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Changing Faces Skin Camouflage Clinics: An interactional Study of a Patient Centred Service

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Abstract

Changing Faces Skin Camouflage Clinics (SCC) provide an intervention for individuals with facial or bodily disfigurements and skin conditions. A series of five SCC interactions between three Skin Camouflage Practitioners (SCP) and five clients where transcribed. Using Conversation Analysis (CA) it was shown that, due to the interactional endeavours of the SCP, Shared Decision Making, patient participation and patient-centred prescribing styles (Byrne & Long, 1976) are rife in this form of medical encounter. This is in contrast to other kinds of medical interaction (Godolphin, 2009). It is concluded that through continued research in this area appearance concerns may eventually be placed higher on the health care agenda and the benefits of the addition of Changing Faces SCC's to the National Health Service will be considered by authorities. Recommendations concerning the future of applied research in this area are developed.

Introduction

Over 1 million people in the UK have a significant facial or bodily disfigurement[1] and 415500 people are expected to acquire either a temporary or life-threatening disfigurement in the period of a year (Harcourt & Rumsey, 2008). It follows that psychological research into the area of disfigurement could be relevant to and appreciated by many. This report provides a unique insight into some of the interactional features relevant to the operation of a Changing Faces Skin Camouflage Clinic (SCC). This introduction will explore the small but developing cohort of research into the psychology of disfigurements; the psychological effects of a disfigurement and the interventions currently relied upon to help those with a disfiguring condition. A Changing Faces SCC will be viewed as a medical encounter therefore research into the interactional practices that take place during other medical encounters will be reviewed.

Disfigurement Research

Rumsey (2008) confirms that out of those who have a disfigurement between 34 and 51% suffer from significant psychosocial difficulties, but the care, support and interventions needed to help the psycho-social needs of these individuals are negligible. As the number of people being reported as having a disfiguring condition increases, so too does the breadth and depth of the research that focuses on disfigurements. However this area of research is still limited in psychology with the majority appearing in medical (Clarke, 1999) and dermatology journals. The issues that have been addressed by research so far explore: 1) how those with a visible disfigurement view themselves (Grogan, 1999; Harter, 1999; Herskind, Christensen, Juel & Fogh-Anderson, 1993; Strenta & Kleck, 1985), 2) how visible disfigurements can impact on social interactions (Bull & Rumsey, 1988; Macgregor, 1990; Robinson 1997; Rumsey, Bull & Gahagen, 1982; 1986; Rumsey,1983; 2002) and 3) how visible disfigurements affect a person's quality of life (Rumsey & Harcourt, 2004). By addressing these issues it has been established that individuals with a disfigurement can have reportedly low confidence and self-image due to their disfiguring condition (Turner, Thomas, Dowell, Rumsey & Sandy, 1997) along with low levels of self-esteem and high levels of self-doubt (Lansdown, Rumsey, Bradbury, Carr & Partridge, 1997).These findings may be somewhat overgeneralised, Walters (1997) found that self-esteem was sometimes equal to or higher in individuals with a disfiguring condition in comparison to their peers. Herkind, Christensen, Juel and Fogh-Anderson (1993) however found that suicide rates were twice as high in a population of Danish adolescents with a cleft-lip compared to their peers. This could be due to the high levels of anxiety, unhappiness and self-doubt experienced by many individuals with a disfigurement (Millard & Richman, 2001). The difficulties in social interactions and feelings of low self-esteem, confidence, and self-image have

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[1] The term 'disfigurement' has been chosen in this article over the sometimes preferred term 'visible difference' as this is the term that the charity Changing Faces, who assisted with data collection for this research, uses. It describes "the aesthetic effects of mark, scar, asymmetry or paralysis to the face or body…this term is enshrined in British law in the Disability Discrimination Act (DDA) 1995" (Coutinho, 2006, p3).

been shown to significantly impact on a person with a disfigurements quality of life (Rumsey & Harcourt, 2004).

Intervention research

Due to the overwhelming impact a disfigurement can have on a person's quality of life, research focusing on the most effective interventions, management and coping strategies for living with a disfigurement has emerged. Rumsey and Harcourt (2004) categorise these 'interventions and provision of care' (P.91) into three distinctive categories: Biomedical (e.g. cosmetic surgery), psychosocial (e.g. CBT therapy, counselling), and educational (e.g. supplying specific and relevant information about the patient's condition). Biomedical approaches such as medical and surgical interventions are currently the favoured choice with the benefits of 'normalising appearance' being clearly apparent (Rumsey & Harcourt, 2004, p.91), however as Sarwer (2002) warns, altering a disfigured individuals appearance doesn't always change their overall body image. It is naive to presume that changes to appearance and adjustment to a disfiguring condition are related, and that enhancement of physical appearance will improve a person's quality of life. As suggested by Harcourt and Rumsey (2004) surgeons should not be overly enthusiastic about innovative appearance enhancing treatments as individuals with a disfigurement may feel pressured into 'improving' their looks, rather than accepting them.

The use of camouflage creams, a non-invasive, non-permanent treatment that reduces the appearance of a disfigurement, has been shown to significantly improve quality of life and reduce levels of appearance anxiety (Holmes, Beattie & Flemming, 2002; Kent & Thompson, 2002; Ongenae, Dierckxsens, Brochez, Van Geel & Naeyaert, 2005) in individuals with a disfiguring condition. It may be a better treatment option than cosmetic surgery for disfigured individuals as the effects are easily reversible. The Charity Changing Faces focuses on providing psychosocial provisions of care and education to individuals with disfiguring conditions. An evaluation of Changing Faces' social interaction skills training programme showed it to be a successful intervention (in a six month follow-up) in decreasing levels of social anxiety additionally class-room based interventions where shown to ease problems arising while adjusting to a disfigurement (Lovegrove, 2002).

Changing Faces was set up in 1992 by James Partridge for "people and families whose lives are affected by conditions, marks or scars that alter their appearance" (Changing Faces, undated, a). Its aim is to promote a better future for facially disfigured people and their families (Clarke, 1999). The charity divides its work into two categories: 1) Changing Lives, 2) Changing Minds. The first category involves providing emotional and practical support, advice and training for those affected by a disfigurement as well as providing advice to health and education professionals (Rumsey & Harcourt, 2004), so they can support individuals with a disfigurement. This is essential for healthcare professionals as many of them feel they have insufficient skills to deal with disfigured individuals' psychosocial issues (Clarke & Cooper, 2001). The Latter category 'Changing Minds' focuses on transforming the public attitudes and opinions towards those with disfiguring conditions through campaign programmes; promoting a more inclusive work and school environment and more integration of the disfigured population within the National Health Service (NHS) (Changing Faces, undated, a). This section has shown that psychological research has mainly focused on the impacts that a disfigurement can have on a

person's quality of life, confidence, self-esteem and anxiety. Research into the interventions available to those with disfigurements mainly focuses on the more invasive biomedical interventions such as plastic surgery where effects are irreversible. There is only limited research on camouflage creams, a non-invasive non-permanent treatment, as an effective treatment and no studies have examined a SCC where individuals obtain these creams. Client-practitioner interactions within this clinical situation have not been studied. In the next section research that considers medical interaction will be reviewed.

Medical interactions

Byrne and Long (1976) through their conversation analysis of medical consultations identify a series of phases that health care professionals progress through during an acute care primary visit. These phases are consolidated into: 'Opening', 'Problem presentation', 'Data gathering' e.g. history taking and physical examination, 'Diagnosis', and finally 'Treatment' (OBSSR, undated). Research into the area of medical interactions focuses on these phases and the interactional tools used by patients and healthcare professionals within them e.g. online commentary during diagnosis (Heritage & Stivers, 1999), problem presentation (Heritage & Robinson,2006a) and typology of physicians opening questions (Heritage & Robinson, 2006b). Although there may be elements of these phases in the SCC, it can be argued that they differ in structure to other medical consultations because the first four phases have already transpired as the clients have been referred by their General Practitioner. The SCC is effectively the 'Treatment' phase of the medical encounter. Byrne and Long (1976) discuss the diagnosis and treatment phase of the medical encounter namely the 'Prescribing' phase, identifying a continuum of 'prescribing styles' that doctors embody when diagnosing and delivering treatment. These range from doctor-centred to patient-centred (Beaumont, 2010) (see Appendix 1), with doctor-centred involving only the doctor making the decision about the treatment and patient-centred involving the doctor permitting the patient to make a decision about the treatment. In a sample of n=1965 medical encounters only 22 involved completely patient-centred stlyles (style 7), while 1304 involved doctor-centred prescribing styles (style 1 &2) (Byrne & Long, 1976, p.106).

More recently the practice of patient-centred prescribing styles has been defined as Shared Decision-Making "a process by which doctors and patients consider available information about the medical problem in question including treatment options" (Frosch & Kaplan, 1999, p.288). As Byrne and Long's (1976) figures suggest Shared Decision Making is a practice that has rarely been put into place and this still holds true today, with a good level of Shared Decision Making only occurring "about 10% of the time" (Godolphin, 2009, p.187). Alongside the absence of Shared Decision Making is the lack of patient participation that is to say "patients rarely ask for information, explanations, or clarification, or volunteer information, opinions, preferences, or concerns" (Robinson, 2003, p.28). Through the use of Conversation analysis Stivers and Heritage (2001) found that during the history taking phase of a primary care visit many patients expand on the questions asked by their doctor and these expansion in some cases should be recognised as important and useful.

To encourage Shared Decision Making and patient participation in the healthcare system in the United Kingdom the General Medical council (2008) has proposed a set of guidelines to ensure healthcare professionals work in partnership with their

patients (Appendix 2). Research suggests that patient participation and Shared Decision Making gives patients a greater sense of personal control, more satisfaction with their treatment and lower levels of concern about their condition (Lerman et al, 1990). Studies investigating whether or not patients want to participate in medical decision making have provided varying results (Frosch & Kaplan, 1999) some suggest that the more severe a condition becomes the less patients want to be involved in a decision about treatment (Ende et al 1989; 1990). However research by Strull et al (1984) indicates that patients would prefer to be provided with more information so that they can be involved in making the decision about their treatment. Shared Decision Making has been labelled 'the meeting of experts' with the patient being the expert on their own life and body and the physician being the expert in medicine (Tuckett et al, 1985). Coming to a decision about the right medical treatment should be a collaborative process between the two experts.

Unlike other medical encounters e.g. doctors' appointments, to date no-one has studied the practitioner-client interactions that occur during a SCC, it is not known whether patient participation, and Shared Decision Making transpire in this particular medical setting. This study will therefore use Conversation Analysis (CA) to examine the interactional practices produced and oriented to by practitioners and clients in a SCC appointment. The general assumption of CA is that 'ordinary talk is a highly organised, socially ordered phenomenon' (Hutchby & Wooffitt, 2008, p.11). It has been the dominant method of analysing social interactions since it was developed at the University of California in the 1960s (Sacks, 1992). CA systematically analyses the talk produced in every day human interactions (Hutchby & Wooffitt, 2008). CA studies 'utterances as social activities, sequencing, interactional details as a site of organisation, analysis of participant orientations, single cases and collections (of data)' (Maynard & Heritage, 2005, p.429).

Reflective Commentary

The motivation behind this research is personal to the main researcher, who is herself a trainee Skin Camouflage Practitioner (SCP). It was bought to her attention during her training that the Skin Camouflage Clinics (SCC) appeared to be more patient-centred than other medical encounters with clients actively participating in the decision making process. Despite this, research focuses only on the effectiveness of the skin camouflage creams (Holmes et al, 2002; Kent & Thompson, 2002; Ongenae et al, 2005). The benefits of the service and the SCC's as a whole have never been researched using a fine tuned method of analysis like CA and the accomplishments and contributions of the SCP's have been naively ignored. Due to this lack of research only a small proportion of the disfigured population are aware that the Skin Camouflage Service is available. It is the aim of this research to bring about more awareness and be the starting point for continued research into a service that may be beneficial to a growing population.

Research questions

1) Does a Changing Faces Skin Camouflage Clinic involve Shared Decision Making and patient participation? How are these achieved interactionally?

2) Do practitioners, as the medical expert, claim authority over decision making, if so what interactional tools to they use? How do clients resist practitioner authority?

3) Do the interactional tools the Skin Camouflage Practitioner uses fit in with the Prescribing styles identified by Byrne & Long (1976)?

Data and Method

Skin Camouflage Clinic procedure

On 14th November 2011, as part of their 'Changing lives' initiative Changing Faces took over the Skin Camouflage Service that was originally set up by the British Red Cross in 1975. James Partridge, the founder of Changing Faces used the service when he was left disfigured after a car accident at the age of 18 (The Guardian, 2012) and has since identified it as "a crucial part of the tool-kit which can build a person's confidence and enable them to live their life's to the full"(Partridge, 2011, p.1). A Skin Camouflage Clinic (SCC) consists of four one-hour appointments; one client is seen per appointment. In each appointment a Skin Camouflage Practitioner (SCP), who has received 30 hours of accredited training by the Royal College of nursing (Changing Faces, Undated, b), finds the appropriate colour and brand of camouflage cream for the client attending the appointment and then shows them the techniques required to apply the camouflage creams along with any other necessary products (e.g.setting powder). There are over 200 different coloured creams available at a SCC (see adjacent image) therefore the treatment choice options are

Figure 1: Camouflage creams

extensive. At the end of the appointment clients are given a letter to return to their General Practitioner (GP) so they can obtain a repeat prescription of the camouflage creams. Appendix 3 shows the structure of an appointment.

Data collection

Five hours of audio and three hours of audio-visual data were collected from Five Skin Camouflage Clinics (SCCs) run by Changing Faces involving three Skin Camouflage Practitioners (SCP) and five clients. A digital video camera and dictaphone was set up unobtrusively in three of the appointments. In two of the appointments only a dictaphone was used at the request of the client. Effort was made to generally inform all participants of the overall aim of the research via an information sheet (see Appendix 4) and cover letter (see Appendix 5) that was sent out when the client was informed of their appointment. General information about the research and the value it holds was reiterated to participants on the day of their appointment by the main researcher. All participants signed an informed consent form (see Appendix 6).

Participants. Three participants in this research are SCPs who volunteer their services to run the SCC's for Changing Faces. The remaining participants (n=5) are clients who are attending the clinic to receive a prescription of a camouflage cream

to disguise the appearance of a disfigurement. Clients are either referred to the service through their GP, Surgeon, Dermatologist or they are self-referred, via the self-referral service on the Changing Faces website (http://www.changingfaces.org.uk/Skin-Camouflage/Self-referral). The age of the clients ranges between forty and sixty years of age. None of the clients are under the age of eighteen or over the age of sixty-five. Seven of the participants (including the SCPs) are female, one is male.

Ethical considerations. All participants gave ethical consent (see Informed Consent form, Appendix 6) for the appointment to be recorded and for anonymized data extracts to be included in the final research paper. Due to the sensitive nature of the appointments it was reinforced to participants that they had the right to withdraw themselves, or their data from the research at any time. All clients were informed a month prior to their appointment that the research was taking place, to avoid increasing anxiety levels in a setting that may already be distressing. Due to the extensive waiting list for the service it was explicitly stated that those who did not want to take part in the research should still attend their appointment and it would not be recorded. Prior to the clinic SCP's informed the researcher of any clients who it would not be suitable to ask to participate based on their age (under eighteen, or over sixty-five years of age) or medical notes passed on by their GP. So to adhere to the Data Protection Act (1998) the medical history of clients was not passed on to the researcher.

Transcription and analysis of data. This research employs Conversation Analysis (CA) to analyse the orientations of and interactional tools used by the clients and SCPs during a SCC. Five hours of data from the SCC's was transcribed using both Verbatim (Appendix 7) and Jeffersonian transcript conventions (Jefferson, 2004) (Appendix 8). Verbatim transcripts allowed for fast searches through the corpus, while Jeffersonian transcript enabled the inclusion of "sound, pace, intonation and interaction in conversation, which gets lost during the conversion of sound into text" (Evers, 2011). These interactional features of delivery are central to the formation of actions in talk.

Analytic Resources. A large amount of literature was engaged with to distinguish a number of analytic resources; this is presented in detail in Table 1. The analytic resources are epistemic authority (Heritage, 1984:2012, Heritage & Raymond, 2005), Assessments, tag questions, yes/no interrogatives, negative interrogatives, dispreferred/preferred responses, agreements/disagreements, directives, interrogative syntax, intonation and face threat minimisers. They are drawn upon throughout the analysis of the data.

Analysis

In this section the interactional tools deployed by Changing Faces Skin Camouflage Practitioners (SCP) and clients during the colour matching phase of a Changing faces Skin Camouflage Clinic (SCC) will be analysed to answer the proposed research questions. Particular attention will be paid to the ways in which the SCPs make the process of colour matching collaborative and a shared decision; encouraging and welcoming patient participation, while at the same time maintaining their expert and epistemic authority (Heritage & Raymond, 2005; Heritage, 2012).

Table 1- Analytic Resources and Relevant Literature

Epistemic authority	
Research	**Findings**
Terasaki (1976/2004), Godwin (1979) Heritage (1984),	Speakers are "exquisitely sensitive" to their epistemic position, K- (unknowledgeable about information being discussed) or K+ (knowledgeable about information being discussed), in relation to their co-converser when developing a turn at talk.
Heritage and Raymond (2005)	In everyday talk, epistemic authority; the rights to evaluate states of affairs, is ranked by speakers in relation to one another and is continuously guarded and protected.
Heritage (2012)	Epistemics refers to the transmission of news to otherwise unknowing recipient(s)
Stivers, Mondada and Steenstig (2011) Pollner, (1974, 1975)	The authority to 'know' information is socially sanctioned; in such a way that expertise is "permitted to take precedence over the judgement of amateurs" (Pollner, 1974).
Lindstrom and Mondada (2009)	"A client experiencing the effects of a service on her own body can be the primary party entitled to assess these effects" (P.304).
Assessments	
Research	**Findings**
Pomerantz (1984)	With an assessment a speaker claims knowledge of that which he or she is

Heritage and Raymond (2005)	Distinction between first position assessments, which initiate an assessment sequence and second position assessments, which are responsive to an assessment. By making a first positioned assessment about a state of affairs the speaker is claiming primary epistemics and a moral right to make an assessment. Assessments can either be downgraded or upgraded. Downgraded first position assessments are usually produced by individuals with less epistemic authority (K-) to assess the state of affairs. Upgraded second position assessments are likely to be used when the second assessor has more epistemic authority (K+).
	When epistemic authority is equal between both assessor they first position assessor may downgrade there assessment with a tag question and the second position assessor is likely to respond with a declarative.
Edwards and Potter (2012)	Categorization of assessments into *object-side assessments*, which characterise the event or object e.g. "it was good", and *subject-side assessment,* which predicate the person or subject making the assessment e.g. "I love it". Object-side assessments are the format of most assessments while subject-side assessments individualise the assessment, giving the individual the right to make an assessment. They require personal experience of the assessed object or event.

Tag Questions

Research	Findings
N/A	These are structures that transform a declarative or imperative into a question with the addition of an interrogative e.g. "wasn't it?" a declarative e.g. "that was good" can be changed into a question "That was good wasn't it?"

Lakoff (1975)	In classic sociolinguistic work tag questions have been treated as weak moves
Hepburn and Potter (2011)	The importance of tag questions as a way of managing advice resistance in institutional settings. Their work illustrates that the use of a tag question directs an individual to confirm information even if it has been previously resisted by the listener.

Yes/No Interrogatives

Research	Findings
Raymond (2003)	The grammatical form of a question constrains the form of an answer that is relevant and expectable. Yes/no interrogatives make relevant a "yes" or "no" response. Respondents can however respond with a non-type-conforming answer that does not fit the grammatical structure of the question, this signals that they view the question as somewhat problematic.

Negative Interrogatives

Research	Findings
Heritage (2002)	These are questions that "begin with interrogative frames like 'Isn't it..., 'Doesn't this...', and 'Don't you...'. Such questions are quite commonly treated as expressing a position or point of view" (p.1428). Structuring a question in the format of a negative interrogative strongly invites the co-converser to respond in agreement.

Preferred/dispreferred responses, agreement/disagreement

Research	Findings
Pomerantz (1984)	Agreement after an assessment is usually the preferred response with the exception of a self-deprecating assessment whereby the preferred response is disagreement. When a dispreferred response is given there are a number of face threat minimisers that can be utilised by the respondent (see below). In many cases when a conversant is going to respond with a dispreferred response, namely a disagreement they employ a number of delay devices such as no immediate forth coming talk, repair initiators, which request a clarification from the speaker, and agreement tokens, which are an initial weak agreement which is then followed by the disagreement (the disprefered response).

Directives

Research	Findings
Goodwin (2006)	Directives are utterances designed to get someone to do something
Heinemann (2006) Curl and Drew (2008) Craven and Potter (2010) Antaki and Kent (2012) Kent (2012)	Contingency and entitlement have been acknowledged as significant dimensions of directive. Entitlement refers to the extent to which a speaker displays the right to expect compliance from their co-converser and the right to control the co-conversers actions. Contingency refers to the extent to which the speaker is aware of any potential barriers to compliance in the design of their utterance.

Interrogative Syntax

Research	Findings
Heritage (2012)	Interrogative syntax is the standard means of accomplishing the kind of social action that seeks information; they are usually used as a neutral form of questioning.

Intonation

Research	Findings
O'connor & Arnold (1961)	A rising intonation can be used to change a declarative statement into a yes/no question.
Couper-Kuhlen & Ford (2004)	Intonation indicates to the listener the completion point of the speakers Turn Construction Unit (TCU); a piece of conversation that comprises an entire turn. Therefore signalling their right to now speak.
Bolden (2010) Raymond (2010)	Rising intonations at the end of a unit of speech may indicate that the speaker has low epistemic access to what they are saying, whereas falling intonations indicate a high degree of epistemic access.

Threat Face Minimisers

Research	Findings
Goffman (1955, 1967) Brown & Levinson (1987)	During an interaction both individuals act and interpret their co-conversers acts in such a way that maintains the face of self and other. The term 'face' is defined as 'the positive social value a person effectively claims for himself [sic] by the line others assume he has taken during a particular contact' (Goffman, 1967, p. 5).

A line is the verbal and non-verbal behaviour that conveys appraisal for both individual's in the interaction, especially the appraisal of him/herself. The aim of face work is to manage the impressions of one's self and other. When one's face is threatened, e.g. giving a dispreferred response to an assessment, it can lead to emotional anxiety therefore face threat minimisers are used by co-conversers to signal that a face threatening act is imminent.

Owen (1981, 1983)

Jucker (1993)

Lakoff (1973)

The 'Well' preface (owen, 1981, 1983), which is used at the beginning of a turn to mitigates confrontation by signalling to the co-converser that the speaker is about to act in a way that is potentially face threatening. The 'well' preface signals to the client that the following information is not going to directly answer their question.

Pomerantz (1984)

"No immediate forthcoming talk" can be used to delay having to give a dispreffered

Shared Decision Making and patient participation

In extract 1 the SCP and Ann, the client, are trialling camouflage creams to cover the "spider veins" on Ann's legs. Ann has previously explained to the SCP her problem and how she would like to make the spider veins less visible so that she can go swimming and not have to wear stockings all of the time to cover them, especially during the summer.

Extract 1: Ann (1)

Practitioner is applying the camouflage cream to the Ann's leg.

1. **SCP**: an that's quite good isn't it?
2. **Ann**: yes (.) yeah (.) that's a good match actually

Lines 4, 5, 6 omitted. Ann asks practitioner how to apply camouflage cream, practitioner
   provides an explanation.

7. **SCP**: >thats a very good match< isn't it=i think well go with tha' one
8. **Ann**: that's a good match ((leaning in very closely to inspect leg and

The encouragement of patient participation. In line 1 the tag-question 'isnt it?' used by the SCP indexes Ann's right to make an assessment and acknowledges that Ann has access to the state of affair being assessed- the colour of the camouflage cream in relation to her skin tone, the SCP is inviting Ann to make an assessment. The downgrade "quite" (Line 1) used by the SCP emphasises her acknowledgement that Ann has the priority to assess (Heritage & Raymond, 2005). This surrendering of epistemic authority by the SCP encourages Ann's participation and allows her to feel as though she has some control over the colour selection process and as a result control over her disfigurement.

Maintaining epistemic authority in Shared Decision Making. Despite the colour matching process being collaborative in this extract, the SCP still appoints certain interactional tools that assert her epistemic authority as the expert (Pollner, 1974, 1975; Stivers, Mondada & Steenstig, 2011). The tag-question "isn't it?" (line 1) is directing the client to provide a type-conforming 'yes' or 'no' response (Heritage & Raymond, 2005) such that agreement is the preferred response. The SCP continues to display her expertise and entitlement to also assess the colour with the declarative in line 3 "this is a very good match yeah" this follows with the repetition and upgraded assessment "very good" (line 4) that reasserts her entitlement to assess the colour in first position (Heritage and Raymond ,2005). The SCP incorporates the use of another tag question "isnt it" (line 4) however this is latched onto the declarative statement "=I think well go with tha one" (line 4). This strategy of embedding a tag question mid turn has been described by Hepburn and Potter (2011) as one way of managing advice resistance, and here it secures further agreement from Ann. This extract demonstrates how epistemic authority and the right to assess the colour choice are balanced during a Changing Faces SCC appointment making the decision making process. The SCP acknowledges Ann's

entitlement to assess the colour choice but asserts her expertise when a shared decision has been reached to confirm the treatment choice.

Resourcing epistemic authority to encourage patient participation and to assist in client's assessments. Extract 2 and 3 are from the second clinic recorded for this research, with a different SCP. The client, Pam, is attending the clinic to conceal a scar on her cheek that she obtained through surgery for the treatment of cancer. In Extract 2 the colour matching phase has been in progress for a while, two colours have already been tried and the SCP has just applied a third colour. The SCP in directing Pam to assess the three colours

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   Extract 2: Pam (1)

   1. **SCP**: oka:y >have a look<
   2.   (.)
   3. **Pam**: ooh that is a better cula isnt it?
   4.   (4.00)
   5. **SCP**: .hhhhhh
   6. **Pam**: i can still see it if that's what your mea[ning
   7. **SCP**:   [uummm] (2.0) .hhh hava look at
   8.   the first one
   9.   (0.5)

   10. **Pam**: i think the first ones looking very good
   11. **SCP**: ye::ah I::D like to try <u>that</u> one [beca- THis sec- this thi::rd one is st-
        quite goo:::d=you
   12. **C**:   [urmyes]
   13. **P**:   =might no'see its got a<u>lot</u> of <u>bro::</u>wn [in it¿

The SCP uses a directive (in line 1) that does not orientate towards any potential resistance in compliance from Pam (Kent, 2012). This directive is encouraging Pam to make the first position assessment and acknowledges her entitlement to assess for herself. Pam observes the colour match responding with an assessment "ooh that is a better cula isn't it?" (line 3). The compliance orientated directive used by the SCP in line 1 to encourage an assessment from Pam, leads her to presume that the colour she is assessing is better than the one previously shown; however this is not the case. Instead of disagreeing with Pam's type-conforming yes/no tag question (line 3), the SCP responds with "no immediately forthcoming talk" (Pomerantz, 1984, p.70) followed by an extended inbreath, to avoid giving an explicit disagreement and discrediting Pam's assessment. Pam requests a clarification "I can still see it if that's what your mea[ning" (line 5) from the SCP who did not respond to Pam's previous tag question (line 3). The SCP responds with an agreeing intonation 'ummm' (line 6) followed by an inbreath indicating to Pam that a topic shift is imminent (Walker, 2013), in this case, from the assessment of one colour to the assessment of a previously applied colour. This topic shift is another directive (line 6), encouraging Pam to make a first position assessment. The SCP is using her expert status to change Pam's assessment; although this is a directive move, it makes the process

more collaborative, by handing over the primary rights to assess to Pam. In line 8 Pam accepts her entitlement to assess the colour; making a subject-side assessment that claims personal experience of the state of affairs (Edwards & Potter, 2012). The SCP responds in agreement with Pam's assessment (line 9) producing a subject-side declarative, reassuring Pam that her assessment is now correct.

 Extract 3 is from an earlier point in Pam's appointment, one of the creams is being assessed in comparison to a previously applied colour. The SCP has just applied the cream to Pam's face.

Extract 3: Pam (2)

1. **SCP**: so pam ca-can y >jus have a look<=can y jus see::: tha-[that is too::: th'is too::-]
2. **Pam**:   [ooh right i got ya   ]
3. **Pam**:→   thas too urrm
4.   (.)
5. **SCP**:→   O:ringe [(.) can ysee its got more ori::nge¿
6. **Pam**:→   [aurr rite]   yes definite[ly
7. **SCP**:   [n so we can see it as a patch so that's
8.   [a no::   ]
9. **Pam**:→   [definitely (no)] i quite agree with you

The directive used by the SCP (line 1) implies high entitlement (Drew & Curl, 2008) an authority over the state of affairs, similarly to the directives used in extract 2. The SCPs assessment that directly follows this is overlapped with an agreement from Pam (line 2) who then proceeds to make an assessment, however Pam appears to struggle with completing her assessment (line 3→). The SCP collaboratively completes the assessment and asserts her expertise through the use of an interrogative syntax, "O:ringe [(.) can ysee its got more ori::nge¿", this summons a second assessment and a further agreement from Pam (Heritage & Raymond, 2005) (line 5 →). The following declarative "so that's a no::" (line 7 and 8) asserts the SCPs epistemic authority as the expert ensuring that the wrong treatment choice is not selected. Extracts 2 and 3 demonstrates how the SCP exert their expertise and epistemic authority by resourcing interactional tools such as directives and tag questions to encourage client participation and to assist in helping clients to assessments. Through the analysis of the above extracts (1 to 3) it is revealed that Shared Decision Making and patient participation are encouraged in Changing Faces SCC's by the practitioners who resource their expert and epistemic authority to ensure clients make the right treatment choice.

Client resistance and maintaining epistemic authority

 The next part of this analysis will look at what happens when clients are given too much of the responsibility in the colour matching phase, how clients resist SCP's authority and how the SCP react to this resistance.

Client resistance to a wholly patient-centred approach. The following extract (4) is from Ann's appointment, the colour matching process is just about to commence and the SCP is selecting a cream to trial against Ann's skin tone. The extract demonstrates client's resistance to being given too much responsibility in the selection of the colour cream. This extract illustrates how clients expect the SCP's to provide the solution to their problem.

 Extract 4: Ann (2)
Practitioner is over by the table with the camouflage creams on it. Her gaze switches between the camouflage
creams and Ann's leg. The practitioner selects a palette of creams and brings it over to Ann.

1. **SCP**: an with your legs really ˚urum˚ you have a choic::e of what colour you want them to
2.   be::: in some ways [because ((shrugs shoulders)) ˚you can be::˚ as near as that- to=
3. **Ann**:   [well really as near as my natural skin tone i think =
4.   =would be better wouldnt it?   ]
5. **SCP**: = your natural colour yeah let's try that one] ˚˚D53˚˚

In line 1 the SCP's declarative acknowledges Ann's entitlement to choose the colour of the cream, giving Ann primary rights to assess the colour cream that the SCP has selected. The client however resists this by overlapping the SCP's uncompleted turn with "well" (Line 3) signalling a dispreffered, disagreement (Owen, 1981, 1983). Ann does not want there to be a "choice" she wants the correct colour, "well really as near to my natural skin tone I think would be better wouldn't it?" (lines 3 and 4) . The use of the subject-side assessment "I think" enables Ann to distinguish her own opinion from that of the SCP's; she has the right to disagree with the SCPs declarative (Edwards & Potter, 2012). The use of the negative interrogative "wouldn't it?" (line 4) strengthens her disagreement with the SCP's proposal. The SCP acknowledges Ann's entitlement to make a disagreement by responding to her type-conforming tag question with the preferred response "yeah" (line 5). The SCP finally offers the declarative "lets try that one" (line 5) taking control of the appointment at Ann's request. It is apparent from this extract then that client's look to the SCP's as experts and rely on them to assert themselves as such. Clients attend the clinic with expectations of seeing a medical expert therefore they expect the SCP to make the "choice" about the right colour cream.

Partial resistance to SCPs treatment choice. Extracts 5 demonstrate how clients resist the SCP and how the SCP's preserve their expert status while maintaining a patient-centred, Shared Decision Making environment. Extract 5 is from Dave's

appointment, he is attending the clinic for Vitiligo a skin condition which causes pale white patches to form on areas of the skin due to a deficit in melanin production (National Health Service, 2012). A camouflage cream has already been applied to his arm over an area of skin that is affected by the Vitiligo.

Extract 5: Dave

Previously discussing holidays they have both had to Africa. Practitioner stands up and beings to move towards the camouflage cream table. She then turns back and looks at Dave's arm.

1. **SCP**:→ I quite like that one
2. **Dave**:→ yeah °maybe a touch I dunno a touch darker?° watduya reckon?
3. **SCP**: well what we can do is put mo::re on but with a <u>splash</u> of powder in the >middle¿<
4. **Dave**: arh okay
5. **SCP**: urrm ((practitioner now over by the camouflage cream table)) because we have to use
6. powder to <u>se:t</u> it (.)

 The SCP claims entitlement to assess the colour she has chosen by making a subject-side declarative assessment line 1 (→) (Edwards & Potter, 2012), this is however downgraded, showing her acknowledgement that Dave also has epistemic entitlement to make an assessment (Heritage & Raymond, 2005). In line 2 (→) Dave orientates his turn with an agreement token to minimise the overt disagreement that follows (Pomerantz, 1984); an assessment that is in disagreement with the SCP's first positioned assessment, furthermore Dave's interrogative "watduya reckon?" (line 2) makes him the first position assessor. Dave is displaying his epistemic rights as the client experiencing the service (Lindstrom & Mondada, 2009). The SCP uses the face threat minimiser "well" (Line 3) to signal to Dave that her response is dispreferred and will not specifically answer his question (Lokoff, 1973 cited in Jucker 1993; Owen, 1981) this makes the SCP's response to Dave's first positioned assessment non face threatening but allows the SCP to upholds her epistemic superiority. The SCP acknowledgement of Dave's entitlement to make an assessment at the beginning of this extract encourages a Shared Decision Making approach. When met with resistance from Dave regarding her colour selection she effectively uses the face threat minimiser to avoid criticising Dave's contribution, the additional information within the turn that follows "what we can do is put mo::re on but with a <u>splash</u> of powder in the >middle¿<" (line 3), reinforces her expert and epistemic authority as the health care professional.

Complete resistance. Throughout the clinics recorded for this research, SCP's are rarely met by complete resistance from a client. As can be seen in the above extract (5), the resistance is minor. The last two extracts (6 and 7) are from an appointment where the client, Kim, who is attending to find a cream that can cover the hyperpigmentation on her hands and legs, is resistant to the SCP's colour choices throughout the appointment.

Extract 6: Kim (1)

Kim is practising applying the camouflage creams with the assistance of the SCP.

1. **Kim**:   WHa- im stro:gglin with [its the d]istinction from my ma::in cola=[˚don think] its˚=
2. **SCP**:   [ummm]   [u↑umm?]
3. **Kim**:   =obviously its not the yknown <is it not possible to find the pa:rfect match¿or is it
4.   jus mat- tr[ial an erro]r¿
5. **SCP**:   [aawel I er] (.) t- th-ee (.) well we can try another cula

  Similarly to Dave's resistance in extract 5, Kim orientates her resistance to reduce the "uncomfortable, unpleasant, difficult" (Pomerantz, 1984, p.77) and face threatening (Goffman, 1967; Brown & Levinson, 1987) nature of disagreeing. By starting her turn with the declarative 'WHa-im stro:gglin with' (line 1) Kim is identifying that the 'struggle' is her struggle, she avoids explicitly criticising the SCP. The SCP's rising intonation at the end of line 2 "u↑umm?" that overlaps Kim's continuing talk is in disagreement to Kim's suggestion that there is a problem. Kim then displays her epistemic authority with the beginning of a disclaimer in line 3 "=obviously its not the yknow", however she then self-repairs her turn into a yes/no type-conforming interrogative "<is it not possible to find the perfect match¿" (line 3) (Heritage & Raymond, 2005) positioning herself as the first positioned assessor to further display her superiority. This puts the SCP in a problematic position, if she responds with the preferred response 'yes' she is admitting her original colour choice was incorrect, if she says 'no' she indirectly suggests there is no treatment for Kim. Kim's interrogative "or is jus mat-tr[ial an error¿" (line 4) is latched on to her first question as a way of managing any resistance and securing agreement from the SCP, in a similar way to the embedding of tag-questions mid turn (Hepburn & Potter, 2011). Although met with hesitation from the SCP, signalling disapproval, "aawel I er] (.) t- th-ee (.) well" (line 5), Kim's epistemic superiority and status as the expert of her own body, are acknowledged and the SCP proceeds to find another colour "we can try another cula" (line 5).

  Later on in the same appointment (Extract 7) Kim continues to display her epistemic superiority, disregarding the SCP's status as the expert by making a subject-side assessment (Edwards & Potter, 2012) (line 1) that does not invite a second assessment from the SCP. The SCP's dispreferred disagreement is explicit and exaggerated by an initial increase in volume of her speech, however this is followed by the declarative "WE can t-try another one cos the important thing is that we get the ri- right one" (line 2). This emphasises that the SCP acknowledges Kim's entitlement to disagree with the colour of the creams selected so far, she is reiterating to Kim the collaborative nature of the appointment "WE" (line 2) and that her aim is the same as Kim's aim; finding the right colour camouflage cream for her.

  Extract 7: Kim (2)

1. **Kim**:   An AN I think its gonna take a while re[ally to (fin a match)]
2. **SCP**:   [WELL AR NO WE c]an t-try another one
3.   cos the important thing is that we get the ri- right one

Extracts 5 through to 7 demonstrate how clients are able to resist SCP's expert and epistemic authority by repositioning themselves as first positioned assessors, using interrogatives and employing face threat minimisers to buffer the effects of their disagreements. The SCPs do not 'pull rank' when this occurs, instead they allow the clients to make assessments and participate in the collaborative process of finding the right colour camouflage cream. SCP's appear to utilise their epistemic authority more as a way to guide clients into making the correct choices, as can be seen in extracts 1 to 3, rather than as a resource against client resistance. The allowance by the SCPs, for clients to claim primary assessment rights and participate in the appointment, illustrates Shared Decision Making.

Prescribing styles; patient-centred or doctor-centred? (Byrne & Long, 1976)

The final part of this analysis looks at the prescribing styles and behaviours (Byrne & Long, 1976) of the SCPs. The majority of the time a more patient-centred prescribing style is adopted by the SCP. In extract 1 by acknowledging Ann's priority to make an assessment of the camouflage cream through the use of the downgraded tag question (line 1), the SCP is employing a prescribing style that is patient-centred; similar to Byrne & Long's (1976) prescribing style 7, she is reflecting on the camouflage creams she selected and encouraging Ann to assess her selection. In extract 2 a prescribing style similar to style 5 is found whereby the SCP presents a problem (line 1) and seeks suggestions from the client (line 1) but makes the final decision, based on her expert opinion with the subject-side declarative (Edwards & Potter, 2012) "I::D like to try <u>that</u> one" (line 9). In this extract (2) the SCP gives information to Pam that justifies the assessment of the cream chosen, "This sec- this thi::rd one is st-quite goo:::d=you might no'see its got I of <u>bro::</u>wn [in it¿" (line 9 to 11), and clarifies any uncertainty through the use of directives (extract2, line 1 and 6), leading to a collaboration.

Extract 3 again encompasses a more patient-centred prescribing style by encouraging, seeking client ideas, using client ideas, giving information, advising, and clarifying (Byrne & Long, 1976). However towards the end of the extract (line 7 and 8), when the SCP acknowledges that Pam is having difficulties making an assessment, a more doctor-centred prescribing style is recruited (style 2) whereby a decision is made by the SCP and she announces it (Byrne & Long, 1976) through the use of a declarative assessment that invites no further talk "so that's a <u>no::</u>" (line 7&8). This doctor-centred approach involves the SCP claiming her epistemic entitlement as the expert (Pollner, 1974; 1975) to ensure that the wrong colour camouflage cream is not chosen. Extracts 4 displays a patient-centred practice whereby the client is given complete control in deciding the treatment choice.

When met with minor resistance a more doctor-centred prescribing style (Byrne & Long, 1976) is utilised. In Extract 5 the SCP has to 'sell' (style 3) her decision to the client by providing additional information about the treatment choice she has chosen (line 3). This prevents the client from making an incorrect colour choice. Surprisingly when met by complete resistance from a client, as in extracts 6 and 7, the SCP uses a more patient-centred prescribing style whereby she acknowledges the patients ideas, reflects on them and emphasise the importance of getting the right treatment for the client "the important thing is that we get the ri- right one" (extract 7, line 2).

Discussion

Research into disfigurement is expanding with issues such as 1) how those with a disfigurement view themselves (Grogan, 1999; Harter, 1999; Herskind et al, 1993; Strenta & Kleck, 1985), 2) how disfigurements can impact on social interactions (Bull & Rumsey, 1988; Robinson 1997; Macgregor, 1990; Rumsey, Bull & Gahagen, 1982; 1986; Rumsey, 1983; 2002) and 3) how disfigurements affect a person's quality of life (Rumsey & Harcourt, 2004) being addressed. Additionally research into interventions and provisions of care for the growing population of disfigured individuals is mounting (Rumsey & Harcourt, 2004). However the majority of this focuses on the biomedical (e.g. surgery) approach to treatment which is invasive and irreversible. The use of camouflage creams, a non-invasive, non-permanent treatment that reduces the appearance of a disfigurement, has been shown to significantly improve quality of life and reduce levels of appearance anxiety (Holmes et al, 2002; Kent & Thompson, 2002; Ongenae et al, 2005) in individuals with a disfiguring condition. However this research conducted so far has only focused on the effectiveness of skin camouflage creams and does not investigate the benefits of a Changing Faces Skin Camouflage Clinic (SCC) as a whole. The main aim of this research is to explicate the interactional practices produced and oriented to by practitioners and clients in a Changing Faces SCC where these creams are obtained. The specific focus of this research is to examine whether SCC's are an environment where Shared Decision Making and patient participation flourish and if it is due to the interactional endeavours of the SCP's that a patient-centred (Byrne & Long, 1976) service is provided. In the analytic section of this research an in-depth analysis of the data using Conversation Analysis (CA) to investigate the proposed research questions is conducted.

Shared Decision Making and Patient Participation

Previous research by Lerman et al (1990) suggests that patient participation and Shared Decision Making give patients a greater sense of personal control, however reports show this only occurs "about 10% of the time"(Godolphin, 2009, p.187). Shared Decision Making and patient participation were evident throughout the data, facilitated by the SCP's interactional endeavours. SCP's utilised tag questions (extract 1) to acknowledge the clients rights to assess the treatment choice and directives (extract 2) were oriented in a way to explicitly encourage the clients to participate and claim their epistemic entitlement by becoming the first positioned assessor (Heritage & Raymond, 2005) or in times of assessment difficulty, guiding them towards a correct assessment.

Exerting Authority Over Decision Making

Recent research by Stivers, Mondada and Steenstig (2011) proposes that the authority to 'know' information is socially sanctioned; in such a way that expertise is "permitted to take precedence over the judgement of amateurs" (Pollner, 1974; 1975 cited in Heritage, 2012, p.6). However Lindstrom and Mondada (2009) suggest that "a client experiencing the effects of a service on her own body can be the primary party entitled to assess these effects" (P.304). It is apparent throughout the data that epistemic authority; the right to evaluate a state of affairs (Heritage & Raymond, 2005) is equally distributed due to both parties being 'experts' (Tuckett et al, 1985). SCPs do not use their status as the socially sanctioned expert to override client

decisions and assessments, instead as discussed above, they use it to encourage a Shared Decision Making environment and patient participation. It is only when clients have difficulty correctly assessing the treatment choice that the SCPs assert their epistemic superiority and make final decisions (this can be seen in extract 3).

Client Resistance

When clients are in disagreement with the SCP they resource a number of interactional tools to assert their epistemic authority as the client experiencing the effects of the treatment on their body (Lindstrom & Mondada, 2009). Interrogatives and tag questions are used by the clients to assert themselves as first positioned assessors (Heritage & Raymond, 2005). Subject-side assessments (Edwards & Potter, 2012) are made to claim personal experience and the entitlement to make a disagreeing assessment. It was found that clients are resistant to the SCP giving them too much responsibility in the decision-making process (extract 4). Clients utilise a number of face threat minimisers such as the well preface, the agreement token and 'no immediate forthcoming talk' (Owen, 1981; 1983; Pomerantz, 1984) to buffer the effects of their disagreement with the SCPs. When SCPs are met with complete resistance by the client they do not use their status as the healthcare expert to disagree with the client, instead they concede to the client's resistance and endeavour to find an alternative colour cream.

Prescribing styles (Byrne & Long, 1976)

Byrne and Long (1976) identify a continuum of 'prescribing styles' that doctors embody when diagnosing and delivering a treatment, these range from doctor-centred to patient-centred (Beaumont, 2010) (Appendix 1). The thorough analysis of the data revealed that in most instances SCPs orientate their talk in a way that is patient-centred. This was especially apparent when met by complete resistance from the client (extract 7). However when clients have difficulty assessing the colour of the camouflage creams or finalising a decision the SCP resort to a more doctor-centred prescribing style (style 2) where a decision is made and announced (extract 3). Additionally when met with minor resistance from a client a doctor-centred prescribing style is utilised, as in extract 5 whereby the SCP has to 'sell' (style 3) her decision to the client. This analysis have revealed that the SCP prescribing styles and behaviour can change from patient-centred to doctor-centred during a very short space of time therefore it is correct of Byrne & Long (1976) to propose it as a continuum, this analysis also demonstrates the robust reliability of the continuum that was developed more than thirty years ago showing its applicability to healthcare settings other than general practitioners appointments.

Implications of the research findings and the development of future research

The benefits of a health service that provides Shared Decision Making, patient participation, and patient-centred prescribing styles has already been identified by the General Medical Council (2008) (Appendix 2). It has additionally been acknowledged that very few healthcare professionals are able to incorporate this into their practice (Braddock et al, 1999; Campion et al, 2002; Elwyn et al 2003; Towle et al 2003; Young et al, 2008; Godolphin, 2009). Yet this research has exposed that SCP's, who receive only 30 hours of accredited training, which mainly focuses of practical skills training, are effectively and expertly managing to interactionally deliver

a service that involves these components. Clarke & Cooper (2001) report that many healthcare professionals feel as though they do not have the skills to deal with a disfigured individuals psychosocial needs. This pioneering study of the interactional tools utilised by SCP who confidently interact with their clients, enables future research to be carried out that investigates how other healthcare professional interact with individuals with a disfiguring condition. Based on this and future research training can be developed to improve the skills of healthcare professional so that the needs of the disfigured population are met within other areas of the National Health Service (NHS).

Research limitation

The preliminary methodological aim of this research was to collect twelve hours of video and audio footage for analysis, which would have been achievable by recording all four appointments in three SCC's. However only five hours of footage was collected due to seven clients not attending their appointments. This research has bought to light the problem of appointment attendance with over half of the individuals not attending their appointments that they have, in some cases, had to wait for, for six months to a year. A better understanding of the reasons why individuals do not attend is urgently needed and the service, which relies solely on charitable donations, would benefit greatly from an intervention to increase clinic attendance. Implementation Intention (Gollwitzer, 1993.1996) a self-regulating strategy of an 'if then' plan e.g. 'if situation X arises then I will do Y', has been shown to significantly increase the attendance at breast screening clinics (Rutter et al, 2002). Research into the effectiveness of Implementation Intention for a SCC may be valuable to the Changing Faces Skin Camouflage Service. An Additional limitation was that the small corpus of data makes it hard for general claims about clinical interactions to made, however the use of Conversation Analysis (CA) as a tool generated a more in-depth understanding of the interactions studied.

Concluding remark

The addition of the current study to the small but expanding cohort of research investigating disfigurement intervention and provisions of care (Harcourt & 2004) is hopefully a beneficial addition that can aid Changing Faces in their campaign for a National Health Service (NHS) that provides more integration of individuals with a disfiguring condition (Changing Faces, undated, a). Through continued qualitative research in this area it is the aim that the NHS will finally put appearance concerns higher up on the health care agenda and acknowledge the benefits of funding Changing Faces SCC's so they can continue to run.

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