to give advice [11,22–28]. Exceptions, where lifestyle talk was more prevalent and participative, included a study of older people who were in ongoing therapeutic relationships [25] and a study of nurses in diabetes clinics [29].

This asymmetry and the accompanying paucity of communication about self-care has spawned a number of debates. Pilnick and Dingwall, noting the persistence of asymmetry in doctor–patient interaction despite the provision of communication skills training, return to the classic work of Talcott Parsons and suggest that asymmetry in consultations persists because of the power accorded to doctors by society to adjudicate on the ongoing legitimacy of patients claims to the sick role [17]. A similar explanation was suggested to account for the 'predominantly unilateral character of the ways Health Visitors both initiated and delivered advice' during their state sanctioned home visits to first-time mothers [30]. However, Blakeman et al., analysing video-recordings and interviews in UK primary care, explained the reluctance of doctors to engage in self-management advice in terms of the importance of maintaining comfortable relationships [27]. Maintaining 'self-other relations' – a key tenet of conversation analysis theory [16] – was a prime objective for patients and professionals in their study and because discussions of lifestyle issues such as weight loss threatened this relationship these discussions were avoided or minimised.

Another area of debate, originating from studies that include psychotherapy and complementary therapy consultations, is the way in which interactions around self-care are shaped by the theories and goals of the participants [31]. For example, Lindfors and Raevaara [32] found that the therapeutic theory base of homeopathy required homeopaths to elicit information about food preferences to guide their choice of remedy but that they rarely offered advice. In Western medicine, interactions around self-care are largely based on theories imported from psychology, such as cognitive behavioural approaches and the promotion of self-efficacy [33–35]. Traditional acupuncture, the subject of the study reported here, is based on Chinese medicine theories and the concept of 'qi', vital energy, or more precisely 'qi flow' (*yun qi*) which permeates the whole bio-psycho-social-political world of the patient [36]. Whether self-care interactions in everyday acupuncture practice are influenced by this therapeutic theory has not previously been investigated.

Our aim was to investigate how practitioners and patients communicate about self-care within traditional acupuncture consultations. We have published an exploratory analysis elsewhere [37]—here we have built on this with an extended dataset and analysis. Research questions include how such verbal interaction is co-constructed by practitioner and patient and what place it takes within the overall structure and activities of the encounter.

2. Method

The study, approved by the Peninsula Medical School Research Ethics Committee, took place in 2009–2011. It is based on a constructivist perspective and the theoretical approach of conversation analysis (CA) [16] used within a mixed method design [15]. Two experienced qualitative researchers (CP and ME) shared the data collection and analysis. They met with the other (practitioner) authors of this paper every 6–10 weeks throughout the planning and execution of the study to discuss design, data collection and data analysis. The mixed method design combines audio-recorded consultations and patient interviews. Analysis of recorded consultation data was augmented by integrating the data from patient interviews and practitioner discussions—a method which aims to promote reflexivity and ground interpretations of the data in professional and patient perspectives [38].

2.1. Data collection

2.1.1. Audio-recorded consultations

Seven traditional acupuncture practitioners, who were registered with the British Acupuncture Council and worked in private clinics in Somerset and Bristol, audio-recorded a convenience sample of 44 routine consultations. A group of four research-active practitioners recruited three other practitioners to achieve variation in sex, experience and location. Patients were provided with written information about the study (either face-to-face or by post) prior to the index consultation and practitioners obtained written informed consent. Of the 38 consultations listened to by researchers, five did not include any self-care talk and were excluded. A final purposive sample of 27 consultations were selected (details in Table 1). The 27 consultations involved 23 patients: four patients had a pair of consecutive consultations recorded. Consultations were generally about 40 min long, except the three new consultations which were considerably longer.

2.1.2. Patient interviews

The researchers selected a purposive sub-sample of patients from the above consultation sample and carried out audio-recorded semi-structured telephone interviews. In addition to availability, patients were selected to give a range of age, therapist and presenting problem. A topic guide included questions about: the history of acupuncture treatment; the type, amount and role of talking in the consultations; discussions of the acupuncture diagnosis and self-care in the consultation; and 'doing' self-care. Interviewers used open questions and probes and varied the order and details of the questions so that patients could expand on their own ideas and experiences. Fifteen interviews, of 20–40 min duration, were completed.

2.2. Data analysis

Data collection and the inductive analysis went on side-by-side. Audio files, transcripts, notes and memos were organised and annotated using N-Vivo software (NVivo8, QSR International). All names were replaced by pseudonyms. The following stages of analysis involved a number of iterative cycles.

Table 1
Method of purposive sampling of audio-recorded consultations.

Purposive sampling of audio-recorded consultations
Seven traditional acupuncture practitioners audio-recorded a convenience sample of 44 routine consultations, using a digital recorder. These recordings took place in two phases. In Phase 1, the four practitioners who co-author this paper (and had developed the protocol and questions) recorded 21 consultations that formed the basis of our previous preliminary analysis [31]. In Phase 2 three more practitioners, who were informed of our interest in communication but not about our interest in self-care, recorded consecutive consultations in half day sessions, and another 'new' consultation was recorded by a phase 1 practitioner. The last practitioner to join the study recorded 11 consultations, twice the number of other practitioners, so only the first five, comprising one session, were included. These 38 consultation recordings were listened to by the researchers and five were excluded because they contained no self-care talk. From the remaining 33 consultations a final sample of 27 consultations was selected for verbatim transcription and analysis – this sample size remained within our resources whilst providing adequate amount and scope of data. This final sample was selected for variation in practitioner, age and sex of patient, duration of treatment and type of health problem

Table 2
Study participants.

Practitioner	Patient	Duration of treatment[a]/ number of previous sessions	Sex	Age	Health problems	Interview
Sam	Keith	18 months	Male	55	Ulcerative colitis/ca. prostate	Yes
	Helen	Session 6	Female	43	Blood pressure/weight loss	Yes
	Dora	Sessions 5 &6 (home)	Female	87	Neck and shoulder pain	
	Anne	Session 2	Female	38	General lack of energy	
	Sue	Session 10 (home)	Female	43	Lung cancer (terminal)	
Brenda	Tanya	One year	Female	32	Preparation for IVF	
	Beth	Long-term with gaps	Female	51	Multiple Sclerosis	Yes
	Kate	Session 4	Female	48	itchy rash	
Pete	Valerie	15 years	Female	50	Minor head injury/various pains	Yes
	Emma	8 months	Female	23	Knee pain	
	Joe	New patient	Male	77	Back operation/pain and immobility	
Sarah	Glenda	Session 4	Female	51	Broken ankle/thyroid problems	Yes
	Bill	20 years	male	51	Back problems/general health	
	Hannah	15 years	Female	40	Back pain/migraines/cystitis	Yes
	Maggie	30 years (2 sessions)	Female	82	Cataract op/viral illness	
	Edith	New patient and follow-up	Female	60	Sjogren's: dry mouth etc.	Yes
Anna	Jason	5 months	Male	34	Back and neck pains/general health	Yes
	Richard	18 months	Male	59	Sinusitis/general health	Yes
Lily	Jane	New patient & follow-up	Female	35	Stress/digestive problems	Yes
	Irene	18 months	Female	45	Chronic fatigue	
Judy	Ros	7 years	Female	51	Stress, low energy, hot flushes	Yes
	William	4 years	Male	43	Stress, fractured ankle	Yes
	Ulla	2 years	Female	30	Endometriosis	Yes

[a] Duration of treatment = continuous or episodic periods of treatment. For more recent patients this is replaced by the total number of sessions.

(a) The researchers listened to the consultations on a number of occasions, both before transcription and whilst checking and annotating the transcript. Categories of talk were developed during this process and refined through research team discussion and by referring to patient interview data. Seven final categories – self-care talk, symptoms talk, acupuncture talk, life-world talk, bio-medical talk, complementary therapy talk, and other talk – were applied as codes to the consultation transcripts. Each of these coded segments of transcript was termed a sequence – sequences varied from a few words to extended periods of talk.
(b) Each consultation was considered as a trajectory and the transcripts were annotated with the audible sounds and silences associated with the acupuncture treatment (such as hand washing and needle packets being opened). This resulted in dividing each consultation into three 'Acts' (see below).
(c) Sequences of self-care talk were analysed in more detail and codes were developed for the content of the talk and who initiated it. Matrices and diagrams were used to explore these sequences for each patient and each practitioner, looking at the relationships between who initiated the talk, its interactional features, what its content was and the timing of the sequences in relation to the acupuncture treatment.
(d) The interactional features of the self-care talk were noted, including the extent to which there was mutual interactive discussion and who asked and answered questions. This drew on the methods of conversation analysis but did not extend to full CA transcription and analysis.
(e) The other categories of talk, and their relationship to the self-care talk, were analysed. Each self-care talk sequence was reviewed in the context of the whole consultation and the dialogue immediately preceding and following it.
(f) Emerging findings were explored using matrices [39] and by attending to negative case analysis. For example the relative lack of self-care talk in some consultations led to our hypothesis about it being commoner in experienced practitioners. Analytical findings from the consultations were also tested by systematically inspecting the patient interview transcripts and by the discussion of data at team meetings.

3. Results

The 23 patients (6 men:17 women; age 23–87 years) included 3 new patients, 5 more who had been seen 10 times or less, and 15 who had been consulting, often episodically, for many months or years. They had a wide range of health problems (Table 2).

We begin this results section with a description of the seven categories of talk and how the category of self-care talk is woven into the different stages, or 'Acts', of the consultation. Next we report on the interactional features of self-care talk, such as who initiates the talk and how practitioner advice and support are constructed, delivered and received. Finally, we set these findings within the context of the patient–practitioner relationship.

3.1. Categories of talk

Each consultation was analysed as a trajectory, or timescape [40], in which seven categories of talk interwove with each other and with periods of physical examination, needling and silence. These categories were self-care talk, symptoms talk, acupuncture (procedures and theory) talk, life-world talk, bio-medical talk, complementary therapy talk, and other talk. Our category of

Table 3
Self-care talk: content subcategories of sequences and who initiated them.

Content category of self-care talk	Initiated by patient: number of sequences (patients)	Initiated by practitioner: number of sequences (patients)
Diet and eating practices	11 (8)	12 (9)
Over-the-counter medications, herbs, supplements	15 (10)	7 (6)
Physical activity and back care	12 (6)	22 (8)
Rest and relaxation	9 (5)	16 (10)
Practice of therapies (including Chi Gong instruction)	12 (6)	13 (8)
Protection from the elements (e.g. keeping warm)	3 (3)	5 (4)
Other	7 (6)	9 (6)

life-world talk draws on the concept of life-world as described by Habermas (1984, p. 70) [41] and used in consultation analysis by Mishler [42] and, more recently, by Barry et al. [43]. This category, that we labelled 'social talk' in our earlier work, includes talk of the patient's everyday life, such as activities and concerns relating to work, family, leisure and relationships. Acupuncture talk relates to the acupuncture treatment procedures, such as examination and needling, and to acupuncture and Chinese medicine explanations and theory. This paper focuses on self-care talk.

3.2. Self-care talk within the overall structure and activities of the encounter

The overall structure and timing of the consultation was determined by the acupuncture tasks of verbal and physical examination and needling. The self-care talk flowed through spaces in this structure without disrupting these procedures. The consultation is depicted below as being made up of a number of Acts: self-care talk took place in all of these Acts.

Act 1 : *extensive symptom and lifestyle discussions including this* lifestyle talk sequence*, leading on from symptom talk:*

Sara: So do you push yourself quite a lot of the time?
Edith: I think I probably do unbeknown to anybody else because I think, you know there is no point in.
Sara: Yes.
Edith: I feel that if I give in it is going to be downhill all the way and we do have a good life, we have fun. I go to the theatre and erm we have a wine club in our village, we belong to that. We are on the committee of a film club in the village, and a book group.
Sara: Oh yes so you have got plenty going on in (your village) haven't you it is a great place.
Edith: Oh busy, busy, busy, busy it is lovely.
Sara: Yes okay.

Act 2. *Acupuncture talk, this is the 2nd half of a sequence that immediately precedes self-care sequence 9 (below)*

Sara: ……Your Yin is extremely depleted which means that your Yang is running out of control. Erm, so the Yin is the body fluids, so you know, the fact that you are unable to produce these fluids is the sort of base line underneath all of this. Erm and I think that is why actually you have managed to remain remarkably active, because actually it has made you more Yang, which has made you more active, and more able to sort of go out there and do things.
Edith: Don't wreck the Yang then [laughter].
Sara: No I am not going to wreck your Yang, but what it does mean is that your Yin is your deep tank of reserve energy, that is your sort of your deposit account of life if you like. So what is happening is that you are always running on your deposit account. You are running it off all the time, so your body has difficulty building up reserves and hence it keeps getting into trouble because it doesn't have anything to fall back on. So although you appear to have a lot of running energy, actually you are running off on your current account and dipping into your deposit account.
Edith: Which is why occasionally I go into the red.[laughter]

Act 2, needles are in.*Self-care talk, sequence 9*

Sara: Absolutely, so the main bit of advice I would like to give you is that actually I do think you need to pace your life really carefully. And that should make quite a difference. So what I would like you to think about is imagining that your, your, energy levels are like a bank account that holds interest if you like. What is important is never to run your bank account down to the point beyond which it can't regain interest.
Edith: So I have got to learn to say "no I can't do that".
Sara: Yes you have got to leave ten pounds in the bottom because actually nothing can grow if you haven't got something to grow on.
Edith: Yes, yes.
Sara: And so it is a kind of thing about stopping short of draining the tank and I think that is probably, I am asking you quite a lot at this.
Edith: Can I have it in writing and show it to B (husband) please [laughter].
Sara: Yes I mean at this point in your life it is a hard thing to ask because you have come habituated in the way you do things.
Edith: I think also I have grown to think that I have to push myself because otherwise I am giving into it.
Sara: Yes that is right it is and that is a change of attitude completely. And I wouldn't see it as giving in to it; I think you need to reframe that. I think it is actually about conserving yourself, because what has been happening is that you have been getting major organ damage. You know it is not like just a little bit of skin or a little bit of joints, you know you have had a lot go wrong. Erm and you have dealt really admirably with it and you know it is incredible that you are looking so good, but I think underneath.
Edith: Yes I think you are right, there is a frailty there I know there is, I know there is erm.
Sara: And whilst you know, whilst I can see it has been easier to push it away and not look at it, I think actually for the point of view of long term recovery, you are not going to get recovery until you get yourself a bit of a rest really.
Edith: Slow down a bit, yes, yes.
Sara: You know and so maybe okay you get these disturbed nights so how about thinking about siestas?
Edith: Well we do quite often have twenty minutes on the sofa, you know in the afternoon.
Sara: Good, right.
Edith: You know we quite often do that because B gets very tired.

Fig. 1. Edith, consulting practitioner Sara as a new patient with complex health problems including Sjogren's syndrome (self-care talk in red, life-world talk in green serif font, acupuncture talk in blue italic). (For interpretation of the references to color in this figure legend, the reader is referred to the web version of the article.)

Edith's second consultation

End of Act 2, during removal of needles. *Self-care talk, sequence 2,*

Sarah: Yeah absolutely.[pause] How are you finding it the, erm, conflict of resting a bit more, does that feel
Edith: Well yes erm, nice to be able to read my book, erm but in my mind I've got to get the washing in, when I get home I've got to do the ironing, unfortunately it doesn't do itself.
Sarah: No it does, it doesn't and it, it's, it is about pacing.
Edith: Yeah I know, I am, I told (husband) all about it and he's always saying 'I keep telling you not to bounce… [unclear]'.
Sarah: Well it's a little bit like, it's like a contrast of running on empty, you know it's almost like the emptier you are the more frantic you become because it's like the feeling of impending, sort of if I don't do it now I will [unclear]. You push yourself that little bit harder.
Edith: well on Saturday I sat on the balcony and read my book
Sarah: Oh good.
Edith: I have told myself and (husband) that I must stop when I need to relax'
Sarah: Brilliant.
Edith: And I will tell myself that if I read then I will get so much stronger every day: that it's like taking vitamins
Sarah: Yeah. (Pause) There we go, all gone *(NB, this relates to removal of needles).* Great.
Edith: Thank you very much.

Edith's telephone interview

"*She said I should rest more. Although, I don't, because I'm not involved in anything except a book group…* (describes previously running a music festival*). It is quite hard if you run a home* (describes the tasks that have to be done)… *But I do try, we do quite often rest in the afternoon for 15 minutes or so.*(continues with description of how she and her husband seem to spend their time rushing between health care appointments).

Fig. 1. (*Continued*).

Act 1: from the start of the consultation to the point where physical examination begins (e.g. tongue inspection, pulse taking).

Of the 130 sequences of self-care talk, 50 of them were in Act 1 and the majority (36) of these were patient initiated. Most of these were descriptions of self-care being undertaken (especially within the 'first' consultations) and most, but not all, of these 'openers' result in some ongoing interactive discussion, practitioner support or advice, either within the same sequence or at a later time in the consultation. The leading role of the practitioner in moving through the stages of the consultation and the acupuncture procedures was especially marked at the end of this Act, when a shift of speech emphasis and tempo accompanied statements such as '*Okay, fine, so, let's get you up on the couch and do your pulses.*' or '*Okay, right let's have a look at your tongue.*'

Act 2: the period of physical examination and needling that may include an 'intermission' of silence while the needles were in position (and occasionally the practitioner leaves the room). It ends with needle removal.

This is usually the longest Act and typically includes short periods of silence, associated with the 'work' of acupuncture. These silent periods may temporarily interrupt ongoing sequences of talk but may also be used by either party to start a new sequence or topic. The majority of practitioner-initiated advice took place in Act 2, either early on, as the patient and practitioner appeared to settle down to pulse taking and needling, or during or after the period of needle insertions. Act 2 was also used by some patients to initiate or continue discussions around self-care practices, or to engage in longer narratives around specific experiences.

Act 3: from needle removal to the end of consultation: usually a short period.

In many consultations, practitioners used this last part of the consultation to reinforce or enlarge upon advice previously given and/or to teach Chi Gong exercises.

3.3. Initiating self-care talk

We have not used detailed conversational analysis in this study, but we have attended to the overall structure of turn taking within the sequences of self-care talk. From this perspective, the self-care talk was co-constructed by practitioner and patient in ways that varied according to the interactional style, skills, and preferences of both. Patients and practitioners were equally likely to initiate such talk (patients initiated 61 sequences and practitioners initiated 69). Practitioners used both questions and statements ('*Do you take a rest at that time?*'; '*Just make sure that you're keeping those areas warm…*'), whereas patients generally used statements ('*Yeah and I mean obviously I'm trying to regulate my diet*'; '*Yeah, I try taking Fluorodex…*'). Table 3 shows the content codes of the self-care talk: practitioners more commonly initiated talk about 'rest and relaxation' and 'physical activity'; and patients more often about 'over-the-counter products'.

3.4. Self-care advice and support: practitioner variability

Usually, self-care talk included the practitioner supporting the patient's self-care activities or ideas and/or offering new or additional self-care advice. There was one example of the practitioner openly contesting the patient's self-care strategy and offering a different interpretation and advice (Fig. 3). Practitioner's advice encompassed all the topics of self-care talk in Table 3, most commonly diet and eating practices; physical activity and back care; and rest and relaxation. Towards the end of these advice sequences, patients generally gave a token of interactional agreement, such as "*I'll try that, thank you*", "*I'll give it a go*" or "*Okay*". Practitioners differed in how much self-care support and/or advice they gave, and how they fitted it around the acupuncture procedures. A few practitioners recorded a number of consultations that included no self-care talk (the five consultations

that were excluded on that basis) and in their other consultations self-care sequences either contained no support or advice, or tended to give support rather than advice. In our small practitioner sample they were also the least experienced. They made up some of the Phase 2 practitioners who were unaware of the research focus on self-care, but other Phase 2 practitioners gave a lot of self-care advice.

3.5. Interactive discussions and individualised support and advice

Almost all (108 of 130) of the self-care sequences were associated with an interactive discussion (where information, opinions or ideas were contributed by both parties) at some stage in that consultation. Such discussions could be brief or extensive and a number of consultations clearly demonstrated a co-construction of interactive dialogue about self-care which threaded through each consultation and also through a series of consultations (see Figs. 1 and 2). In these consultations the practitioner, or sometimes the patient, repeatedly returned to aspects of self-care in ways that appeared to build a shared understanding on the basis of symptom, life-world and acupuncture talk. This led to individualised advice and support. There were exceptions to this individualised advice, especially in relation to over-the-counter products.

Examples of individualising advice in relation to the patient's life-world included advice about diet being based on knowing about the patient's pattern of meal-times and shopping; or advice about exercise taking into account everyday work and family

Act 1. *Self-care sequence 1, a few minutes into the consultation*
Brenda: Mmm. Thinking of keeping calm, did you manage to do your meditation (laughing]?
Tanya: Not good at that kind of thing.
Brenda: No.
Tanya: But I will try.
Brenda: All right.
Tanya: But I've, erm, we've booked various comedy sessions in.
Brenda: Excellent. Good. Excellent.
[sequence continues for several minutes to discuss comedy and the patient returns the dialogue to meditation (previously discussed as visualising a peaceful walk) , receiving support and more information for trying again, which ends with:]
Brenda: and, and see how far down the path you can get.
Tanya: I just kind of thought I was rubbish and gave up [laughing].
Brenda: No, no. And that was from a Buddhist Monk who'd been meditating...
Tanya: Oh, really?
Brenda: for years.
Tanya: Oh.
Brenda: So you're doing...
Tanya: Fantastic.
Brenda: well, yes.
Tanya: I'll aim for 2 by next week.
Brenda: Yes. I'll, how many steps down you get, right, good. And in yourself?

Act 1. Self-care sequence 2,(follows life-world and medical talk about patient finding situation difficult)
Brenda: Erm, so, yes, you've booked in lots of comedy so that'll keep you relaxed.
Tanya: Yes.
Brenda: And you're going away for weekends, that's good.
Tanya: Yeah, absolutely.
Brenda: And relaxing is a, is a good one.

Act 1. Self-care sequence 3, followed by *acupuncture talk*
Tanya: Comedy.
Brenda: Comedy, indeed. *And I'll do some calming down points for you, do some nice calming down points.*
Tanya: *Yeah.*

Act 2, during needling, Self-care sequence 5, preceded by *acupuncture talk*
Brenda: Mmm. [silence, sounds of moving around, 1 minute]
Well, the good news on your pulse is that the kidney pulse is stronger...
Tanya: Oh, that's good.
Brenda: from whatever it was, so that, that's good, so that's, and that's the thing that, that's a lot to do with making good eggs and
Tanya: Oh good. °So it's continue not-caring then?°
Brenda: Yes, yes, yes. Carry on being relaxed and [unclear]
Tanya: Yeah.
Brenda: [unclear] and down the path.

Fig. 2. Tanya, consulting practitioner Brenda for several months for fertility problems: currently having IVF (self-care talk in red, acupuncture talk in blue italic). (For interpretation of the references to color in this figure legend, the reader is referred to the web version of the article.)

Act 2, needles in, *Self-care sequence 7 , including some acupuncture talk [self-care sequence 6 patient initiates discussion of where and how she eats her lunch]*
Brenda: And when you've eaten your lunch in the kitchen does that make your stomach feel easier afterwards?
Tanya: It did in that I was having Rivita, and I don't know whether it's something to do with the bread as well...
Brenda: Mmm. That might be.
Tanya: whether it just, yeah, at all.
Brenda: It could be.
Tanya: But sometimes there's an, I still snack at my desk in the morning. Erm, like...
Brenda: Mmm.
Tanya: ...plums and my carrots and stuff, and that definitely makes me get an 'ow-y' tummy, because all, you know, almost immediately I get a really...
Brenda: Right. I hope you chew your carrots very well? No?
Tanya: Probably not, because I'm doing 5 other things at once.
Brenda: Yes. *The Chinese have an expression, "the stomach doesn't have any teeth".*
Tanya: True.
Brenda: You need to do the chewing first.
Tanya: Yes.
Brenda: So, yeah, stop and...
Tanya: I need to work on that.
[sequence continues with more interactive discussion about this, ending with:]
Brenda: I was thinking of being good for your stomach energy to have something, it can work on it, digest it and then have something else.
Tanya: Right.
Brenda: Where it has a little rest and then you...
Tanya: Yeah.
Brenda: eat something else. So you've been doing that. It's just the point, eating too fast I suspect.
Tanya: Probably.
Brenda: Oh, you'll be a new woman

Fig. 2. (*Continued*).

commitments. The dialogue in Fig. 1 illustrates how discussion of Edith's very busy life in Act 1, led to self-care advice about pacing herself and resting in Act 2. This topic was returned to in her subsequent consultation.

Individualising advice on the basis of the Chinese medicine explanation or the acupuncture points, took place in over half of consultations. This talk could be brief or extensive and although it sometimes involved Chinese medicine terms, such as '*yin deficiency*' or '*damp*', it more commonly used lay terms such as '*energy moving*', '*replenishing*' or '*calming (acupuncture) points*'. In Fig. 1 the practitioner Sara shares aspects of her Chinese medicine diagnosis with Edith and constructs a metaphor to link it to the need for rest. Fig. 2 illustrates how another practitioner, Brenda, linked her advice to relax to her choice of acupuncture points, and also linked her advice about eating to Chinese medicine understandings of stomach function.

In their interviews, patients expressed varying preferences and interest in these linkages, and as most of the practitioners

Emma is a 23yr old who has been consulting practitioner Pete for 8 months re knee pain.
Self-care sequence 3- in red- during needling (2 long discussions of same topic in Act 1),
Emma: So I thought I'd give that a go, and I've also booked and appointment – do you know [name]? She's a sports therapist and I saw her in, quite early on with my knee, so I thought, well, it's nice to see what they think, what they think's going on there.
Pete: Personally I think that's too much therapist shopping that you're doing, to be frank.
Emma: Really?
Pete: Yes. I'd just go and spend it on your own regular self help.
Emma: Yeah. If I was – yeah, I suppose.
Pete: Because everyone will give you a viewpoint.
Emma: Mm.
Pete: We're all, we're all in it to help you, we all have our own viewpoints, and you've been round a lot of people.
Emma: Mm. I just like, if I have done something
Pete: You might find it reassuring, you might find it reassuring, but for me I think the answer's been changing your work play, work life
Emma: Yeah.
Pete: Work exercise lifestyle.
Emma: Sure, yeah.
Pete: Got to get you more smooth.

Fig. 3. Example of practitioner giving advice and contesting the patient's self-care strategy.

introduced these links in some of their consultations and not in others, it seems likely that they were adapting to patient preferences

3.6. Co-construction of self-care talk in the context of (mostly) long-term therapeutic relationships

The data indicated that communication was facilitated by a patient-practitioner relationship characterised by continuity of care (see Table 2) and a non-hierarchical relationship built on mutuality and trust. Mutuality was indicated, at interview, by patients using descriptors such as '*friendly*', '*got to know him quite well*' and '*we are probably of a similar mind*' and, in the recorded consultations, by observing a relaxed easy flow of speech with few interruptions; both parties initiating humour and laughter; and discussions of shared community activities and acquaintances. Most, but not all, practitioners shared some personal experiences with their patients, and there were instances of patients initiating brief discussions about the practitioner's life. This mutuality was, however, set within professional boundaries. Patients noted that the practitioner knew much more about them than they did about the practitioner and practitioners discussed how they chose personal disclosures that were not emotionally loaded. Mutuality was linked to developing confiding relationships based on trust. At interview patients reported that they could '*talk about anything*' and '*would answer anything she asked*' and most consultations included examples of patients sharing concerns of a personal and sometimes potentially embarrassing nature. Interviewees explained that trust was built on the success of their previous acupuncture treatment, the practitioner's demeanour, detailed taking and recording of their history and progress, and a sense of the practitioner's commitment and care. In addition, there were a number of interviewees who indicated that this trust generally led to them trying to carry out self-care advice. Some patients reported that they '*like being told what to do*' whilst others appreciated being given strategies that empowered them to take care of themselves.

4. Discussion and conclusion

4.1. Discussion

These findings indicate that the asymmetry present in conventional medical consultations, as described in the introduction, is barely discernable in traditional acupuncture consultations. Additionally the extent of patient participation in the interactive discussions and the individualised advice in the context of the patient's life-world are much more evident than in studies of conventional medicine. In terms of other health professionals, communication patterns appear most similar to those of specialist diabetes nurses [29].

There are many possible explanations for these differences, including the limitations of the study population – fee-paying patients who self-referred to acupuncture. In private conventional medical consultations doctors refer more to the patient's social world and patients ask more questions, than in the public sector [44]. It is also possible that the longer consultations in acupuncture practice may influence the co-construction of talk, although this assumption has not been borne out in other studies [23,29,45]. Other limitations of our study include the potential effect that the research process had on behaviour, our restricted ability to study non-verbal behaviour, and the lack of resources for comparing consultations that did and did not include self-care talk.

Turning to the explanations for the asymmetry that we described in the introduction, it is clear that acupuncture practitioners in UK private practice do not have the same societal role, and associated power, in relation to patients' claims to the sick role as that of conventional doctors [17]. In this respect then, our findings of lack of asymmetry in acupuncture consultations may be expected and support the explanations of Pilnick and Dingwall [17]. However, the findings of Blakeman et al., that GPs avoided discussions of lifestyle change because they threatened the therapeutic relationship [27], provide an interesting contrast to our findings. In the context of the acupuncture consultation, both patients and practitioners initiated talk about lifestyle issues and they did so in the context of a flourishing therapeutic relationship. Here, it is likely that the type of relationship, the opportunities for interactive discussion and the individualised nature and the content of the advice may all play their part in a co-construction that builds, rather than threatens, the relationship.

Lastly, our findings support the proposition that consultation interaction patterns are linked to the underlying therapeutic theory [31]. The theoretical basis of Chinese medicine encompasses the whole bio-psycho-social-political world of the patient and consequently, life-world talk and interactive discussions may be seen as a necessary part of examination and a pre-requisite for acupuncture needling. Additionally, because treatment is seen as promoting self-healing, individualised explanations, increased self-understanding and appropriate self-care can be viewed as an integral part of the process. Consequently, the integrated, individualised and participative self-care talk that we observed reflects the holistic theory base of traditional acupuncture.

4.2. Conclusion

As far as we are aware, this is the first observational study of communication patterns within traditional acupuncture consultations. We analysed consultations as a trajectory, in three Acts, in which seven categories of talk interwove with each other and with periods of physical examination, needling and silence. Self-care talk did not demonstrate the marked asymmetry which pervades conventional medical consultations. Instead, both patient and practitioners initiated interactive discussions and practitioner advice and support was individualised in terms of the patient's life-world and/or the Chinese medicine diagnosis. These communication patterns appear to be grounded in the holistic explanatory theories of Chinese medicine.

4.3. Practice implications

The initiation and participation of patients in self-care talk in these consultations suggests that there is an unmet need for self-care advice that is underpinned by a holistic theory base and is delivered using patient-centred communication skills. Our findings may be a useful resource for the continuing professional development of health care professionals. They also suggest that building therapeutic relationships based on continuity, mutuality and trust may enhance self-care communication. They add some support to the view that doctors may have a limited role in this area, because of both their role within the social system and the biomedical theory from which they practice. Consequently, the inclusion of traditional acupuncturists in multi-disciplinary teams may be beneficial.

Conflict of interest

The authors have no conflicts of interest.

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