QUALITATIVE HEALTH COMMUNICATION
VOLUME 4, ISSUE 1, 2025
ISSN: 2597-1417

Approachability features and their application as a qualitative method of analysis for clinical healthcare interactions and ethnographic interviews

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ABSTRACT

Background: Effective communication is crucial for positive health outcomes in clinical healthcare interactions. Patients value friendly, approachable, and informative clinicians who facilitate open communication and shared decision-making. Clinicians can use discourse features to influence how approachable patients and other clinicians believe them to be. **Aims**: To introduce and define the concept of approachability features as a qualitative analytical framework for investigating healthcare interactions and ethnographic interviews and to guide health communication researchers in their application. **Methods**: Drawing on existing literature on interpersonal pragmatics, rapport management, and healthcare communication to define and delineate the scope of approachability features, a step-by-step approach is provided for researchers to use and adapt the framework to suit diverse contextual and analytical needs. Two illustrative examples from existing studies are briefly described. **Findings**: The approachability features framework provides a versatile tool to gain insights into common discursive patterns used in healthcare interactions and to interpret their impact on the relationships between interlocutors. Researchers need to consider the importance of context as well as language and cultural adaptations. **Conclusion**: By introducing the approachability features framework, this paper contributes to the growing body of research on effective healthcare communication. It offers a structured, evidence-based analytical approach with applications across various health settings and topics.

KEYWORDS

Approachability, clinical healthcare interactions, interviews, qualitative analysis, rapport, trust

BIOGRAPHY

Dr Maria R. Dahm is a Senior Lecturer in Health Ethics and Professionalism in the School of Medicine at Deakin University. Her research focuses on investigating the impact of health communication in quality and safety of care. She is a leader in the field of diagnostic communication. She was previously a Senior Research Fellow at the Institute for Communication in Health Care at the Australian National University.

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Introduction

Effective communication in clinical interactions is crucial for the provision of safe and high-quality health care and for positive health and patient outcomes (Haskard-Zolnierek et al., 2021; Ong et al., 1995). When patients seek help for their health problems, their 'ideal' clinicians (i.e. doctors or nurses) are friendly, approachable, unrushed, good listeners and able to explain complex medical ideas in easily understandable language (Huynh et al., 2021; Stenner et al., 2011; Walsh et al., 2016). These characteristics and behaviours make it easy for patients to open up to clinicians, participate in shared decisions-making and negotiations about their health, and trust clinicians' judgement thus more likely to follow management and treatment recommendations (Forsey et al., 2021; Maguire & Pitceathly, 2002; Mikesell, 2013; White & Preda, 2022). In contrast, poor communication skills can lead patients to worry, feel dismissed, delay seeking care in the future or to seek second opinions, or file complaints or malpractice claims (Haskard-Zolnierek et al., 2021; Levinson et al., 2013; Miles & Leinster, 2010). Clinicians can use language and behavioural choices to influence how patients and other clinicians perceived them; to make themselves appear more or less friendly or approachable and to mitigate any real or perceived differences in relation to social distance, power and knowledge (Dahm & Yates 2013). The discursive strategies they use to do so have been conceptualised as 'approachability features' – subtle discourse features that help speakers project impressions, manage rapport, and co-construct interpersonal relationships in their interactions (Dahm et al. 2015; Dahm et al. 2022; Dahm & Yates 2013).

In this article, I will introduce the concept and application of approachability features as a qualitative method of analysis for clinical healthcare interactions and ethnography. The following sections will provide a concise overview of interpersonal pragmatics and rapport management, which form the theoretical underpinnings of approachability features. I will then define and delineate the scope of approachability features as an analytical framework before providing a step-by-step approach guiding health communication researchers in the use and adaptation of the approachability features framework to suit diverse contextual and analytical needs. By describing approachability features as an entry point for qualitative discourse analysis, this paper contributes to the growing body of research on effective healthcare communication and provides a structured, evidence-based analytical approach with applications across a wide range of health settings and topics.

Theoretical underpinning

(Interpersonal) pragmatics and relational work

Questions related to what makes people appear friendly and approachable in human interactions are not new. Approachability has been widely studied in psychology, (higher) education, business and health contexts focusing on paralinguistics (incl non-verbal) aspects of interactions such facial expressions, and body posture, but also exploring linguistic interpersonal discourse features such forms of address and or pronouns (Denzine & Pulos, 2000; Handford, 2010; Miles, 2009). For example, Handford's corpus-driven analysis of

business meetings discussed the development and maintenance of relationships through linguistic practices at length (Handford, 2010).

The approachability features as discussed here, have their origin in the linguistic field of pragmatics. Pragmatics is at its core “the study of language in the social contexts in which it is used” (Barron et al., 2017, p. 1) and “goes beyond the meanings of linguistic expressions used" (Clark, 2021, p. 4). Pragmatics relates to how we use contextual and other information (Clark, 2021) to know 1) what and how to say something (e.g. the difference between politely asking a superior or ordering a child to close a window) and 2) how to understand what others are telling us (e.g. recognise irony, rhetorical questions or dad jokes). Our pragmatic competence allows us to draw on the interactional context to interpret the meaning of a sentence such as “I have a headache” as merely providing factual information, indirectly requesting pain medication, indirectly declining an invitation, indirectly ordering someone to reduce the volume of their voice/music/television, or etc.

Socially oriented pragmatics has evolved from studying how “specific ‘local’ conditions on language use” (Leech, 1983, p. 10) shape interlocutors’ interpretation to form a new subfield known as ‘interpersonal pragmatics’ (Locher & Graham, 2010) focused on how language is used to establish, maintain, and modify social relationships. Interpersonal pragmatics is especially concerned with ‘relational work’, that is how social interactants negotiate relationships and get ‘things done’, i.e. achieve interactional goals, by means of language. Locher and Watts (2008, p. 96) defined relational work as “all aspects of the work invested by individuals in the construction, maintenance, reproduction and transformation of interpersonal relationships among those engaged in social practice’’. That means to get things done using language, we need to know the ‘rules’ of how we are expected to act and what to say in particular situations so we can shape relationships and thus interactions. For example, knowing when we need to mitigate a request and when we can make a bold order can impact the outcomes of our interactions. In other words, we need to be able to understand how we can influence and manage what impressions other people have of us.

Impression and rapport management

‘Impression management’ has its origins in sociology when Erving Goffman, in an anthropological study of social interactions on the Shetland Islands, wrote about how everyone one of us “guides and controls the impressions [others] form of [them]” (1959, p. preface). Impression management refers to how our use of language influences how people see us and thus how they interact with us. Goffman found that people would display more of the linguistic and paralinguistic (e.g. nonverbal, tone, speech rate etc) features that supported the image they wanted to project of themselves and would try to downplay features that cast them in less favourable light. Goffman applied theatrical metaphor to his analysis and thus spoke of people actively managing their impressions – in a performance (Goffman, 1959). In a similar vein, Goffman also developed a theory of face management, arguing that individuals engage in specific communicative strategies to project or protect their desired social image – or 'face' – during interactions (Goffman, 1955). This face represents the positive social value or public self-image that a person claims for themselves and strives to maintain through interaction. However, looking at impression management from a more linguistic or pragmatics informed perspective, it has been pointed out that managing impressions can happen

consciously or unconsciously as people often "do not give too much thought" about the signals they sent or how they might be interpreted (Bilbow & Yeung, 1998, p. 407).

Helen Spencer-Oatey (Spencer-Oatey, 2000, 2002, 2005; Spencer-Oatey & Franklin, 2009) – an expert in intercultural pragmatics – approached the way language can be "used to construct, maintain and/or threaten social relationships" (Spencer-Oatey, 2000, p. 12) by drawing on the concepts of rapport and rapport management:

> We use the term 'rapport' to refer to people's subjective perceptions of (dis)harmony, smoothness–turbulence and warmth–antagonism in interpersonal relations, and we use the term 'rapport management' to refer to the ways in which this (dis)harmony is (mis)managed. (Spencer-Oatey & Franklin, 2009, p. 102)

Through the language they use, speakers hold their orientation to rapport and can build, preserve, ignore, or undermine the (harmonious) relations between themselves and others (Spencer-Oatey, 2000; Spencer-Oatey & Franklin, 2009). Additionally, speakers can draw on multiple competencies to effectively manage rapport (Spencer-Oatey & Franklin, 2009). Among these competencies are 1) 'contextual awareness' (e.g. understanding the type of communication activity interlocutors are involved in as well as their power relationships and related relational rights and obligations within that activity); 2) 'interpersonal attentiveness' (e.g. what interlocutors expect to happen with the given context as well as whether their goals in the interaction focus on relations or tasks); 3) 'social information gathering' (e.g. being able to gather information to read the social context either through observation or direct inquiry); and 4) 'social attuning' (e.g. being able to infer how one is perceived by reading interlocutors nonverbal and paralinguistic cues and adapting behaviours accordingly).

Given the unique dynamics of healthcare interactions, clinicians and patients need to be able to apply these rapport management competencies to find "an appropriate balance between meeting [their] own needs and the needs of the other" (Spencer-Oatey, 2005, p. 338). Clinicians need to be able to accurately set, negotiate or interpret the nature of their communication activity with patients. For instance, what a clinician might perceive or 'frame' (Goffman, 1974; Tannen & Wallat, 1987) as a routine history-taking conversation, patients may experience as an interrogation. This misalignment can lead to divergent expectations regarding the interlocutors' roles and rights, and potential confusion between the relational and task-oriented goals of the interaction: having a chat vs gathering/ providing/ being forced to reveal clinical information. Clinicians need to be aware of and able to mitigate the real and perceived power and knowledge imbalances inherent in healthcare interactions. To do so they require a nuanced understanding of the social context, communication activity and interlocutors expectations and the ability to read indirect cues, for example to notice when they have 'lost' a patient who is no longer actively listening or absorbing the information provided.

Approachability features

Definition

Depending on the specific clinical context and who they are talking to, clinicians might want to project a particular image of themselves in order to enhance or maintain rapport with their

interlocutors. They might seek to position themselves anywhere along the professional spectra of professionally detached vs empathic, uncertain vs all-knowing, wisdom dispensing vs shared-decision making, light-hearted vs serious, or friendly vs authoritative. Clinicians can consciously or subconsciously use language to do relational work, and establish and manage interpersonal rapport to appear e.g. friendly and approachable. They use language to mitigate social and epistemic distances in healthcare interactions and show they are listening and responding attentively to their patients' concerns.

My colleague Lynda Yates and I have argued that the “discursive reduction of social distance, and the establishment of rapport and trust suggests that subtle communication features can be important in perceptions of approachability.” (Dahm & Yates 2013, p. 26). We initially defined such ‘approachability features’ as: "those subtle interpersonal strategies that speakers use to establish rapport and trust and help them appear approachable.” (Dahm et al. 2015, p. 829). When we first wrote about approachability features in clinical interactions, we focused on intercultural domains (e.g. internationally trained doctors navigating interpersonal and clinical dimension of health interactions; Dahm et al. 2015; Dahm & Yates 2013; Dahm & Yates 2020; Yates & Dahm 2016). In these early studies, we included short lists of discourse features (Dahm & Yates 2013) that were readily identifiable in the existing health communication literature, such as small talk, genuine empathic statements and backchannels signalling attentive listening, which were later extended (Dahm & Yates 2020).

More recently, I have further expanded, developed and applied the concept in analysis of diverse health communication contexts and propose the following updated definition (Dahm & Crock 2023; based on prior work; Dahm et al. 2022):

> Approachability features are subtle interpersonal strategies that speakers use to shape the interaction environment, and manage rapport and trust with their interlocutor. These features can drive perceptions of an individual's approachability and the interaction environment on a continuous spectrum from very approachable and supportive to less approachable and controlling.

In line with Spencer-Oatey’s concept of rapport orientation (Spencer-Oatey, 2000; Spencer-Oatey & Franklin, 2009), approachability features can be used to enhance, maintain, neglect or challenge new or existing relationships between interlocutors. Accordingly, I have suggested an approachability continuum along which speakers can use discursive feature to create environments ranging from approachable to non-approachable discourse. Approachable discourse describes interactional environments with a positive social atmosphere and reduced power distances in which rapport is enhanced or maintained through signalling solidarity and building common grounds (cf. Dahm et al. 2022). In non-approachable discourse, environments are perceived as highly controlled with one interlocutor holding power, displaying a lack of caring and neglecting or challenging relationships through distancing behaviours (cf. Dahm et al. 2022).

It is important to note that approachability should not be viewed as a binary construct where individuals are simply categorised as either approachable or not; rather, it should be understood as a dynamic spectrum. While interlocutors may move along this spectrum in response to various contextual and interpersonal factors throughout an interaction, their behaviours may also be more aligned with either end point of the spectrum.

Foundational analytical framework

Informed by extant health communication and social interaction literature, I have developed a foundational analytical framework to assist readers in applying approachability features as a method of analysis. The framework outlined in Figure 1 and further detailed in Table 1 covers five main discourse domains on the approachability continuum: social attuning, engagement strategies, interpersonal strategies, framing and lexical choice. Table 1 provides explanations, examples and supporting literature across all five domains.

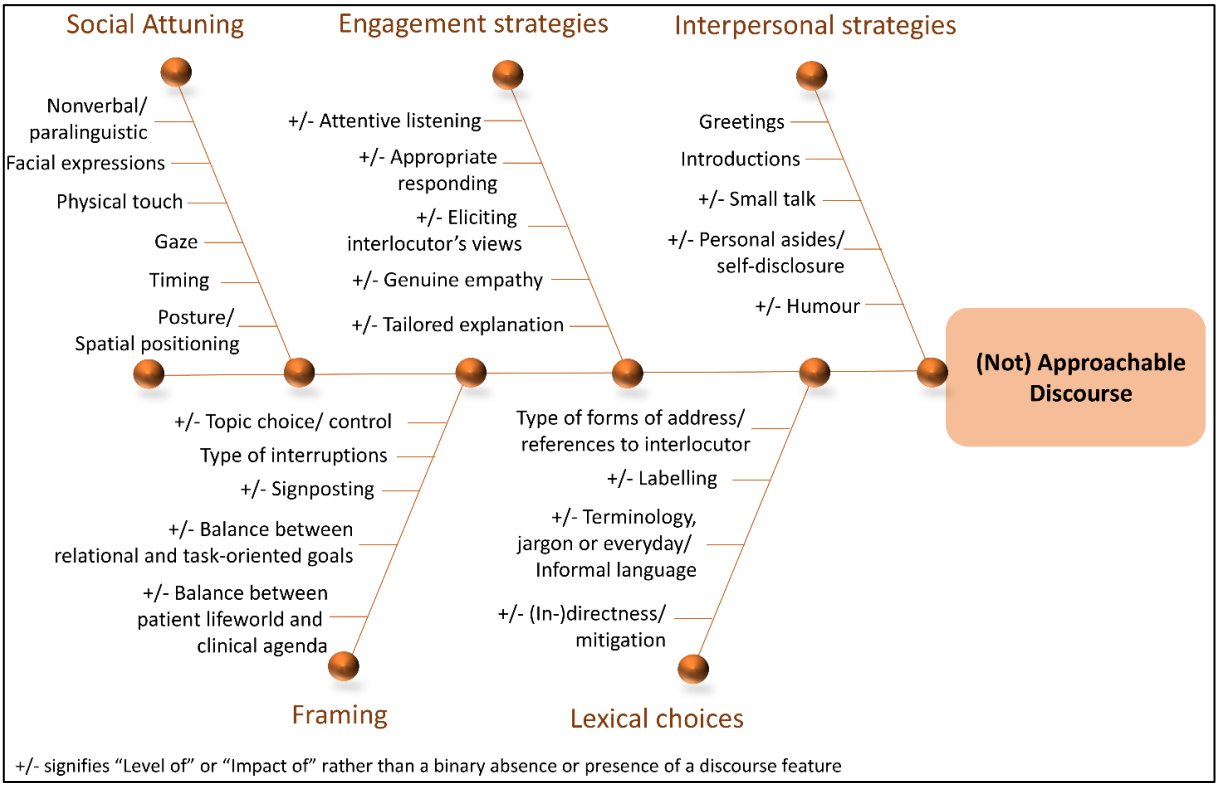


Figure 1. The foundational approachability features framework outlining the five domains of discursively constructed approachability.

Social Attuning refers to "indirect signals" (Spencer-Oatey & Franklin, 2009, p. 102) such as non-verbal and paralinguistics features that interlocutors send and receive and interpret to manage rapport.	- Intonation, stress, pauses, silences, sighs etc (Spencer-Oatey & Franklin, 2009) - Gaze, facial expressions, physical touch (Hall et al., 1995; Harrigan et al., 1985; Marcoux et al., 2024) - Posture (open vs closed), positioning (sitting, standing, leaning), spatial location (e.g. hallway, physical barrier e.g. desk) (Hall et al., 1995; Houchens et al., 2024; Kraft-Todd et al., 2017) - Timing (e.g. in relation to direct and indirect interlocutor signals, attentive silence) (Coulehan et al., 2001; O'Grady, 2011)

Engagement strategies refer to communication techniques that demonstrate genuine interest, attentiveness and encourage participation.	- Attentive Listing (e.g. minimal responses, backchannels, mirroring) (Coulehan et al., 2001; Forsey et al., 2021; Handford, 2010; Lipp et al., 2016; Suchman et al., 1997; Yates et al., 2016) - Attentive responding (e.g. open (follow-up) questions, paraphrasing and reflecting, requesting and accepting correction (Coulehan et al., 2001; Lipp et al., 2016; Roberts et al., 2003) - Eliciting interlocutor views (Crawford et al., 2017a; Forsey et al., 2021; Roberts et al., 2003) - Genuine, personalised empathy vs tokenistic statements or missed empathic opportunities (Crawford et al., 2018; Lipp et al., 2016; O'Grady, 2011; Roberts et al., 2003) - Tailored explanations (Forsey et al., 2021; Street, 2003)
Interpersonal strategies refer to discursive features used to do relational work (Locher & Graham, 2010) and build relationships.	- Greetings and introduction (Makoul et al., 2007; Sobczak et al., 2017; Wallace et al., 2009) - Small talk (Benwell & McCreaddie, 2016; Crawford et al., 2017b; Hudak & Maynard, 2011; Ragan, 2000; White & Stubbe, 2022) - Personal side sequences and self-disclosure (Beach et al., 2004; Kadji & Schmid Mast, 2021; Montgomery et al., 2020) - Humour (Crawford et al., 2017b; Macqueen et al., 2024; Ragan, 2000; Schöpf et al., 2015)
Framing refers to the "interactive frame" (Tannen & Wallat, 1987, p. 206) interlocutors attach to and use to interpret the type of interaction they are engaged in as well as related interactive goals, roles, rights and expectations (cf Goffman, 1974).	- Topic choice and control, agenda setting, signposting (Barnes & Woods, 2024; Roberts et al., 2003; Robins et al., 2011; Street, 2003; Virtanen et al., 2007) - Interruptions (Černý, 2010; Giroldi et al., 2016) - Relational vs clinical task, lifeworld vs clinical agenda ((Barry et al., 2001; Crawford et al., 2017a; Forsey et al., 2021; Mishler, 1984)
Lexical choice refer to the specific words and phrases and level of directness employed by interlocutors in the interaction.	- Forms of address, how other interlocutors are referenced in their presence or absence (e.g. names, titles/honorifics, terms of endearment) (Doherty, 2008; Moore et al., 2011; Parsons et al., 2016) - Labelling of interlocutors or behaviours, and use of stigmatising language (Carroll, 2019; Goddu et al., 2018; Healy et al., 2022; McCartney, 2015) - Medical terminology, (un-)explained jargon, everyday/ colloquial/ informal language (Crawford et al., 2017b; Dahm, 2012; Forsey et al., 2021; Robins et al., 2011) - (In-)Directness and mitigation (e.g. vague language, hedges, euphemisms) (Adolphs et al., 2007; Caffi, 2007; Forsey et al., 2021; Prince et al., 1982)

Table 1. The five domains of discursive approachability features, explanation, examples and supporting literature.

Notes on scope

At this point some explanatory notes on the scope of approachability features as an analytical tool are necessary, particularly in relation to the interactional participants (interlocutors), and the interactional contexts (environment) that can be examined using this method. Interlocutors can be 1) patients, 2) patients' families or carers, 3) clinicians or allied health staff with same or different area and level of clinical expertise (e.g. case presentations from

junior doctor to specialist, or handovers between registered nurses), 4) managerial or administrative staff (e.g. receptionist, ward clerk) or 5) various permutations of the above. In the examples presented later, I will focus primarily on clinician-patient interactions but readers should be reminded that approachability features can be applied to interactions involving all of the above, or in fact, supported by the evidence-based literature, can be applied to additional interlocutors within or even outside of healthcare interactions contexts.

There is overlap between proposed approachability framework for qualitative discourse analysis of health interactions and communication skills training in medical schools (e.g. process skills outlined in the Calgary Cambridge Guides (Silverman et al., 2016) or training described elsewhere (e.g. Locher, 2017). However, my framework distinguishes itself by providing a systematic analytical tool applicable across all healthcare interactions, not limited to patient encounters with medical staff, encompassing various healthcare professionals as well as managerial staff who may have received different levels of communication training, and patient and carers. Communication skills training in medical education is increasingly recognised as a core skill, yet research into its application and interpersonal use beyond memorised communication skill checklist remains stagnant (White & Preda, 2022). The framework proposed here provides a new avenue for inquiry – a detailed analytical lens for understanding how subtle interactional features collectively create an environment that facilitate or hinder successful interaction in health care environments. Rather than being synonymous with good communication skills, approachability emerges as a broader construct that encompasses both learned communication techniques and naturally occurring interactional features that impact interactions in health settings.

While this framework presents multiple components that can influence approachability, it serves as a scaffold or analytical toolbox from which researchers can select and contextualise elements relevant to their specific 'frame of reference' or interactional context. Rather than prescribing a rigid analytical structure, it offers systematic guidance that can be adapted to examine different types of healthcare interactions.

The foundational framework outlined in Figure 1 and Table 1 provides overarching features across five domains that are broadly applicable across diverse health care environments. However, each domain can also be further tailored to particular health communication contexts (e.g. hospital, general practice), tasks (e.g. handover, end of life discussions) or themes (e.g. patient participation) via targeted literature reviews.

Step by step - Application of approachability features framework in qualitative analysis

This section offers practical steps for researchers to follow to conduct their approachability feature study, before discussing two practical examples, focused on bedside handover and diagnosis communication, in more detail.

Collect and prepare data or check existing data for suitability

Types of data

Researchers need to carefully consider what data they may already have available or want to collect and ensure data are suitable to analyse using the approachability framework. Data can take the form of recorded healthcare interactions (naturally occurring, simulations or roleplays) and/or ethnographic context or follow-up interviews. While ethnographic observations and fieldnotes can be used to supplement and triangulate findings during data analysis, by themselves they do not provide sufficient details for the fine-grained analysis of approachability features. Further supplemental data including demographics, medical records or surveys can provide further information to ensure trustworthiness (Patton, 2015).

Healthcare interactions are here broadly defined as synchronous communication events that occur within health environments and involve at least two interlocutors. Such data may be collected specifically for a particular project, or researchers may also draw on the growing number of healthcare interaction corpora available internationally (e.g. Jepson et al., 2017; Stubbe, 2017). Questions regarding authenticity and representativeness need to considered when analysing simulated and/or roleplay interaction (Stokoe, 2013).

Ethnographic interviews can take the form of context or follow-up interviews. Open or semi-structured context interviews provide background information and ethnographic context about the health environment and/or communicative event being studied, and can be conducted in conjunction with collecting healthcare interaction data. While context interviews can also be held prior to recording interactions, potential priming effects that could alter interlocutors' interactional behaviours need to be taken into consideration. Follow-up interviews further explore or elaborate on specific findings after initial data collection and analysis to provide insights into observed behaviours and as from or data triangulation (Patton, 2015). They can be formal qualitative interviews with an interview schedule but also conducted more informally as member checking (participants validating findings; e.g. Patton, 2015). The approachability features framework can be applied to inform the preparation of questions for context and follow-up interviews or to serve as a deductive framework for analysis for interview data.

Data collection and transcription

For all types of data, researchers need to prepare data collection or check to ensure that data are suitable to be analysed with the approachability features framework especially in relation to how data are/were recorded and transcribed. Ideally, approachability features analysis requires audio and video-recorded data transcribed at a high level of granularity to capture non-verbal and paralinguistic social attuning features (cf. White, 2022). However, transcribing often lengthy healthcare interaction at a high level (e.g. drawing on conventions from multimodal conversation analysis; Mondada, 2018) can be time-consuming and costly and thus transcription can be adapted to capture only selected social attuning features (e.g. gaze only). Video-recordings in any health environments also raise ethical considerations and challenges that others have already extensively discussed (e.g. Parry et al., 2016; White, 2022).

Contextualise the framework

Researchers will need to decide whether they want to apply the more generic foundational framework (Figure 1, Table 1) or if they want to further contextualise the framework to target a particular micro clinical interaction context or communicative activity (e.g. end of life discussions in respiratory care, shared decision making in dialysis, diagnosis communication in Emergency Departments) or the larger macro socio-political or cultural context. Any further contextualisation to the foundational framework should be grounded in health communication or social interaction literature, with systematic or narrative reviews often providing valuable starting points. Researchers might thus opt to contextualise in healthcare interaction context that are relatively well studied and have an established evidence-base, or to apply the unaltered foundational framework to study less established fields. However, contextualisation to the foundational framework can also be inductively derived, as in the latter case, where researchers may apply the more generic foundational framework to identify new features and to build an evidence base and, in this way, adapt the framework to a new context.

Analysing data

Applying an approachability features framework allows health communication researchers to combine the concepts of relational work and interpersonal rapport (management) in the analysis of healthcare interactions. Approachability features can be used in diverse research methodologies. For example, as a sole analytical lens for a whole data set (e.g. Dahm & Yates, 2013), a case study (e.g. Dahm et al., 2022; Yates et al., 2016) or to conduct comparative analysis (e.g. Dahm & Crock, 2023). Approachability features can also be useful tool for pluralistic analysis, e.g. in combination with ethnographic observation, interviews and focus groups (e.g. Dahm et al., 2022), to aid reflective practice and education (e.g. Dahm et al., 2015), or to compare the development of approachable communication skills.

Selecting an analytical approach

Depending on the research questions and goals, researchers need to decide on an appropriate qualitative approach when applying approachability features as an analytical tool. This approach can be deductive, inductive, or mixed content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005), thematic analysis (Braun & Clarke, 2006) or discourse analysis (Brookes et al., 2023; Roberts & Sarangi, 2005). In deductively-oriented approaches such as directed content analysis or summative content analysis (Hsieh & Shannon, 2005), researchers can use the foundational or contextualised framework as starting point for a coding scheme. More inductive approaches such as conventional content analysis (Hsieh & Shannon, 2005) or thematic analysis can work from the overarching discourse domains and identify or develop new codes (i.e. discursive approachability features) from the data during analysis. In mixed approaches, researchers may start with the foundational framework for deductive analysis but remain open to inductively identifying new (contextualised) features from the data.

Data analysis

Regardless of the chosen approach researchers should following the "data analysis spiral" (Creswell & Poth, 2017, p. 185) – a re-iterative approach that involves immersion in the data, applying or developing a coding framework or further revising of codes following constant comparison and noting outliers. This re-iterative process ensures a thorough examination of the data and allows for nuanced insights to be identified. To facilitate this process, researchers may draw on qualitative data analysis software such a NVivo, MAXQDA or Qirkos which can assist in organising, coding, and analysing large amounts of qualitative healthcare interaction or interview data efficiently.

Researchers might want to further triangulate their analysis by using multiple coders (e.g. linguistics, clinicians, consumers/patients) or diverse data sources (interactions, interviews, fieldnotes, artefacts) to enhance the trustworthiness of the analysis, validate findings and reduce potential biases (Patton, 2015). To ensures transparency and enhance the credibility of the qualitative analysis, researchers should also reflect on their personal perspective and keep coding books (especially for new inductive codes), and reflexive journals (Patton, 2015).

Reporting findings

In reporting, researchers should consider including the foundational or contextualised framework diagrams in the methods alongside supporting literature. Newly contextualised frameworks informed by inductive analysis can also be presented in findings or results sections. Findings from approachability analysis should include rich descriptions including representative quotes that illustrate the approachability features identified or discussions of features that were notably absent. For studies employing a mixed analytical approach, researchers should also ensure to identify which features were part of the foundational or (literature-informed) contextualised framework and which feature were developed inductively.

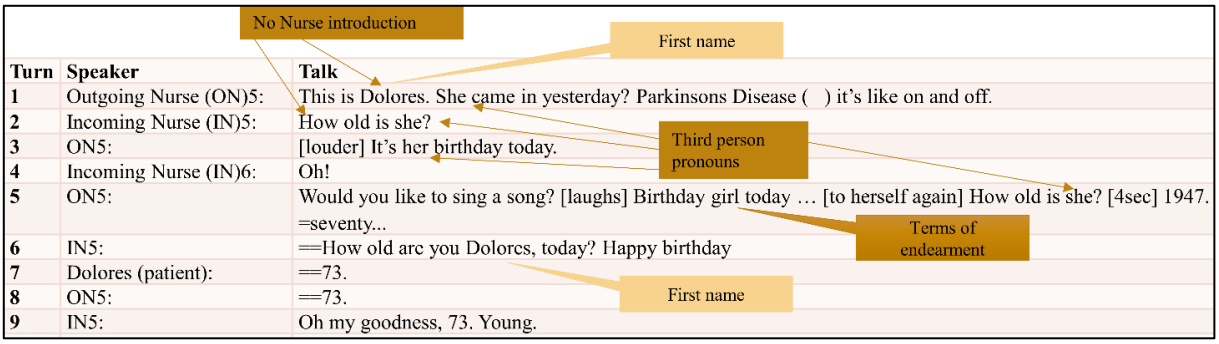
Example 1 – Approachability features and patient engagement in nursing bedside handover – case study approach

This example draws on Dahm et al. (2022) and shows how approachability features can be used as the analytical tool in a case study analysis of patient engagement in nursing bedside handover. The study described and traced common communication strategies nursing staff displayed during bedside handovers, gauging the impact of approachability features on (dis-) empowering patient engagement in bedside handovers.

In this study, we traced approachability discourse features across four case studies to explore and describe behaviours associated with approachable and non-approachable discourse among outgoing and incoming nurses during bedside handovers as informed by extant literature. Here, I will briefly describe two case studies drawing only on partial segments of

the recorded handover for two patients named Dolores (Figures 2 and 3) and Rita (Figures 4 and 5).

In Dolores' handover, the nurses' interpersonal and lexical choices as well as engagement strategies varied among the nurses and created diverse environment and opportunities for patient involvement in the interaction. Patient involvement in nursing handovers is crucial for patient safety and quality of care, enabling informed decision-making and greater patient autonomy (Chien et al., 2024; Tobiano et al., 2018). However, the level of patient engagement in these common and essential healthcare interaction can be significantly influenced by nurses' communication style, particularly displays of approachability (Crawford et al., 2017a; Tobiano et al., 2016). Figure 2 shows that the outgoing nurse 5 (ON5) used Dolores' first name (turn 1) but did not announce the handover nor introduce the incoming nurses. The incoming nurse 5 (IN5) inadvertently initiated a small talk sequence rather than the expected clinical exchange when she uncovered it was the patient's birthday while inquiring about the patients age (turn 2 "How old is she?"); but notably using a distancing third person pronoun and not asking Dolores directly. While initially joking about singing a song and using a potentially infantilising term of endearment (turn 5 Birthday girl), ON5 focused on obtaining clinical information (the patient's age) but excluding the patient from the question (see Figure 2) and continuing to talk about Dolores using third person pronouns she as if she was not there. IN5's approach was more engaging, directly asking Dolores using her name (turn 6 "How old are you Dolores, today?") and congratulating her.



Turn	Speaker	Talk
1	Outgoing Nurse (ON)5:	This is Dolores. She came in yesterday? Parkinsons Disease ( ) it's like on and off.
2	Incoming Nurse (IN)5:	How old is she?
3	ON5:	[louder] It's her birthday today.
4	Incoming Nurse (IN)6:	Oh!
5	ON5:	Would you like to sing a song? [laughs] Birthday girl today … [to herself again] How old is she? [4sec] 1947. =seventy...
6	IN5:	==How old are you Dolores, today? Happy birthday
7	Dolores (patient):	==73.
8	ON5:	==73.
9	IN5:	Oh my goodness, 73. Young.

Figure 2. Dolores' handover – Interpersonal strategies (introduction) and Lexical choices (forms of address).

Figure 3 shows how IN5' question produced clear patient answers demonstrating Dolores' capability to be involved in the handover exchange. IN5 also engaged in humorous banter with Dolores' husband, further building rapport. This approachable demeanour encouraged Dolores and her husband to actively contribute to the conversation, as evidenced by their humorous responses and shared laughter.

Turn	Speaker	Talk
1	ON5:	This is Dolores. She came in yesterday? Parkinsons Disease ( ) it's like on and off.
2	IN5:	How old is she?
3	ON5:	[louder] It's her birthday today.
4	IN6:	Oh!
5	ON5:	Would you like to sing a song? [laughs] Birthday girl today … [to herself again] How old is she? [4sec] 1947. =seventy...
6	IN5:	==How old are you Dolores, today? Happy birthday
7	Dolores (patient):	==73.
8	ON5:	==73.
9	IN5:	Oh my goodness, 73. Young.
10	Patient's husband:	[chuckle]
11	ON5:	==exactly 73
12	IN5:	== Still young.
13	Dolores (patient):	I was born in 47 and it's 2020.
14	Patient's husband:	See, she's like her mother though, she loses five years somewhere along the line.
15	[Laughter]	
16	Patient's husband:	No, she doesn't. I'm just joking ==[laughs].
17	IN5:	===It's okay, she needs a laugh. Yeah.
18	Dolores (patient):	Yeah
19	Patient's husband:	==[laughs].
20	IN5:	Yeah, that's ==why you're still looking younger.
21	Patient's husband:	==[laughs]

No direct patient engagement

Excluding question about patient

Engaging direct question to patient

Clear patient answer

Shared humour/ banter

Figure 3. Dolores' handover – Interpersonal strategies (Humour) and Engagement strategies (Eliciting patient views).

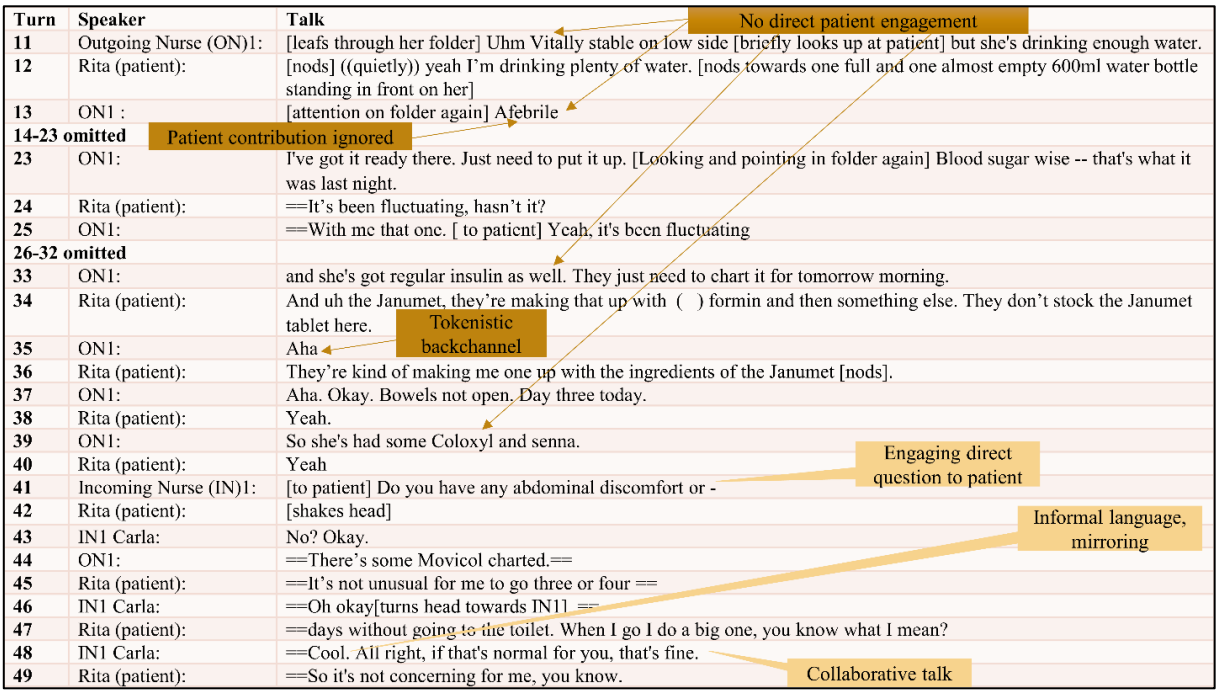
Turn	Speaker	Talk
11	Outgoing Nurse (ON)1:	[leafs through her folder] Uhm Vitally stable on low side [briefly looks up at patient] but she's drinking enough water.
12	Rita (patient):	[nods] ((quictly)) ycah I'm drinking plenty of water. [nods towards one full and one almost empty 600ml water bottle standing in front on her]
13	ON1 :	[attention on folder again] Afebrile
14-23 omitted		
23	ON1:	I've got it ready there. Just need to put it up. [Looking and pointing in folder again] Blood sugar wise -- that's what it was last night.
24	Rita (patient):	==It's been fluctuating, hasn't it?
25	ON1:	==With me that one. [to patient] Yeah, it's been fluctuating
26-32 omitted		
33	ON1:	and she's got regular insulin as well. They just need to chart it for tomorrow morning.
34	Rita (patient):	And uh the Janumet, they're making that up with ( ) formin and then something else. They don't stock the Janumet tablet here.
35	ON1:	Aha
36	Rita (patient):	They're kind of making me one up with the ingredients of the Janumet [nods].
37	ON1:	Aha. Okay. Bowels not open. Day three today.
38	Rita (patient):	Yeah.
39	ON1:	So she's had some Coloxyl and senna.
40	Rita (patient):	Yeah
41	Incoming Nurse (IN)1:	[to patient] Do you have any abdominal discomfort or -
42	Rita (patient):	[shakes head]
43	IN1 Carla:	No? Okay.
44	ON1:	==There's some Movicol charted.==
45	Rita (patient):	==It's not unusual for me to go three or four ==
46	IN1 Carla:	==Oh okay[turns head towards IN1]==
47	Rita (patient):	==days without going to the toilet. When I go I do a big one, you know what I mean?
48	IN1 Carla:	==Cool. All right, if that's normal for you, that's fine.
49	Rita (patient):	==So it's not concerning for me, you know.

Attention/ gaze away from patient

Third person pronouns

Figure 4. Rita's handover – Social attuning (gaze) and Lexical choice (references to patient).

In Rita's handover, the nurses' non-verbal behaviour and lexical choices were less inclusive. As Figure 4 shows the outgoing nurse 1 (ON1) frequently looked away from the patient Rita, focusing instead on her notes (turns 11, 13, 23). Rita was repeatedly referred to by the third person pronoun *she* (turns 11, 33, 39) rather than by name or not addressed directly by ON1. As in Dolores' handover, this behaviour created a sense of depersonalisation when talking about patients as if they were not actually present and ready to contribute to the communicative event.



Turn	Speaker	Talk
11	Outgoing Nurse (ON)1:	[leafs through her folder] Uhm Vitally stable on low side [briefly looks up at patient] but she's drinking enough water.
12	Rita (patient):	[nods] ((quietly)) yeah I'm drinking plenty of water. [nods towards one full and one almost empty 600ml water bottle standing in front on her]
13	ON1 :	[attention on folder again] Afebrile
14-23 omitted		
23	ON1:	I've got it ready there. Just need to put it up. [Looking and pointing in folder again] Blood sugar wise -- that's what it was last night.
24	Rita (patient):	==It's been fluctuating, hasn't it?
25	ON1:	==With me that one. [to patient] Yeah, it's been fluctuating
26-32 omitted		
33	ON1:	and she's got regular insulin as well. They just need to chart it for tomorrow morning.
34	Rita (patient):	And uh the Janumet, they're making that up with ( ) formin and then something else. They don't stock the Janumet tablet here.
35	ON1:	Aha
36	Rita (patient):	They're kind of making me one up with the ingredients of the Janumet [nods].
37	ON1:	Aha. Okay. Bowels not open. Day three today.
38	Rita (patient):	Yeah.
39	ON1:	So she's had some Coloxyl and senna.
40	Rita (patient):	Yeah
41	Incoming Nurse (IN)1:	[to patient] Do you have any abdominal discomfort or -
42	Rita (patient):	[shakes head]
43	IN1 Carla:	No? Okay.
44	ON1:	==There's some Movicol charted.==
45	Rita (patient):	==It's not unusual for me to go three or four ==
46	IN1 Carla:	==Oh okay[turns head towards IN1] ==
47	Rita (patient):	==days without going to the toilet. When I go I do a big one, you know what I mean?
48	IN1 Carla:	==Cool. All right, if that's normal for you, that's fine.
49	Rita (patient):	==So it's not concerning for me, you know.

Figure 5. Rita's handover – Engagement strategies (attentive listening, appropriate responding) and Framing (topic control).

The non-approachable engagement and framing style are further illustrated in Figure 5. Rita attempted to provide detailed information about her fluid intake (turn 12), blood sugar levels (turn 24) and diabetes medication (turns 34, 36). ON1 only acknowledged some of these contributions with minimal (sometimes tokenistic) responses, and also redirected the conversation to the clinical agenda, adopted an impersonal, biomedical tone when reporting patient assessments and actions (turn 37 "Bowels not open", turn 39 "She's had some Coloxyl and senna") and effectively ignored most of Rita's input (turns 36, 38, 40).

The incoming nurse (IN1) showed more interest in Rita's perspective by asking a direct question about her abdominal discomfort (turn 40) to see if the lack of bowel movement was actually problematic for Rita. This led to a brief exploration of the patient's perspective, in which Rita volunteered a non-verbal response (turn 42) that IN1 rephrased for confirmation (turn 43). Rita's persistence in discussing her concerns, even when previously ignored, highlighted her desire to be heard (turns 45, 47). IN1's mirroring of Rita's informal style (turn 48 "Cool […]") and acknowledgment of her perspective demonstrated a more collaborative approach (turns 45-49). Yet, these positive features were also offered while being turned away from the patient towards ON1 (turn 46) which diminished approachability.

These examples illustrate how approachability features can significantly influence patient involvement in bedside handovers provider interactions. Our case studies showed that by employing more approachable discourse features such as using patients' names, engaging in social small talk and humour, and actively listening, nurses could create a more welcoming and supportive environment, in which patients feel their contributions are wanted and valued. On the other hand, patient participation and positive environments could be diminished when

the nurse did not look at the patient, ignored patient contributions and pursued purely clinical tasks.

Example 2 – Approachability features and trust building in diagnostic interactions – comparative approach

This example draws on Dahm and Yates (2023) and demonstrates how approachability features can be used as one of multiple analytical tools for a comparative analysis of trust building in role-played interactions. We traced approachability discourse features associated with building relational trust and explored how these features were distributed in a set of Objective Structured Clinical Examinations (OSCEs) roleplays which simulated one specific scenario analysed for diagnostic accuracy

The data set comprised 16 recordings of the same role-played clinical scenario in which clinicians interacted with the mother (an actor) of a boy to find the right diagnosis and suggest treatment and management. Half of the participants (n=8) made the correct diagnosis (a foreign object in the ear) while the other half gave incorrect diagnoses.

All role-plays were coded for all five approachability discourse domains in NVivo followed by a comparative analysis in relation to diagnostic accuracy. This study had a more summative content analysis (Hsieh & Shannon, 2005) or quantitative focus compared to some other applications of the approachability features framework. Findings were presented in graphs supported by quotes.

The analysis revealed both shared approachability features across interaction with correct and incorrect diagnoses, but also revealed marked differences related to diagnostic accuracy. Clinicians in both groups used informal language, actively engaged with the mother by mirroring her language, responding to her questions and seeking her opinions (albeit often in a token manner). They also offered reassurance, but occasionally missed opportunities for empathetic connection.

We found that in interactions with correct diagnoses, clinicians employed more humour, particularly to put the patient's mother at ease. They also used more closed questions and maintained stricter topic control during history-taking. Conversely, in interactions with incorrect diagnoses, clinicians used more signposting, more familiar naming practices (the boy’s first name) but also more unexplained medical terminology.

These findings suggest that different communication strategies may be associated with diagnostic accuracy. The use of humour and more structured questioning in interactions with correct diagnoses might indicate a balance between building rapport and maintaining clinical focus. In contrast, the greater use of signposting, familiar naming, but unexplained terminology in interactions with incorrect diagnoses might suggest more or less successful attempts to build rapport and trust.

By quantifying these features, we were able to draw connections between specific communication strategies and diagnostic outcomes.

Limitations for consideration

The two examples discussed above have demonstrated the versatility of the approachability features framework, showing how it can be applied as sole analytical tool or integrated into studies with a more quantitative focus and combined with other analytical methods to provide insights into the relationship between communication patterns, and patient and health outcomes (i.e. patient participation and diagnostic accuracy).

However, researchers should also consider some inherent limitations in applying approachability discourse features as a qualitative tool of analysis for clinical healthcare interactions and ethnographic interviews.

While the approachability features framework has its roots linguistic research on intercultural pragmatics (Dahm et al., 2015; Dahm & Yates, 2013; Spencer-Oatey, 2000; Spencer-Oatey & Franklin, 2009), research on health communication and behaviours has primarily focused on English-speaking or Western contexts. Therefore, researchers should be aware of potential cultural and language bias. Application of the framework to more diverse languages and cultures may require adjustments to account for cultural nuances and linguistic differences.

Qualitative healthcare interaction data frequently involve a smaller number of participants. Collecting and preparing data for analysis is often a time-consuming and resource-intensive process and while the sample size may appear small, researchers have a large amount of data to analyse. Despite this, sample sizes may be seen to limit the generalisability of findings to a broader population and the context-specific nature of the analysed data should also be specifically considered in reporting findings.

Lastly, the complex nature of approachability features covers a spectrum of behaviours rather than a binary distinction. While this framework presents multiple components that can influence approachability, it serves as a scaffold or analytical toolbox from which researchers can select and contextualise elements relevant to their specific 'frame of reference' or interactional context. Rather than prescribing a rigid analytical structure, it offers systematic guidance that can be adapted to examine different types of healthcare interactions and researchers should be mindful and always take into consideration that all features (such as humour or laughter) can have beneficial or detrimental effects depending on the context, how the feature is used and by whom.

Conclusions

This paper provided a structured, evidence-based approach to applying approachability features as a versatile analytical tool for researchers across a wide range of health communication contexts and communicative events. The framework of foundational approachability features presented here can form the basis for inductive, deductive or mixed analysis, either as a standalone method or as part of a pluralistic approach, allowing for flexible integration with other research methodologies. Researchers can use this framework to guide analysis of both interactional data and interview data, and by doing so can make the hidden impact of language and communication behaviours visible. Analysing approachability as it plays out in healthcare interactions can, for example, help to identify discourse features

that explain why patients may feel dismissed or fail to connect with clinicians. Thus, the framework offers a valuable tool for improving feedback to clinicians and students in the health professions as well as supporting professional development, enabling more targeted and effective communication training in healthcare settings. By improving awareness of specific discourse features and their impact, approachability analysis can also assist in reflective practice, empowering healthcare professionals to critically examine and enhance their communication strategies.

Acknowledgements

I would like to acknowledge my colleague and mentor Prof Lynda Yates for getting us started with working in approachability all those years ago and my former PhD supervisor A/Prof Peter Roger for introducing me to Goffman and Tannen and Wallat's idea of 'interactive framing'. I would also like to thank A/Prof Matilde Nisbeth Brøgger for inviting to give a seminar talk at the Qualitative Methods in Health Communication seminar series hosted by the Center for Health Communication, Aarhus University, which provided inspiration and a scaffold for this paper.

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