Constructing the Model Citizen in Healthcare Communication

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Abstract

This thesis investigates the discursive construction of the model citizen, or ideal user, in public information from the UK's National Health Service (NHS). Employing Multimodal Critical Discourse Analysis, it unearths evidence that the model citizen is a frequently-used and multimodal discursive strategy. The study takes as its texts an extensive range of health promotion and public information from the NHS. These include a multimedia health campaign, leaflets, posters and other materials found in A&E waiting rooms, web pages and health promotion messages attached to the exteriors of hospitals and ambulances. They are grouped and analysed according to the stage at which they are found in a theoretical 'journey to emergency healthcare'.

In an NHS under constant pressure, the field of emergency healthcare has often been the setting for news stories of overcrowding, missed waiting time targets and chaos. Published by an organisation known for its political impartiality, these texts fulfil an information-providing, or ideational, function. Yet this study finds that they are ideologically motivated artefacts, which can be classified as technologies of governmentality, shaping ideologies in this emotive corner of the healthcare system. The thesis seeks to understand the nature and the purpose of the model citizen construct, and finds it is intertwined with other multimodal strategies to perpetuate asymmetric power relations. Furthermore, the model citizen becomes an instrument of governmentality, as it is manipulated and remade depending upon the requirements of the NHS in different circumstances. The texts are also found to expand the remit of 'health' into new subject areas and new settings, combining neoliberal and collectivist ideologies whilst transferring responsibility for 'saving the NHS' from Government to citizen.

By considering the semiosis present in all communicative resources across a range of linked texts, the study demonstrates an effective way of expanding the use of established analytic tools to study large and diverse datasets. Modes are consolidated into lexical and multimodal communicative strategies, one of which is the construction of the model citizen. The findings are likely to be of interest to researchers in CDA, multimodality and health communication, and to practitioners and policymakers in health and other public services.

This thesis is dedicated to my parents

Ruth McIntosh (1941-2019)

John McIntosh (1932-2016)

They inspired me to cherish opportunities for learning, supported me in every endeavour and were extremely proud in my undertaking of this doctorate.

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1. Introduction

The early years of the twenty-first century have seen many changes to the UK's National Health Service, with Accident and Emergency Departments often one of the most visible indicators of these changes, frequently hitting the news with stories of overcrowding, missed waiting time targets and overworked staff. This thesis takes a step back from the sensationalist headlines and looks at emergency medicine from a new perspective. It investigates and critiques multimodal strategies to construct a 'model citizen' or ideal user of NHS services, taking as its texts materials produced for the public by national and local branches of the NHS. These texts fall into the category of health promotion, which has largely evaded the attention of scholars in Critical Discourse Analysis, despite the discipline's consensus that health settings are sites in which power is produced and reproduced. This study sets out to uncover the ways that health promotion materials, which some may consider banal or containing only unadulterated facts, are ideological artefacts, and to discover the role of the model citizen construct which, I have found, occurs in such texts.

1.1 Who is the model citizen?

Although 'freedom' and 'choice' are watchwords in contemporary western society, governments, or the 'elite', are particularly concerned with the behaviour of citizens, and seek to control it in numerous ways. My thesis investigates the discursive construction of the 'model citizen' or model user of health services. This model citizen is the person who absorbs the information and advice produced by governments and health organisations, and follows the guidance, modifying their behaviour appropriately in order to stay or become healthy, or to use services in the way service providers intend them to be used. The impetus for the model citizen as a thesis topic grew out of a previous, smaller study, which investigated the discursive strategies in a multimedia health promotion campaign (McIntosh 2014). Construction of the model citizen was one of several strategies identified in the campaign, and the multimodal construction and treatment of this 'model citizen' was sufficiently

intriguing to warrant a larger investigation to discover whether the same construct would be evident in other health texts.

The thesis examines in detail the discursive strategies of model citizen construction, which in these data are built up through many linguistic devices and techniques, and creative deployment of semiotic non-linguistic communicative modes. I argue that choices made by the text producers from the meaning potential (Ledin and Machin 2018: 17) of such modes, deliberately construct a specific type of user or patient. As I shall show, through the device of the model citizen, the expected behaviour of the real-life citizen is shaped and honed each time the model citizen is invoked. The construction of the model citizen is of importance because

> how audiences are constructed ... is linked to whom audiences are imagined to be, which in turn leads to particular imagined behaviour of audiences, alleged consequences, or costs to society, and finally, how to deal with these audiences (Butsch and Livingstone 2014: 9).

The model citizen in these texts may be theoretical and imagined by text producers and readers, but the construct represents the individual and the public at large. The way in which health organisations construct their audiences, in other words how the model citizen is treated, will impact upon real citizens, and their relationship with those organisations. This study will illuminate the importance of the model citizen construct in public texts about health, showing how it is achieved and developed. It will also investigate the subtle ideological journey along which the real-life citizen is drawn, culminating in their participation in the production of discourses which may threaten the future of the NHS.

1.2 The healthcare context in 2020

The NHS is almost constantly at the centre of ongoing political contention. Health is a topic of national interest in which discourses vie for dominance, and while it is on face value a 'health organisation' because it provides health services, and is 'presumed to be morally neutral' (Cicourel 1999: 184), the NHS is also a branch of

government, ultimately controlled by the Department for Health and Social Care, accountable to Parliament and staffed by public servants. In an attempt to create a 'marketplace' in UK health, the NHS has been fragmented into numerous 'NHS trusts' which operate as financial units (Brookes and Harvey 2016: 289). Importantly, the services they offer can still be regulated or curtailed by those in power, and although dependent on the whims of government for increases or decreases in funding, their construal as independent organisations allows the government to allocate blame when services do not achieve their centrally-set standards.

Throughout almost the entire period of work on this study, and certainly during data collection, Accident and Emergency (A&E) departments in British hospitals were the focus of frequent and frenetic news stories about a 'crisis' framed as 'too many people attending for the wrong reasons'. Much less coverage was given to the alternative discoursal position of underfunding and insufficient recruitment, and there were attempts to shift responsibility for the problem, with politicians blaming GPs (BBC News 2017) and local authorities (Knapton 2016). It is in this context that the texts I analyse were produced. Remarkably, after years of difficulties in A&E, particularly during the winter months, in March 2020 the headlines changed with the arrival of the global pandemic of a new coronavirus dubbed Covid-19. Numbers of people attending A&E dropped dramatically, with news sources speculating that people may have stopped attending because they feared catching the virus in hospital. A&E staff began to voice concerns that that patients who should have been at A&E may be staying at home, and might die or become very ill as a result. In surprising scenes, the NHS put out appeals, for people to continue to dial 999 and attend A&E when appropriate, and not to stay at home when experiencing symptoms of serious conditions (Roxby 2020b; Marsh and Parveen 2020). At the time of writing this is still the case, and recent public health messages from the NHS encourage people experiencing health emergencies to 'seek help as you always would' (NHS England 2020). It remains to be seen what the long-term impact of Covid-19 on A&E departments will be. While the timing of this thesis does not allow for full investigation of this phenomenon, I note, particularly in my second analysis chapter, that the NHS themselves have supported the notion that the willingness of A&E to respond to less urgent cases depends upon how busy each department may be at the

time. While it has not been possible to analyse texts produced during the Covid-19 pandemic, the model citizen is certainly invoked in many of them, and is a potential future application of the method followed in this study.

1.3 Methodological approach

> We believe it necessary to analyse comprehensively the nature of citizens' identities in contemporary society (Sarangi and Slembrouck 1996: 10).

This thesis investigates texts from the field of health promotion, applying textual and multimodal critical discourse analysis methods. I analyse texts from various contemporary health promotion genres, including web pages, a TV advertisement, signs and banners in hospitals, and a poster affixed to an ambulance, alongside more traditional printed materials such as leaflets and forms. Despite the broad reach of critical discourse analysis there have been remarkably few published papers which focus on the discursive elements of public information in the health field. There is a body of work on the analysis of spoken discourse in dialogues between health professionals and patients (Sarangi and Roberts 1999; Mishler 1984 for instance) and policy and political statements have received attention (Fairclough 2010: 239-251; Prior et al. 2012) but with the exception of a few papers which cover related areas (Makoni 2012; McManus 2009; van den Berg and Parastou 2009), published and distributed public information has been neglected thus far. I therefore hope this research will contribute to debate and development in this area. To some these texts may seem to be a mundane and routine element of healthcare, but I aim to show how they contribute to the relationship between the NHS and the citizens of the UK.

Even before consideration of their content, the producing, giving, and receiving of these texts are forms of information exchange which contribute to this relationship. This study analyses a small part of this information exchange, in the form of materials produced for the public about emergency healthcare, and will show that far from being 'used for primarily transactional purposes' (Brown and Yule 1983: 4) these texts work to reproduce relationships and produce social actions. Critical Discourse Analysis (CDA) is a suitable approach for the analysis of such texts, as they are born

out of ideology, mediated via legislation or Health policy and recontextualised into formats deemed suitable for the public to digest. Such texts are frequently multimodal, so linguistic analysis alone is not sufficient. Multimodal Critical Discourse Analysis (MCDA) allows us to consider the underlying issues relating to ideology and power which are central themes recurring in this approach, particularly notions of institutional power, which have been discussed by Fairclough, and Sarangi and Slembrouck, among many others. My analysis will reveal the hidden ideologies in these materials, pointing to their importance in the production of power, not just in health settings but also in the home and elsewhere. The increasing use of such materials as a method of advising and informing the public is a technology of control, and as such I will consider whether it is a form of 'governmentality' (Foucault 2007: 122) and/or manipulation (van Dijk 2006).

Because 'we need an analysis which focuses on the creation of social identities and objects' (Sarangi and Slembrouck 1996: 10), I investigate the role of the model citizen construct in educating or persuading NHS users about correct ways to use emergency healthcare services. My lines of enquiry are:

- What discursive strategies are used to construct, reproduce and evolve the purpose of the NHS and the 'correct' use of services by 'model citizens' in health texts?
- What form does this model citizen take? What kind of 'person' is constructed?
- How do the various communicative modes, both textual and non-textual, contribute to or disrupt this construction?
- How is power demonstrated and is it resisted?
- What is the significance of the model citizen construct, and what lessons can we learn about its use in health texts and settings?

This focus upon the model citizen in contemporary texts, through a MCDA lens, will contribute to an understanding of the mechanisms operating in society to influence and control the population.

1.4 Structure of the thesis

In Chapter 2, I define concepts used in the thesis, and first discuss *discourse* and related terms before providing context for the notions of citizenship and health which underpin this study. Health, even including its promotion and governance, may be seen as a completely separate domain to citizenship, but there are many areas where the two concepts intersect. This is particularly so in the UK, where health services are mostly publicly funded and government run, so are entangled with the rights and responsibilities of citizenship. I conceptualise notions of governing and being governed, and link these to the healthcare context, providing background to relevant areas of healthcare, including the practicalities of producing health promotion materials.

In Chapter 3, I explain how my methodology will draw upon and develop theories in CDA and MCDA, within the wider field of Applied Linguistics. In this chapter I also discuss the two themes of power and ideology which are frequently confronted in critical studies. There are many approaches to CDA, for a summary see Wodak and Meyer (2009: 1-33), but all examine the social meanings embodied in texts and the impact they have on people. Whilst acknowledging the importance of linguistic content and the many devices and techniques relied upon, I also specifically note the multimodality of these texts, exploring the affordances of individual communicative modes and media, and their contribution to semiosis. Although van Leeuwen and Jewett (2001), and Kress and van Leeuwen (2001) propose methods of analysis which include multiple modes, there is, so far, no single framework which can satisfactorily fulfil all the requirements of MCDA across a range of materials. I therefore develop a framework which considers the contribution of people, places, processes and discourses to the construction of the model citizen, investigating the discursive strategies present in sets of data. I identify the communicative modes present and analyse their individual contribution to the production of meaning, also considering their combined effect. I draw on Fairclough's (2015) theoretical approach to CDA in which language and power are inextricably linked, whilst also employing various practical techniques for the analysis of multimodal texts. Full details of the texts and datasets are also given in the Methodology.

The analysis of the data is arranged over three chapters (4-6). It is organised in this way partly due to the volume of data, but I also delineate the texts by what I perceive as stages on a 'journey' to A&E. This grouping results in combined analysis of data from differing genres, but with similar objectives, and is useful because it allows us to consider the construction of the model citizen as a progression, starting with the multimedia texts of a 'preventative' campaign, progressing through texts from stages of decision-making about whether to use emergency services, and finishing with texts found in the A&E department itself. In the first analysis chapter (Chapter 4) I analyse a television advertisement and a leaflet jointly produced by Public Health England and NHS England as part of the *Stay Well this Winter* campaign. In Chapter 5, I look at materials produced by various NHS trusts in the English East Midlands, for those about to use NHS emergency healthcare services. In Chapter 6, I investigate the leaflets, forms and posters found in two A&E waiting rooms, which aim to elicit responses for the Friends and Family Test, a major national project to collect patient feedback. Most of the texts are addressed to the public at large, and I will indicate the few examples where this is not the case. All were freely available, and many, as I write, are still in use.

My Discussion (Chapter 7) develops themes encountered in the data analysis, and explores the findings of the thesis in relation to the model citizen in health communication. These findings strengthen the position of MCDA as an approach and augment its valuable contribution to critical discourse studies, while venturing into new subject matter. I propose that with each dataset the NHS attempts to remake the citizen in a new form and with new characteristics which suit the purposes of the elite political administration. In line with notions of governmentality (Foucault 1997, 2000) the public must feel that they have made a choice to undertake certain actions, rather than being forced to do so. Achievement of this outcome requires the generation and perpetration of discourses which maintain authority whilst convincing the population that they are independent citizens, with a degree, at least, of power, and in control over decisions in their own lives. Although the goal of model citizenship in relation to health services is never stated as an explicit aim in these texts, I show through analysis that this is indeed a tacit objective.

I conclude this study (Chapter 8) by reflecting upon my findings and recommending actions for those information producers in healthcare and further afield and practitioners in emergency healthcare, as well as suggestions for researchers wishing to investigate further the phenomenon of the model citizen. The issues addressed in this thesis are topical, yet they are unlikely to be short-lived, and my findings will be applicable and relevant for some time to come.

1.5 Impacts of the findings

Invariably when problems arise between public bodies and citizens, communication is cited as a cause or contributory factor. Problems with communication in the past have resulted in the need for legislation, and for over 20 years duties on public institutions to produce information have increased (for example Department of Health [DH] 2014: 25). Consequently public sector organisations endeavour to produce useful information for the public. The subject area of this research is topical and timely, as emergency healthcare is an ongoing focus of attention for politicians, NHS trust management and the media alike. A&E departments have been busy to the point of overcrowding, and have repeatedly been reported as failing to meet government targets on treatment times. The subject is of interest not only to health professionals and academics, but also to members of the public—the citizens themselves—who are familiar with, and have opinions on A&E departments, and the concept of citizenship. If CDA 'engages scholarly enquiry with matters of immediate and pressing concern in the non-scholarly world' (Widdowson 2004: 89), then NHS emergency healthcare, is surely an ideal subject matter, and its copious and omnipresent health information texts worthy of investigation. The dearth of studies on these media provides another reason to carry out such an investigation, and is surprising as these public texts are usually freely available, plentiful and largely free from ethical impediments.

The NHS is valued highly by the British people, founded upon socialist principles of free healthcare with equal access, and paid for through taxation. But the neoliberal policies of successive governments over the last 35 years have complicated the picture, due to the gradual but inexorable drive to place public services in private

hands. A complex situation is emerging, in which hospitals are encouraged to think of their patients as customers, and individuals are encouraged to take responsibility for their own health. How this will affect the balance of power between citizens and their NHS, and whether it genuinely reflects the wishes of visitors to A&E, remains to be seen. The behaviour of NHS users is key, and detailed critical analysis of the way in which the model citizen is constructed in NHS publications may provide clues to the future relationship between the British people and their NHS.

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2. Health and the Model Citizen: Background and Context

2.1 Introduction

In this thesis I analyse a collection of texts from the NHS, with a focus on the techniques used in the production of model citizens when communicating with the public through health promotion materials. I assert that the discursive production of the model citizen can be traced through ideologies found in political and medical domains, and I argue that this data can be used as a concrete illustration of the concept of 'governmentality'. Before proceeding with the analysis, I will provide context for my study of the model citizen in health communication, and in doing so will bring together several topics which while pertinent to the study may at first appear incongruent. I shall, however, endeavour to substantiate the links between them and will show that in combination these themes provide a backdrop to my study. The Chapter consists of four sections: Firstly, in order to investigate the discursive construction of the model citizen it is important to address the meaning of 'discourse' as understood within the field of Applied Linguistics, and as used in this thesis. I shall do so in section 2.2, and will explain how, through the process of entextualisation, discourses are recontextualised and texts generated.

In section 2.3 I will initially focus upon citizenship and the model citizen identity itself, including the ways in which the 'good' or 'bad' behaviour of citizens may be produced discursively and moulded to suit the needs of the state. I will then go on to establish the context in which the model citizen is produced, starting with 'governmentality', a key concept in governing and being governed, developed by Foucault in relation to ideologies of control. I will build upon this generic idea by introducing neoliberalism, a dominant ideological force in present-day society, evidence of which can be found in many domains, including that of health. Because the attempts of governments to control the biology of populations are of relevance, I also discuss biological citizenship. Following this discussion of existing literature surrounding citizenship I will move on to introduce, in 2.4, a number of topics relevant to the health context of the data, firstly defining health, then exploring some of the numerous links between health, commercialism and neoliberalism. I will set

the scene for the subject matter of the texts with an introduction to health promotion and the background and recent history of emergency healthcare in the UK.

Finally in this Chapter, having introduced these main themes, in 2.5 I will explore the ways in which notions of citizenship and health overlap and become entwined. In order to understand how, as part of the layering of semiosis into the data, they can be imbued with authority, I also discuss the production of texts within the NHS. To do this I return to the process by which ideologies and discourses are entextualised in the context of health in health promotion, which involves specialist communications teams and is aligned with marketing, creating more links to the commercial world, and will illustrate how discourses are enacted and infiltrated into the population at large. Through each of these areas of focus, and knitting together and combining them in various ways, run the themes of power, and ideology. These two important threads, which frequently materialise in the discourses contributing to production of the model citizen and are of particular relevance in Critical Discourse Analysis (CDA), will be explored in the Methodology (Chapter 3). I begin by defining discourse and related terms, as used throughout the thesis.

2.2 Defining discourse

> It is generally recognized that there is neither a single coherent theory nor a single definition of discourse (Woods 2006: x).

Discourse is a conflicted term, and many have grappled with its meaning and relevance to society, power and ideology. It is a familiar expression within many academic disciplines and in addition to the particular attention given to discourse within linguistics it is considered integral to studies in fields such as anthropology, sociology, philosophy, communication, social psychology, and artificial intelligence (Schiffrin 1994: 5). Each discipline constructs the concept of discourse from its own stance, using a range of methodologies, and applies a variety of definitions which stem from numerous points of view (Woods 2006: xvi). Consequently discourse evades precise definition, however there is general consensus that the nature of discourse concerns the interrelationships between language, actions and knowledge.

Within the wide subject area of Linguistics, definitions of discourse have not been resolved, but fall largely into two schools of thought depending upon whether one favours the structuralist or functionalist viewpoint. Structuralists, focusing on 'the way different units (of language) function in relation to each other' (Schiffrin 1994: 23) define discourse as a unit of language larger than a sentence or a clause, which is made up of smaller units. Applied Linguistics, on the other hand, tends towards the functionalist school of thought which views discourses as language with a particular function, or 'language in use' (Brown and Yule 1983: 1). For Jones (2013: 16-17) discourses are representations of 'worlds' through 'voices', each of which has a particular agenda and none of which is ideologically neutral. Discourse can also be understood as a cultural tool, or as 'a mediational means through which action is carried out' (ibid.: 27-28). The definition is further complicated by the allocation of different meaning to *discourse*, *discourses* and *Discourse* (see van Dijk 1998: 191ff; Schiffrin 1994: 41-43; Fairclough 2010: 352). Within Applied Linguistics language is studied in 'naturally occurring' examples of 'the real language that real people use in the real world' (Woods 2006: x). It is generally taken as a given that language, rather than being a free-standing concept which can be studied as an autonomous and discrete subject, is better understood when analysed as part of the social structures and practices in which it is found (Brown and Yule 1983: 1; Schiffrin 1994: 20-23). Applied Linguistics works to identify and comment upon discourses and the actions with which they are associated or the way we 'do things with words' (Austin 1962). It attempts to pin down what it is about discourses that can cause things to happen, and takes as its data examples of real world discourses in an extremely wide range of fields.

Linguists use 'structuralist' knowledge of grammar and lexical items, and their place in the sentence, to use and understand discourse, but discourse is more than the words themselves. It comprises not *just* the lexical and grammatical building blocks of language, but 'at the very least, language plus context … the context that we bring with us when we use language; the context that includes our experience, assumptions and expectations' (Woods 2006: x). Context also includes the ideologies and beliefs of the encoder and decoder of the message, the communicative mode, and many other relevant contextual aspects of the communication such as place, time and reason for

communicating. Our use and understanding of language then, depends not just upon our vocabulary and our knowledge of correct word order but upon our interpretation of a given social situation and our place in it. In CDA discourses may also be viewed as interdependent with the social context, or dialectically produced within given situations, meaning that not only they are produced by society, individuals, structures and particular sites of engagement (see 2.5), but that discourses themselves produce social phenomena, identities and institutions (Fairclough 2010: 38), so that discourses both affect actions and are created and changed by actions. Discourses shaping citizenship are discussed in section 2.3, and their application in this study will become apparent in the analysis chapters.

Although generally understood as manifesting in spoken or written language, discourses may also encompass non-linguistic modes of communication, which may contribute as much to the meaning of a discourse as the words themselves. Indeed a focus on language alone may limit our understanding of identity construction and interaction (Norris 2008: 133). Contemporary channels of communication rely increasingly on combinations of communicative modes, and often upon hypertextuality or moving between different channels (Machin 2013: 348). As will become evident in this study, any semiotic resource capable of communicating meaning or association may be harnessed as part of a discourse (Machin 2007: 12ff), and 'discursive action takes place in, and in articulated in, a multiplicity of practices and a multiplicity of modes' (Kress and van Leeuwen 2001: 25). For the purposes of this thesis I consider that discourses are 'ways of representing the world from particular perspectives' (Fairclough 2010: 418) or 'relatively stable uses of language serving the organisation and structuring of social life' (Wodak and Meyer 2016: 6) in which I interpret 'language' as any communicative mode or sign wherein discourses are realised.

Discourses are not discrete but have many points of overlap with each other (C. Candlin 2002: 185), and unlike texts, discourses as understood by applied linguists and many social scientists, are not fixed and quantifiable. They are dynamic and fluid, and are constantly updated, infiltrated with new ideas and added to by their users. They are frequently combined for particular effect, championed and brought to the fore by those skilled in manipulating language, such as politicians and marketing

workers, for ideological purposes or sometimes simply to make money (van Dijk 2006). Alternatively they may be quashed, derided or confronted with alternative discourses. Participating in a discourse may involve embracing its power dynamic and accepting its ideology, but participants may reproduce a discourse even if they overlook its meaning. A detailed and useful explanation of the interrelationships between discourses, texts and genres is provided by Reisigl and Wodak (2001: 36ff, 2016).

Citizens are exposed to a range of discourses, for example advertising, educational, health, transactional, and intimate discourses, which may simply use the language of everyday life, or the 'specialist' language of particular settings or situations. In certain circumstances, 'health' and 'the conduct of citizens', being good examples, discourses are deliberately designed or cultivated by politicians, to achieve political goals (see 2.3.4). They can be activated using the discursive resources of governments (Clarke et al. 2007: 49-50) including manipulation (ibid.: 83) and political rhetoric (ibid.: 35) which may lead to legislation, initiating a chain of actions which eventually result in changes to the lives of citizens in some way, because discourse is central to requirements to change social practices (Fairclough, Pardoe and Szerszynski 2010: 435). Access to certain discursive resources is limited as they may only be used by certain groups (van Dijk 2006: 362) and are 'strategically drawn upon and exploited by participants in the achievement of their particular personal and ... professional goals' (C. Candlin 2002: 187). Thus the conversations held between medical professionals about a patient's illness will have little in common with the conversations about the same illness between the patient and their family, for example. Discourses are produced by their use. They become reinforced by their re-use and the more frequently a term is used within a particular discourse, the more ingrained it becomes, and the more difficult to extricate it from that discourse (Jones 2013: 28). Our views of ourselves or of others as citizens, in relation to our rights and responsibilities can be influenced by discourses in this way, and may in turn affect moral judgements made towards individuals.

The data in this thesis provide examples of the appropriation of discourses from domains outside health, which I discuss in the analysis chapters. Fairclough (2010) refers to 'orders of discourse', which are the 'totality of discursive practices of an

institution, and relations between them' (96). This points to not just one, but several, discourses in each domain, although one discourse is prominent, and becomes the normalised dominant discourse of the organisation. The dominant ideology is one which can 'take on a quality of truth' (Machin 2007: 14) and is accepted as 'common sense' that disguises its ideological status (Fairclough 2010: 30). I will provide examples of this phenomenon in the analysis chapters to follow.

2.2.1 Entextualisation

Entextualisation is the process by which discourses are captured in texts. We usually think of the creation of a text taking place when something is written or typed, but there are other ways to entextualise discourses, such as the production of images, video and audio materials, web pages and social media content. Processes of entextualisation and recontextualisation are of particular consequence in this thesis because they are a stage in the realisation of discourses which play a part in their transformation into actions by people. These texts are designed to change behaviour which, whether beneficial or not, is an enactment of authority, and hence produces or reproduces power relations. Although they are rarely discussed in detail in critical discourse studies, all processes of entextualisation are important. Even though they are often unseen, they are 'physical work' carried out by humans which add layers of meaning during the design, production and distribution of texts (Kress and van Leeuwen 2001: 4 - 8). The elements of discourse captured in texts are not only reproduced but also undergo change. This occurs through choices made by those involved in these processes (Machin 2013: 352-353), and is also dependent upon the affordances of the media and modes in which they are reproduced (Fairclough 2010: 78).

It is the process or act of entextualisation which causes a text to materialise in the physical world. It transposes something intangible and fluid into a fixed state, so that it is possible to extract and relocate it physically or temporally (Jones 2013, 35-36). Entextualisation affords solidity and durability to discourses and is the fundamental process through which we 'make sense' of the world. It is the way isolated actions bounded by time and space come to be regarded as social practices and social identities (Jones 2013: 35).

The concept of entextualisation is particularly relevant in the public sector, including the field of health, because it is 'essential for the reproduction of institutional authority' (Park and Bucholtz 2009: 487). This process, by which discourse made physical contributes to the very creation of the public sphere (Coulmas 2009), creates signs and artefacts which take on institutional power. So entextualisation is a critical part of the process through which citizens, and their relationship with powerful institutions are constructed, and is undoubtedly relevant to the process of model citizen construction.

Institutional texts for public consumption are always heavily mediated, often in several stages, and in public bodies such as the NHS discourses are entextualised and reproduced many times and in differing formats. Health promotion publications provide good examples of such recontextualisation. Originating in the political or leadership discourses of parliamentary debates, or perhaps within a local NHS trust board, they are first entextualised into long, frequently complex and jargon-ridden documents such as legislation or local health policy. Discourses of health promotion are then transformed through a number of stages of mediation, often involving their adaptation into locally-enactable practices, before being rewritten into formats deemed palatable for the public. Like media texts which are 'a class of texts which are specialised for moving resources for meaning making between texts, and more abstractly between different social practices, fields, domains and scales of social life' (Fairclough 2010: 73), public information, including health promotion texts, may too be seen as involving major changes of meaning. Discourses transformed via this complex process into a leaflet or web page in front of a potential NHS patient are created deliberately and designed to have specific effects (Fairclough 2015: 211), such as encouraging uptake of vaccinations, discouraging unhealthy practices, or training the public in how to use NHS services.

Because semiosis is always added with each new format or genre (Fairclough 2010: 73). whether intentional or not, representing a lengthy policy document by the use of an illustrated leaflet, advertisement or colourful banner must undoubtedly change its meaning. So for example, in The *Stay Well this Winter* Campaign featured in this thesis, government strategies are transformed, through recontextualisation into the texts of the campaign which comprises TV advertisements, posters, leaflets and web

pages. This recontextualisation through change of medium also affords opportunities to delete elements of a discourse which the producer wishes to leave out, focus on the specific details which serve the interests of the producer or reframe the argument (Machin 2013: 352). Further recontextualisation takes place when the many instructions in the texts become individual actions, plans or projects for the citizen. I provide concrete lexical and multimodal examples of extextualisation and recontextualisation throughout the datasets, for example in the pristine NHS settings of dataset one, and the focus on benefits of completing the survey in dataset three.

Entextualisation is a particularly effective method of reproducing discourses, and public information materials such as the texts I analyse here are instrumental in introducing new discourses or reproducing existing ones. They can be used to transfer discourses from one domain to another as they are often used to explain or educate, or in some other ways transmit 'knowledge' to those who lack it. Jones (2013: 15-16) provides the useful example of a packet containing pain relief tablets which introduces discourses of health, risk and safety to its purchaser. My texts operate in a similar way, introducing what is in effect categorisation and sorting of medical conditions into groupings which suit the organisational structure of the NHS, to an external audience. As I will discuss, the texts are also instrumental in expanding the reach of the already powerful medical profession into places outside its traditional sphere of control, through infiltration of previously 'non-semiotic spaces' (Scollon and Scollon 2003:111) and into the home. However, as we have already seen, discourses are not easily described. Discourses are not just words and language but our attempt to articulate ideologies. As such the words we have available for entextualisation may be insufficient to fully capture the essence of a discourse. Likewise, although texts can unlock or provide access to discourses, the individual reader will still recontextualise texts using their own literacy skills, cultural knowledge, life experience and other contextual factors. I return to this topic later in the chapter to establish the context and background of health texts for the public, and the communications teams responsible for producing them. Having defined discourse and entextualisation I now give some background on the notion of citizenship before introducing the model citizen construct at the heart of this thesis.

2.3 Citizenship: Governing and being governed

2.3.1 Defining citizenship

The broad understanding of citizenship as 'a relationship between an individual and a state in which the individual owes loyalty to the state and is entitled to its protection' can be traced back at least as far as Ancient Greece (van Deth 2007: 402). Citizenship is a legal status which bestows or denies certain rights and responsibilities, and notions of citizenship tend to be aligned to the national paradigm (Van Deth 2009: 175), and shaped by governments and others with the power to do so. Views on citizenship may also be affected by the varying ways in which government services and departments are ordered, as this has an impact on how citizens are treated and how they view themselves. For example, in liberal-individualist states, such as the UK, citizenship is defined in terms of the provision of services and the protection of rights, including the right to be different, and any duties on the public tend to be optional rather than imposed. On the other hand, countries with a tradition of civic-republican citizenship, such as France or Turkey, emphasise the duties and obligations of citizens, and require commitment to community goals. This model tends to ignore difference, and citizenship is bestowed upon those who perform the required duties (Polat and Pratchett 2012: 65 - 66).

Concepts of citizenship affect the ways in which governments provide services, evidence for which can be demonstrated to some extent in the way citizenship paradigms have shaped the way they have developed their online presence. Although the internet presents homogenous tools which can be used by governments, in Turkey, the primary emphasis is upon exercising democratic duty, voter registration (voting is compulsory) and paying taxes. In Turkey, parts of the internet are censored to protect citizens, for example to keep children from abuse and corruption, but the UK allows free use except for when intellectual property rights are put at risk. In the UK, the focus has been upon rights and benefits rather than collective duties, and there is a danger that 'citizen-consumers' (Polat and Pratchett 2012: 73-75) will understand the state as merely a provider of services. Citizenship rights may exist before birth or even after death, and the legal rights and responsibilities of citizens can alter when laws are passed, administrative boundaries are redrawn, or with

changes in status such as marriage or employment. The recent withdrawal of the UK from European Union (EU) membership, for example, led not only to wholesale divesting of EU citizenship rights for the whole UK population, but also to a change in the rights of all citizens of EU countries (Yong 2019).

2.3.2 Becoming 'good': What makes a model citizen?

Although the concept of the model citizen is employed in a variety of social domains for varying purposes, there are no moral or political absolutes against which the good citizen can be measured (Pykett et al. 2010: 525). Concepts of good or model citizenship are not static but are part of the dialogue between state and individual, and will vary depending upon the current and historic context in which they are situated. As the enactment of state-citizen relations is driven by the version of citizenship to which the state subscribes, this in turn impacts the archetypal pattern of rights and duties in each nation state. The notion of the good citizen frequently enters into political discourses when certain behaviours need to be encouraged or discouraged, or there is concern about the attitudes or activities of citizens, and during these periods, the model citizen construct can play a key role and undergo transformation. Examples of model citizen discourse occurred during the Covid-19 outbreak when citizens were repeatedly instructed to stay in their homes 'to protect the NHS and save lives' (Johnson 2020, HM Government 2020). An intriguing aspect of political citizenship rhetoric is its tendency to normalise 'good citizen' discourse. Politicians frequently invoke discourses of 'hard working' families (Runswick-Cole et al. 2016), for example. Citizens, it seems, need to be trained and instructed in various ways in order to achieve 'model' status. Politicians discuss the virtues and behaviours of model citizens, as if they were true of all, although this is clearly not the case. This could be seen as an attempt to encourage 'modulation, adjustment and improvement' (Rose 2001a: 24), and suggests that for good citizens themselves to recognise that they are such, they must be defined within a discursive framework which delineates what is expected.

Supplementary to their development of a generic framework which can be used to analyse any 'invocations of the good citizen', Pykett et al. (2010: 523-525) claim that

'good citizen discourse' is always political, and often morally charged and ideologically motivated, with those of different political perspectives emphasising and encouraging the actions most fitting to their own favoured view of the model citizen. Although there may be a variety of opinions about what constitutes good citizenship, they propose that there is always an 'elite' person or organisation which frames the good citizen by defining the standard for citizen behaviour. Implicit in the role of good citizen is an acceptance of this elite, and one's subjected relation to it. The process works something like this: in a given set of circumstances (the domain) the 'elite' define the range of activities, roles and behaviours that are seen as 'good' or 'model', so the model citizen is 'framed' for a certain purpose, and from a certain viewpoint. Ordinary citizens perform their role within the constraints of this frame, for a given domain, so it is the behaviour of the citizen in context which determines the 'model' exemplar. An alternative explanation describes the employment of the governmental technique of 'citizenship agendas' as 'normative framings of citizenship that prescribe what norms, values and behaviour are appropriate for those claiming membership of a political community' (de Koning et al. 2015: 121).

Governments of democracies tend to take the view that a good citizen is an involved citizen, that is, the 'active citizen' who participates in community life by volunteering, thereby relieving the burden on the state, or perhaps contributes to local politics (Crick 2010: 23-24). Here, citizenship is constructed through participation, but control is exercised even when institutions develop technologies of participation with the aim of empowering and emancipating citizens, as in co-operating with government requirement on how to participate, citizens adopt and transmit the discourses they produce thus perpetuating the ideologies therein (Lupien 2015: 381). Active citizens are therefore active also in reproducing government rhetoric and as such are model citizens in terms of their integration into the machinery of government. The viewpoint of citizens about the meaning of model citizenship is somewhat removed from that of the policymakers, however. Contributing to society by being active in voluntary organisations or participating in politics are seen by far fewer people as important facets of being a good citizen. Instead, citizens tend to believe the most important duties of the good citizen are to vote and form independent opinions, to pay their taxes and obey the law (van Deth 2009: 183-186).

The crucial point here is that although citizenship is defined by many, and is mostly constituted as a status, it is really only present in acts of citizenship. Citizens may be identified by their legal status and the documents they hold. Model citizens, however, are defined by their behaviour (Pykett et al 2010: 526).

In any scenario where a model citizen is engendered there exists an inverse, a disobedient, bad or irresponsible citizen, often not referenced explicitly, but nonetheless produced discursively through implicature. Pathak (2013) introduces a number of such scenarios in which the 'bad citizen' is invoked. He explains that, in the UK, for example when the Conservative Party describe their utopia, there is a correspondent silent dystopia which corresponds with their description of life under Labour (Pathak 2013: 71), and that 'while work-readiness is politically expressed as a positive attribute of a responsible and active citizen, the inverse condition of welfare dependency is also suggested' (ibid.: 67). What is implied is that a citizen who does not strive to comply with the stated standards or requirements of the authorities is either deficient in some way or deviant. The idea that some citizens behave badly, or less than ideal ways, is indexed in several of the texts in this thesis. For example several texts in Chapter 5 frame the reader variously as less deserving of emergency care than others. The discursive production of 'bad' citizenship has led at times to the marginalisation of individuals, particularly those from immigrant communities, when public authorities feel it is their place to paint them as such (see, for example Blackledge 2006; Wodak 2015). Migrant populations have been demonised through public health discourses when it suited the local economy, for example in times of high unemployment (Molina 2006) and austerity. Other non-compliant individuals are also at risk of being publicly shamed, and my second dataset provides examples (see 5.5 and 5.6). Although blame for the behaviour of citizens is directed at individuals, successive governments clearly feel that they have some responsibility for producing society's problems as 'political parties invariably blame each other for failings and make claims that their own party, once in government, will put things right' (Pathak 2013: 61).

2.3.3 Governing citizens: Discourses of governmentality

Foucault's (1997, 2000) development of the concept of 'governmentality' involved the exploration of what it means to govern and be governed, the 'conduct of conduct' and how power and subjectivity work together between governments and individuals, and between governments and society. He understood Liberalism, not as an ideology but as a way of governing, which 'does not limit itself to a simple guarantee of freedoms (market freedom, private ownership, freedom of opinion, and so forth) existing independently of governmental praxis' (Bröckling et al. 2011:5), but also controls the situations in which such 'freedoms' can operate. This explains individual freedom not as the opposite of liberalism, but as an effect of it. In this view Liberalism 'replac(es) external regulation by inner production' so that citizens self-regulate, and the costs and risks of legislation and enforcement are therefore diminished. Governmentality is about the many and complex ways in which the governed do the bidding of the governing, or rather act upon themselves without being ordered to do so (Bröckling et al 2011: 2).

A wide variety of techniques and technologies are used to transmit officially sanctioned discourses about citizenship to the population. Governments attempt to shape and control the behaviour of citizens, define categories of citizenship, and to align popular values with those of the governing party (Petryna and Follis 2015: 403). They may use devices which incorporate persuasion tactics such as public health campaigns, voter registration and recycling drives, for example. Legislation, court decisions, and 'direct' appeals including press releases, party political broadcasts and news interviews are further examples of discursive technologies used to re-shape and re-construct citizens. But populations are dispersed, diverse and constantly transforming, and modern populations are also found to be 'reflexive' leading to 'unpredictable combinations of popular doubt and desire' (Clarke et al. 2007: 23, citing Clarke 2005: 228). Citizens do not exist in a vacuum and have to live (or perform their role) within an understood set of circumstances with boundaries. In addition to being subjected, they also have agency and self-will which can make them less predictable but also allows them to remake and transform their role as subjects. Because of this, governments find ways to invoke their subjects as 'autonomous, emancipated, responsible, citizens'. They activate the participation of subjects

through strategies and procedural devices, to shape behaviour (Bröckling et al 2011: 12-14). These begin with government rhetoric which 'might point to the discursive labour of constructing the necessity, plausibility and desirability for some directions; of mobilising social forces and de-mobilising others (Clarke et al. 2007: 35). Governments work to develop their relationship with subjects, by providing 'freedoms', services and benefits of membership which will not only increase the satisfaction levels of subjects but will render them more co-operative and less likely to interfere in the business of government. The threat of freedoms being removed is also present (Brown and Baker: 2013: 119), leading to constant insecurity which must be defended against (Bröckling et al. 2011: 6).

Producing obedient 'ideal' citizens is therefore a critical technology of governmentality, and may be one of the most important tasks of government, because how citizens are formed will impact on their current behaviour and shape future actions. Governmentality reaches into all aspects of life because governments have gradually taken on 'pastoral' powers as well as political ones, attempting to govern formerly spiritual goals such as happiness and salvation, so that religious morals become intertwined with secular ones. Often tacitly, but occasionally overtly and sometimes without the realisation of either party (Fairclough 2010: 38), governmentality enables governments to carry on their work of enacting ideologies with the minimal disruption. In healthcare, as in many other areas of life, it is preferential to those in control that people behave in predictable ways. Governments generate their subjects through their 'rationalities and practices' (Bröckling et al 2011: 13), and it is these technologies, used to control and direct the citizen which are of particular interest in this thesis. Public information texts could be viewed as 'technologies' in that they can be classified as documents but also form part of, or in some cases replace, social practices such as advice giving and medical encounters.

Although other texts from public institutions have been subjected to scrutiny, until now almost no work has been carried out to establish whether health promotion texts, which are 'embedded within the mundane practices of social institutions' (Fairclough 2010: 96) should be viewed as technologies of governmentality, and establishing whether this is the case is one of my lines of enquiry. Governmentality is not inherently bad or good, because the form it will take will depend on the ideologies

and practices of the government of the day. Which actions become important and necessary or disapproved of, are a reflection of these ideologies and practices, for example whether the provision of care is framed as part of a compassionate society or a nanny state. I now move on to discuss discourses of neoliberalism, as this ideology is currently predominant and naturalised within UK governmental discourses.

2.3.4 Discourses of neoliberalism

Much has been written about neoliberalism, so in this section, rather than going over old ground I will point up the elements of this ideology that are most relevant to the topic in hand. Neoliberalism is a tenacious and aggressive ideology which has infiltrated much of 'the establishment' in many countries, particularly the UK, US, Europe and other developed nations, becoming dispersed to the point that it has become invisible. Indeed, neoliberalism relies upon discourses which deflect attention from its true wealth-shifting activities, and those involved in creating and perpetrating it have been careful to avoid referring to it as an ideology. Proponents of neoliberalism rarely name it as such but tend to couch it in positive-sounding terms such as 'choice' and 'freedom', and as it is usually un-named, negative ideas tend not to form associations with it.

Neoliberalism is not, as such, a global movement, as it has been adopted in different ways within different countries because of their varying situations and political models. Nor was it purely generated by governments, but successive UK governments have contributed to the development of the British interpretation of neoliberalism since the latter part of the twentieth century by linking the concepts of citizen and consumer through discourses, in order to transform public thinking about the meaning of citizenship in a consumer society. Neoliberalism is most successful in private sectors, where it has been naturalised and adopted as a norm in business transactions, but it has also attempted to colonise the public sector in many fields. It is generally viewed as situation in which reliance on 'the market' rather than the state is actively encouraged, or even legislated for, and where 'market forces' are seen as natural and fair. Opponents believe that the opposite is true and that market forces are controlled by a small number of wealthy actors who have engineered systems and

manipulated governments for their own benefit (Monbiot, 2016a). Neoliberalism encourages individualism and anticipates that the citizen will behave like a consumer in almost all circumstances, including encounters with health services such as those I explore in this thesis.

Commentators on neoliberalism tend to agree that, alongside individualism, a central tenet of the doctrine is choice in its broadest terms. Choice has been articulated to the population at large in various ways, depending up on the political tendencies of the government in power, to reconcile the general public to the acceptance of consumerism. Clarke et al. (2007) traced the development of neoliberal discourse in relation to public services back to the 1970's, but found that it really began to achieve prominence under Margaret Thatcher, British Prime Minister between 1979 and 1990. Her government viewed the state and the market as polar opposites and encouraged the conversion of public utilities into private companies and the disposal of public assets by a number of means including privatisation, sale of council houses and competitive tendering in the public sector. These changes were achieved, at least in part, by the focus on discourses of 'dependency culture'. Claims were made that 'oppressive, inefficient and monopolistic' (ibid.: 30) state-run services could be 'rescued' by private enterprises and transformed into efficient, customer-friendly and above all, cheaper-to-run, organisations. Prices would be driven down by competition between rival companies, who would vie to provide the best offer to members of the public. At the same time, dependence on 'welfare' began to be branded as shameful, and people were sorted, via government and media rhetoric, into consumers, tax-payers and scroungers. The discourses of 'anti-welfarism' and 'anti-statism' were quite distinct and were worked upon separately, but a key tenet of both was choice 'and its capacity to articulate the contrast between the active consumer and the passive citizen' (ibid.: 29). Linking choice to consumerism was a key move as it opened up various discourses where markets were seen by the public as positive. Conversely state-run organisations could be portrayed as anti-choice and monolithic.

John Major's government (1990-97) developed this discourse of the impenetrable and oppressive public institution by distancing itself from public services and realigning itself as the people's champion by publishing a range of documents focusing on service standards. The first of these was the 'Citizens' Charter' in 1991,

heralded as a new 'bill of rights' for users of public services (HM Government 2017). This was followed rapidly by the publication of the 'Patient's Charter' (DH 1991), guaranteeing standards and rights for users of the NHS, which would encourage citizens to view themselves as consumers of a service. These included 'existing' rights to GP care and emergency healthcare, and 'new' rights on waiting times for treatment, receiving information and making complaints. Under Blair's New Labour governments (1997-2007) this neoliberal rhetoric had come to fruition. Rather than stating consumerist ideals as objectives, Blair declared that Britain was now a 'consumer society' (Clarke et al. 2007: 33). New Labour took for granted that the market was more important than the public domain, relying heavily upon modernist discourses of imperative change, updating and rendering acceptable the grammar of 'old' neoliberalism by use of new terminology to imagine and construct a new style of British public. Now neoliberalism was used to 'bring about a decisive ideological-political-discursive shift' (ibid.: 37) from the image of a collective public to an individual harnessing their own active agency and making their own (spending) choices. Members of the public, rather than passive recipients, became entrepreneurial individuals bringing wealth, and supporting their country, by spending and making wise choices. Although elected as and proclaiming itself as a progressive party of the people, New Labour's leaders combined social democratic ideologies with neoliberal ideas (Hall 2005: 329), probably contributing thus to the acceptability and normalisation of neoliberal values.

Under the Health and Social Care Act, 2012 introduced by David Cameron's coalition government, choice was also to be extended to local General Practitioners in the NHS. GPs would no longer tap into health services provided to them by a regional commissioning group as was formerly the case, but would purchase them using devolved budgets. This iteration of choice discourse has led to a large number of services being provided to the NHS by private companies, and can be seen as gradual and covert privatisation of the NHS. However, this is enabled by discourses of responsible management, decision making brought closer to the frontline, and thrifty use of public money, employed by politicians who approve of the Act (Brookes and Harvey, 2016: 289-291). Subsequent governments under May and Johnson have broadly continued along the same trajectory but have been preoccupied with the

issues of Brexit, and more recently, Covid-19. Each of the above developments in British neoliberalism have been introduced and nurtured using specifically chosen language designed to shift the public understanding of truth, thus attempting to manipulate belief and behaviour, as 'social transformations in contemporary social life are extensively "discourse-led", in the sense that it is discourses which change first' (Fairclough 2010: 77). These discourses which begin life in the speeches of politicians can be traced through legislation, public policy and local procedures and practices, to the information provided to NHS users and to those giving and receiving care.

Healthcare has long been the focus of debates about choice, but although citizens like to feel that they have a choice in their use of public services, they understand that choice does not equal equality, and comes at additional cost (Clarke et al. 2007: 75-79). In any case there are many instances where genuine choice does not exist within the NHS. This is certainly so in the case of emergencies, as casualties are taken to the closest hospital with the appropriate facilities, and treatment often begins before arrival at the hospital. Some argue that neoliberalism actually contributes to ill health. Monbiot (2016b), a strong opponent of the ideology, for example, claims that 'competitive self-interest and extreme individualism' engendered within developed nations contribute to social isolation and loneliness, and hence to an increase in mental health problems, and related physical conditions.

There are many who reject neoliberalism, and now its theories and methodologies are under attack and possibly in decline. In public services, health in particular, there is evidence that despite the monetisation of care, the role of consumer has not been embraced by users. In reality, rather than public services being rescued by the private sector, even before the 2020 Covid-19 pandemic, significant numbers of private and privatised companies were being rescued by the state. In many cases the public sector has been left to pick up the pieces from failed privatisation. Recent examples from the healthcare sector include NHS trusts taking over private healthcare facilities and amenities contracts (BBC 2015; Campbell 2019), and criticism of Private Finance Initiative (PFI) contracts for the building and management of hospitals. These examples suggest neoliberalist capitalism may be breaking down or in a precarious state. Indeed, those at the very centre of financial control are beginning to question

the benefits of an ideology which relentlessly converts every facet of society into monetary assets. A recent IMF working paper (Furceri and Loungani 2015) proved links between the rise, internationally, of neoliberalism, and in particular of free market trading, with inequality, increased economic volatility and financial crises, and reduction in the benefits to working people of their labour. In the analysis chapters which follow, I identify and critique ideologies present in the data, and find significant evidence that neoliberalism has infiltrated the discourses of health promotion. I now examine more closely the discourses of citizenship and health, which will lead into the next section of the chapter.

2.3.5 Citizenship, biology and health

Biology has been important to citizenship throughout modern times, as it is integral to issues such as race, eugenics, degeneracy and entitlement due to lineage. Individuals in the 19th and 20th centuries 'understood their nationality, allegiances, and distinctions, at least in part, in biological terms' (Rose and Novas 2005: 441). In the present day, this is particularly applicable in the UK where healthcare is a domain in which citizens exercise their rights; NHS services are paid for via taxation so are free of charge to users at the point of use and, on the whole, distributed fairly to those who need them (Cookson et al. 2015). In recent years the NHS has been the pawn in debates about fair use. In particular the rights of citizens to use it, and the more tentative rights of those seen as 'others', 'unfairly' accessing free healthcare either because they are not UK citizens, cannot speak English (Wright and Brooks 2019: 72) do not 'look like' British people or for some other reason are not seen as legitimate users. This debate has been stirred up in the right wing media, who invoke a version of citizenship based only upon genealogy.

Evans (2007: 690-691) believes that citizens have a number of duties in relation to their consumption of health services and that their moral force is grounded 'in the interests of contemporary and future patients' (689), being inextricably bound up with our understanding of our relationship with the NHS as a central 'estate' of British society. These duties include the requirement to 'uphold' one's own health and wellbeing, including the avoidance of risk, and the following of a 'responsible lifestyle'

(689). In contrast with previous forms of biomedical authority, which favoured 'passive and compliant patienthood' (Rose and Novas 2005: 448ff) active citizenship is now encouraged in relation to the body. Much of this is constituted discursively. Medical discourses are dispersed in a variety of new ways, including social media, the internet, and other information and knowledge technologies. The obligations of the 21st century biocitizen are numerous. For example the public are expected to read information and follow 'expert' advice, and especially to become knowledgeable about any illness which affects their body or mind, or that of someone they care for. Those with serious medical conditions, such as cancer, and their carers and families, are encouraged to 'fight' the disease and embrace responsibility for the cure (Semino et al. 2018: 631), to raise funds and to be politically active. Patients can become more worthy by being positive and communicating with others to 'spread the word', and citizens learn and use 'increasingly biological' language as part of this process (Rose and Novas 446).

Governments concern themselves intimately with the biology of citizens, which implies that in addition to being morally good, citizens must also be physically 'good'. From birth children are weighed, measured, categorized and tested. Throughout childhood they are sorted depending on gender, age, weight, ethnicity and ability. Later in life they are screened for illness, and subjected to further tests of fitness to carry out certain tasks. Doctors, dentists, opticians and hospitals keep records. Data, reports and statistics on the health of the nation are generated as 'Neoliberal governments have increasingly adopted the biopolitical duty of administering bodies and managing collective life' (Charles, 2013: 776). The co-operation of patients and public is expected, and citizens are 'made up' into members of categories such as sufferers or non-sufferers of a certain condition, so that they can be more easily understood and dealt with by authorities. This categorization both divides and unifies because it draws the boundaries between the different ways people are treated, and affects the people in these groups, as they are less likely to be treated as individuals. In addition, this labelling allows private companies to more easily provide products and services, marketing them to a pre-conditioned audience. Capital enterprises are entwined with healthcare organisations in that they 'seek to represent their activities and their products as beneficial' (Rose and Novas 2005: 447). Indeed those

previously categorized as 'patients' are often now re-labelled as service users or clients in moves to assimilate them into business discourses (Brookes and Harvey 2016: 295). Further links with the commercial world are created through requests for feedback from patients, via purpose-made forms, surveys and websites, such as those in Chapter 6, with satisfaction ratings and 'customer reviews' being published online.

The encouragement of private enterprise in health fields means that the population and its biology have become a profitable resource, and the state is complicit in this, through collection and sharing of data (ibid.: 445). The entextualisation of biological information allows the collected data to become portable, and it may then be recontextualized within, for example, scientific, demographic or educational discourses, or may be bought and sold. 'Biological citizenship' operates 'within an economy, or field of hope', with promises of cures for ailments, prolonged lives and improved quality of life always on the horizon (Rose 2007). But there is an inverse to this view in which, in addition to the prospects of improved health and wellbeing, 'new and unprecedented obligations' such as worry, guilt and distress impinge upon the individual (Charles, 2013: 779).

Despite the increasing demands upon citizens to participate, or perhaps because of them, the requirements upon government agencies from citizens have also increased. 'Novel conceptions of "biological citizenship" have taken shape that recode the duties, rights, and expectations of human beings in relation to their sickness, and also to their life itself' (Rose 2007: 6). Expectations for services and treatments, and the steady rise in requests for more information, are in some cases yielding positive results for citizens. 'Citizenship has become a dominant form of claim-making for people around the world. Citizenship agendas are not only forms of control; they also provide people with important horizons of aspiration and action' (de Koning et al. 2015: 126). Citizens expect to be kept safe, to be rescued if they are at risk (Petryna and Follis 2015: 410), and to be compensated if they come to harm. The rights and responsibilities of the citizen in relation to health now occupy such a central position in societies that health systems impact on citizenship, not only as administrators and health care providers, but as important institutions shaping the citizen experience. Although there have been great advances in medicine, many factors including wealth

and geographical location impact upon their availability, and citizenship does not guarantee health equality (ibid.: 408).

Health citizenship has placed many requirements upon individuals to embrace a new range of duties in order to be viewed as model citizens. Frequently framed in carefully selected terms, by politicians, and often invoked, explicitly or implicitly by other public authorities, the good citizen is obedient inasmuch as reproducing government discourses, but also internalising them. In the above section on biological citizenship, I have introduced some of the links between citizenship and the field of Health. Having discussed citizenship and the relevant elements of governing and being governed, I now move onto the next section of the chapter, in which I explore health-related issues relevant to the data. I begin by defining 'health' and introducing health promotion, which is a technology through which governments may alleviate their responsibilities for the health of citizens.

2.4 Health and the Citizen

2.4.1 Health promotion and patient information

Health promotion, sometimes referred to interchangeably with 'health education', grew out of the field of public health. Initially viewed as a way to improve public health by influencing behaviour (Lupton 1995: 106-109), it is generally seen as taking a preventative approach to the health of populations, acting by alerting individuals to risks and mitigating behaviours, which 'makes identity central to definitions of health and ill health' (Lee and Freyn 2008: 116). Many organisations have their own definitions of health promotion, but an early report commissioned by the World Health Organisation (WHO) explained it as:

> Any combination of health education and related organisational, political and economic intervention designed to facilitate behavioural and environmental adaptations which will improve or protect health (Anderson 1983: 11).

Health promotion techniques suggest that the rational mind can take control of the undisciplined 'health' entity of body and mind (Fox 1993a: 135). This is achieved through the constitution of governments primarily as 'safeguarding their subjects from risks (Isin 2004: 218), and through those subjects demonstrating their model citizenship by electing to 'choose rationally among available options and to assemble from these the risk-minimizing elements of a responsible lifestyle' (O'Malley 2000: 465). Risk discourses are imported into health dialogues in order to conscript citizens to participate in responsible and ethically correct ways, including preventative health measures, and dangers which cannot be fully comprehended by 'ordinary' citizens are invoked in increasingly alarmist discourses.

Large scale advertising campaigns have been used by various government services to educate citizens (Sarangi and Slembrouck 1996: 21), and the NHS has been producing health promotion materials for the general public, patients and carers for many years. Much of the information from the NHS is produced in local trusts, but larger campaigns are run or co-ordinated by a national body, such as NHS England, which is an overarching organisation which leads and regulates the NHS in England (Department of Health and Social Care [DHSC] 2018). Another is Public Health England (PHE) which is not part of the NHS but an 'arms-length business unit' funded by the DHSC. It has responsibilities for reducing health inequalities, 'promoting healthier lifestyles' and 'improving the health of the whole population' among other duties (PHE 2020). In the UK the current style of multimedia public health promotion can be said to have begun with the 1987 HIV/AIDS campaign *Don't Die of Ignorance* (Wainwright 2008: 82). By the end of the twentieth century, many health promotion campaigns were multimedia, incorporating posters, leaflets and TV advertisements, and since 2000 they have increasingly included web content and 'marketing collateral' items similar to those used for promotion of commercial businesses. For example Public Health England's Change4Life campaign (2009 - present) aimed primarily at families with children, includes web pages, apps for tracking sugar use and exercise, recipe cards, quizzes, stickers and vouchers for discounts on healthy foods (McIntosh 2014, Mulderigg 2017). Although aimed at improving health rather than selling, under some definitions this type of public health communication could be classed as marketing. Certainly some of the formats used in health promotion

mimic commercial advertising. PHE, perhaps recognising this, refer to their campaigns as 'social marketing', and publish a marketing strategy which states

> Just as the commercial sector uses marketing to change how people shop, bank, and spend their leisure time, social marketing addresses behaviours relevant to the social good. It takes the tools and techniques of commercial marketing, such as audience mapping, insight generation and customer relationship management, and uses them to create marketing and communications campaigns that address key public health challenges (Public Health England [PHE] 2017a).

Along with similar moves in other areas of the public sector the turn to these techniques can be seen as 'a reflection of the marketisation of public life' (Sarangi and Slembrouck 1996: 33). Significant sums of money are invested in the production of these materials because governments believe that they are worthwhile (Beattie 1991: 169), but despite this,

> educators and policymakers are almost always disappointed by the uptake of advice, whether this be to do with eating fruit and vegetables, participating in health screening programmes, becoming volunteers, taking exercise, or clearing up after their dogs. The penetration of these practices is always incomplete (Brown and Baker 2013: 6).

Success rates for health promotion campaigns are extremely difficult to calculate in most cases, and any measurable change in behaviour they cause can only really be calculated over significant time periods.

Health promotion is not universally lauded and has sometimes been viewed with suspicion or scepticism. The process of shaming or stigmatising citizens who do not take responsibility for their own health and wellbeing in the government-sanctioned manner has been described as 'biomorality' in which 'medical knowledge imperceptibly morphs into a moral language' (Cederström and Spicer 2015). In fact the semiotic signals which guide this process of 'morphing' are not imperceptible, but ubiquitous and discursive. In the case of smoking, for example, public health campaigns include advertisements linking a range of negative emotions with smoking

(Lupton 2015: 7). Combined with legislation banning smoking in public places (Action on Smoking and Health 2015), symbolic reminders in the form of 'no smoking' signs texture this moralistic 'anti-smoking' discourse. Further, the proliferation of 'help' for residual smokers, now cast as needing moral support to achieve a healthy 'non-smoking' lifestyle (NHS 2015a), reproduces and develops a wellness rhetoric which suggests that smokers are deviant. Campaigns featuring the voices of ex-smokers who have 'overcome' the habit and improved their own lives with help from NHS services, also contribute to the discursive transformation of smokers to 'bad' citizens who need corrective treatment.

It has been said that 'health promotion and illness prevention discourses contribute to a rationalizing away of our finitude' (Fox 1993a: 135) suggesting not only that we can always avoid death from a particular cause by taking proscribed actions, but also that prolonging life is always imperative (McIntosh 2014). Health organisations have been accused of employing techniques developed in behavioural psychology to 'change people's behaviours without them necessarily realising this has happened' (Mulderigg 2017: 1). Health promotion has been described as 'the broadcasting of propaganda based on half-truth, simplification and distortion' by those who have 'never come to terms with the complex relationship between the individual and the collective in the field of health and illness' (Davison et al. 1991: 16-17), and others even see minatory elements of health promotion as counterproductive, such as the invocation of the emotion of disgust to encourage behaviour change (Lupton 2015: 7) which may backfire or even encourage risky behaviour, possibly 'causing target audiences to avoid the confronting messages by responding with perceptual and cognitive defence mechanisms'. There are also views that governments and health organisations sometimes develop these campaigns in the full knowledge that they have a high chance of failure, because they are a visible sign to the public that something is being done by the authorities about the problem in question (Beattie 1991: 169). In addition, health promotion discourses tend to simplify complex issues and often ignore the many other factors impacting upon health over which readers of the text have little or no control, such as financial constraints, housing situation and workplace conditions (Nettleton 2013).

If obedience of government advice regarding the body is one aspect of good citizenship, inaction may be deemed, 'risky, irresponsible, and exemplary of negligent citizenship' (Charles, 2013: 777). Those who make a choice to reject the narratives of health and risk include the 'fat acceptance' movement which rejects the weight management aspect of wellness, and those who deliberately indulge in unsafe sexual practices (Cederström and Spicer 2015: 122-127). Also potentially in this category are those parents who choose not to have their children immunized against childhood diseases. Indeed, manipulation of the individual towards model citizenship in the domain of health does not stop with worry and guilt but in some cases neuroticism is incited to activate and secure the allegiance of the citizen (Isin 2004). Public health discourses present 'science' or 'the expert voice' as a given, and unproblematic, whereas those who disagree are problematized as 'misunderstanding' the information they have been given, as 'different kinds of knowledge are implied in practices of articulation and interpretation' (Kress and van Leeuwen 2001: 42).

In addition to health promotion materials, the NHS publishes or disseminates a further category of public texts which cannot be classified strictly as being for the promotion of health. These publications instruct citizens how to use NHS services in order to comply with medical or bureaucratic requirements – for example what to bring when being admitted to hospital, how to act as a visitor to a hospital patient, whether or not to eat before a surgical procedure or before taking a medicine, or what to wear to allow easy access to the body for medical staff. This information may also be given in person, but the provision of published information is common, and serves the dual purpose of reinforcing any verbal instructions and discharging any duties to provide information, so fulfils both ideational and interpersonal metafunctions (Halliday 2014: 30). A wide variety of information is displayed in leaflets or on or posters in NHS settings, and shared through public health messages in other media channels, for example websites, newspaper articles and TV advertising. The proliferation of these materials is due to a number of reasons including a history of complaints of poor communication by public sector services (Sarangi and Slembrouk 1996: 137). High profile court cases against the NHS and other public bodies have pointed to the importance of a culture of openness and

sharing of information, alongside a rise in awareness of the need to protect confidential personal data.

Communications teams in the NHS trace their origins to *Informing Patients* (Coulter et al.), a 1998 report from The King's Fund which stated that despite the promises made in the Patient's Charter over a decade earlier, the quality of information for patients was disappointing in many respects. The authors found, among other problems, that information was simply not made available in many cases, and when provided it was often inaccurate, out of date, or incomplete in its coverage of appropriate topics. *Informing Patients* made many recommendations about providing and improving patient information materials (52ff) and coincided with a reorganisation and refocusing of the NHS in line with the direction of Tony Blair's (1997) New Labour government (DH 1997). In addition, there has been an amplification of the voice of the service user in the public sector, with a proliferation of self-help groups, and consumer organisations, and more recently, internal teams such as the Patient Advice and Liaison Team (PALS) in each NHS trust. As patient feedback has become more important and consequential (Baker et al. 2019: 11) various echelons of the NHS have devoted more resources to producing information which is comprehensive and of a higher quality. To this end NHS communications teams have for some time sought the views of members of the public, and those of professionals outside the NHS including academic consultants. They use software or lay readers to check whether the language used in public information is 'plain' or understandable, request feedback as a standard practice, and constantly review their publications with the aim of keeping them up to date and accurate.

Inspections of services now take account of information and quality of communication, and legislation about health and social care services incorporates broad requirements to inform users and carers of services about their entitlements to particular services, and how to access them, (for example *The Care Act* 2014). The NHS constitution also undertakes to provide information about services (DH 2015: 8), and particularly since the widespread roll-out of the internet, information is now a service in its own right, and has come to be seen as an entitlement. Although they also continue to use 'traditional' ways to contact people, the websites of NHS trusts have become repositories of large quantities of content and typically include information

for the public and patients, and also for staff, partner organisations and for people who want to visit, make a charitable donation, or apply for jobs.

2.4.2 Health, commercialism and neoliberalism:

When seen from the viewpoint of Ayo (2012), health promotion is an embodiment of neoliberalism. She demonstrates governmentality in action by listing the ways in which 'healthism' and neoliberalism are mutually produced using five tenets of neoliberalism (Ericson et al. 2000). These principles of minimal government intervention, market fundamentalism, risk management, individual responsibility and inevitable inequality as a consequence of choice, all impact upon the health of the citizen (Ayo 2012: 99). Ayo's framework also illustrates the multiple ways in which the diverse but interdependent concepts of health and neoliberalism interact. The expansion of the definition of 'health', along with the widening reach of consumerism and the increase in the number of areas of life in which government has at least some form of control, probably meant that it was inevitable for the areas to collide or combine in some way. Each of these expanding concepts has its own discourses which construct the individual in various ways, and in the field of health it is particularly evident that 'patients are increasingly urged to become active and responsible consumers of medical services and products' (Rose 2007: 4).

The positioning of the NHS as a politically neutral provider of health services and information allows scope for its various branches to define and develop the concept of wellness for the British public, as for example, in the first dataset in this study. The general orientation of the NHS is towards improvements in health and reduction in serious illness, but in the public information it produces this is often merged with messages encouraging self-control concerning exercise, diet or consumption of alcohol (Lupton 1995: 110). Through health promotion initiatives governments avoid imposing change upon populations, but incite the desire in responsible citizens to make those changes for themselves. Lupton (1995: 3-4) argues that citizens are manipulated by public health discourses into the generation of a new concept of the 'normal' in which they actively choose 'a kind of regulated freedom'.

Choice, as I have already mentioned, is a key concept in neoliberalism, and the discourses of choice have been discussed by others in relation to health and wellness. On the main NHS website, previously named congruously as 'NHS Choices' (2015), the 'live well' tab provides links to over 100 topics on healthy living, covering such a huge range of subjects that is difficult to discern from this what is not a 'health' topic. Not only is health poorly specified, but this abstraction by the NHS suggests it is not a discrete subject but a weak concept which can be easily diluted, merged with other ideas or conscripted to support other discourses such as finance, voluntary aid or heating the home (see, for example HM Government 2015). The portrayal of such variety implies that users of NHS services have many options. Citizens are encouraged to make 'lifestyle choices' and the discourse of wellness is presented as free will to live life as we choose. However, as explained above, if they choose 'incorrectly' people may be deemed immoral and judged harshly, not only by peers or employers, but also in a range of other contexts such as medical consultations and decisions about one's suitability for benefits or treatment, (see, for example, Persaud 1995 on smokers' rights to healthcare).

Public health campaigns are published by governments and health departments, yet the messages they disseminate can be appropriated by advertisers of commodities in a parasitic manner (Cook 2001: 33ff) and interwoven with advertising discourses so that they resonate with each other and audiences form cognitive connections between them. The UK's NHS is complicit in constructing wellness as a shared enterprise between public and private organisations and the individual. Many of the lifestyle choices which citizens have been urged to make require commercial transactions such as buying essential vitamins or health foods, or taking part in 'healthy' activities. The close association between wellness and physical health has proved lucrative for certain types of private organisations which associate themselves with health discourses, and make their money from products and services designed to enhance or improve the body, including fitness clubs and spa hotels (Anderssen 2015, Wiest et al. 2015:31) and sales of e-cigarettes as the 'healthier' alternative to smoking. As it is thus framed by public policy, promoting health as something that can be bought along with a membership card, 'privileges these commercial entities by making it the citizen's duty to consume the appropriate

commodities and technologies necessary to achieve a state of healthiness' (Wiest et al. 2015: 24). This co-dependency of 'wellness industries' and the citizen is a 'new paradigm of healthcare' in which values of commodities are 'transvalued' into something which is articulated in terms of health (Burrows et al. 1995: 2).

Planning for, and mitigating risk is another element of neoliberalism which has been associated with health and wellness through health promotion. Risk discourses are introduced to the public through the 'medicalisation of society' (Huber et al 2011:1), also referred to as 'the pathologization of normality' (Skolbekken 2008: 19). Risk calculations are now central to modern medicine and are intended to improve the management of conditions and reduce their likelihood through interventions, but instead of making us feel safer the identification of potential conditions often leads to worry. It is no longer possible to trust one's body for signals as to whether one is well, because although symptom-free, we may be identified as needing medical attention, so we become dependent on the medical profession to tell us whether we are well or sick. In this way we can be 'healthy and ill at the same time'. Low-level fear penetrates society and 'civilized character is partly constructed by people's internalisation of fears', with fear of dire consequences 'experienced on a discursive and abstract level' (Furedi, 2007). It would be reasonable to suppose that the proliferation of risk discourses is another reason why people seek medical help by going to A&E for 'trivial' reasons. They may have become very risk averse and scared, and less trusting of their own judgement or capabilities relating to understanding their own health.

Citizens must now take on extra responsibility for becoming healthy. Government, on the other hand, whilst retaining responsibility for maintaining the general conditions for healthiness, such as provision of clean water and regulation of the safety of foodstuffs, has attempted to dissociate itself with some responsibilities such as 'securing individuals against the consequences of illness and accident' (Rose 2001b: 6). As I shall show, this divesting of duties is achieved at least partly discursively through health promotion discourses. I now provide some background information about A&E services within the NHS, which are the focus of my data.

2.4.3 The UK health context and emergency healthcare in England

The UK's National Health Service (NHS) is a large and complicated structure. Employing over 1.5 million people and with a budget of over £115 billion, it provides a wealth of services for the people of Britain and is funded through taxation (NHS England 2016). Each country of the UK has its own version of the NHS, and NHS England, by far the largest, is subdivided into five regional teams which 'support the commissioning of high quality services and directly commission primary care and specialised services at a local level' (ibid.). This thesis examines various texts collected and observed in the East Midlands which falls within the 'NHS England Midlands and East', regional team area. The English East Midlands is a loosely defined geographical area, but for the purposes of NHS provision it comprises the counties of Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland, with a combined population of around 4.8 million people (Office for National Statistics 2020). It is served by ten A&E or Emergency departments, and one NHS Ambulance Trust. Most larger towns and cities in the region also offer facilities for those with less serious urgent care needs, although these do not operate 24 hours. At times I refer to emergency healthcare as if it is one service, but this is by no means the case. Because the NHS is made up of many smaller units, each of the A&E departments mentioned in this thesis, and the ambulance service, are managed by different NHS trusts. I refer throughout this thesis to emergency healthcare services, by which I mean A&E services of hospitals in England. I also sometimes refer, to the ambulance service, by which I mean the overall provision of ambulances by the NHS except, particularly in chapters 3 and 5, when I discuss specific data sourced from the East Midlands Ambulance Service (EMAS).

Hospitals in the UK were brought under the umbrella of the new National Health Service in 1948, but it was not until 1962 that the services offering treatment to those needing urgent help, without appointments, became known as Accident and Emergency departments (Platt 1962). Until this time, 'Accident' or more commonly 'Casualty' departments had existed in almost 800 UK hospitals. Before the creation of the NHS these departments had been used mainly by the poor, as unlike other health services including family doctors, the care they provided was generally free of charge (Guly 2005: 135). Emergency care was not seen as a specialism, so A&E departments

(and their forerunners) were often the 'poor relation' of other departments in hospitals. Casualty departments were not led by specialist consultants but tended to be tagged onto other services, and were managed under a variety of different arrangements which varied from one hospital to another, often depending upon junior doctors or those rostered in from other departments, or from general practice, to support them. This began to change in the early 1970s with a successful pilot scheme to appoint specialist A&E consultants (Guly 2005: 47), however insufficient staffing has continued been an issue since long before the inception of the NHS, and the numbers and type of staff required in A&E has been in contention for decades (ibid.: 125ff).

Another issue at least as old as the NHS is that of 'incorrect use' of A&E which appears to be the catalyst for many of the texts in this thesis. Since its redefinition as a specific type of hospital outpatient department providing a specific range of services, but also long before this time, A&E has been contested space. Its necessity cannot be denied, but its reasons for being are hard to define and its appropriate clientele even less so. What constitutes a legitimate A&E patient has been debated since its early years (see for example Blackwell 1962; Green and Dale 1992). Some patients are very obviously A&E cases to any observer, but whether a condition is considered an emergency is subjective, and will depend upon many variables. Ordinary citizens may have different views over what constitutes an accident to medical professionals (Green 1995). Indeed the doctor seeing the injury or ailment as a discrete medical episode may have a completely different viewpoint to a lay person living the life in which that episode is embedded. But even without this differing interpretation of events, there are many ambiguous circumstances when attending A&E may prove to be an appropriate choice. Take, for example, the person who falls from a roof or is hit by a moving vehicle without any obvious injury, or someone experiencing a mental health crisis, or one of many symptoms such as nosebleeds or vomiting which may in some circumstances indicate a serious condition, and may alarm the sufferer. Parents and others caring for children may also be more cautious and take more urgent action when a child is injured or ill. In practice there is much overlap between A&E departments and primary care, and many cases seen by A&E could equally well be dealt with by a General Practitioner (GP), but such cases may become urgent

overnight or at the weekend when GP surgeries are closed. In 1960, Fry (1960: 166) noted that, 'The present day casualty department has no specific function and runs as a "general practice". It is misused to a considerable extent by the public and their doctors'. GPs were implicated here as being complicit in the problem of over attendance because their pay scheme 'offered the GP no incentives for discouraging patients from attending A&E' (Guly 2005: 135). An initial reduction in the number of attendees was observed after the launch of the NHS, with the advent of free GP care for all, and some even thought that Casualty departments may no longer be needed, but patients still arrived 'in large numbers' (Guly 2005: 135). The NHS began to try and tackle the ambiguity over use of A&E in following a study in 1960 (Nuffield 1960), which highlighted the many discrepancies between services and recommended a national approach with larger and more specialised departments. However despite various amalgamations and reorganisations of services (Brookes and Harvey 2016; Pollock 2005), which have reduced the number of A&E departments to around 230 much larger departments, the problem of appropriacy has not been solved.

Since the introduction of waiting time targets in the early 2000s few A&E departments and ambulance services have been able to meet them (Kings Fund 2020), and average waiting times in A&E have increased over the past decade. There are several reasons for this. Successive governments have eroded the integrity of the NHS, so that it no longer functions as a single entity but as many smaller trusts, and due to the loss of economies of scale, along with other expenses such as the unsustainable costs of Private Finance Initiative (PFI) buildings, the number of beds in hospitals across England has more than halved over the past 30 years. This has left minimum capacity for winter contingencies such as the effects of cold weather on A&E admissions (Pollock 2005; Ewbank et al. 2015). In addition, advances in medical practice have led to more investigations and treatments taking place in A&E rather than after admission, so that patients spend longer in A&E before being transferred to a ward. There are also significant and longstanding shortages of doctors, nurses and other staff in A&E and other hospital departments which are unlikely to improve in the immediate future (Kings Fund 2020). There has also been an increase in the number of people attending A&E over the last decade (NHS Digital 2018). Between

2011/12 and 2018/19 the average increase in attendances at A&E departments in England was around 2% per year which is roughly double the increase in population. Winter does not see substantially higher volumes of A&E attendances, but hospitals are busier in the colder months because there are generally more admissions, and more staff absent due to illness. Nottingham University Hospital NHS Trust (NUH) were among the hospitals instructed by inspectors to 'review what measures could be taken to reduce severe overcrowding in the department' (Care Quality Commission [CQC] 2017a: 25), and EMAS (CQC 2017b: 2) also commented upon their failure to meet government targets for response times.

Other outpatient services may be able to control attendances by limiting the number of clinics, for example, or in extreme circumstances, closing a service to new patients, but A&E departments have much less control over numbers of attendees. As those living in deprived areas are still far more likely to attend A&E than those in affluent areas (Kings Fund 2020), dialling 999 for an ambulance may seem to solve a great number of problems for someone without money or their own transport to get medical help. Green and Dale (1992: 994) recommended as early as 1992 that the battle to prevent 'inappropriate' attenders at A&E should be abandoned and that 'the most appropriate policy may be to provide appropriate care for such patients rather than attempt to deflect such care to the community', a position echoed by Moulton in 2016 with his call to 'extend the brand' of A&E, and by Morris et al. (2018).

Recent years have seen the reported problems in emergency healthcare escalate every winter. Media reports initially focused upon the attitudes of hospital managers and politicians, who issued statements about too many people using emergency services for the wrong reasons. More recently there has been news coverage given to the length of time patients have to wait to get help, and the condition in which they have been waiting. In a recent story a child was pictured sleeping on a hospital floor (BBC 2019), and there are frequent reports of insufficient capacity leading to elderly people on trolleys in corridors while ambulances queue outside unable to hand patients over to A&E (for example Kemp et al. 2019). This has progressed from some A&E departments being unable to meet the government imposed maximum average waiting times, to abandonment by the government of the counterproductive penalties for failing to meet these targets. More recently the Health Secretary announced that

the targets may be scrapped altogether (Campbell and Mason 2020). There have also been knock-on effects on other hospital services as non-emergency or 'elective' surgeries have been cancelled to allow more capacity for emergencies. UK news bulletins now regularly feature doctors issuing warnings about the dire state of services, nurses leaving in droves because of pay and conditions, and the negative effects of Brexit.

2.5 Discourses and documents

In this final section of the Literature Review chapter I return to the ways in which texts come into being, with particular reference to texts in the health domain. C. Candlin (2002: 187) recommends that in choosing texts for analysis, the researcher should have regard to 'sites of engagement', the moments in which 'mediated action' or specific 'intersection of social practices' allow or necessitate particular discourses (Scollon 1998). Candlin further states that we should look for particular examples of sites of engagement which are 'crucial' in that they are important to the participants, or 'critical' in that there are conflicts between orders of discourse which must be resolved and which may challenge the 'communicative resources' of the participants (C. Candlin 2002: 188). These are moments in which important actions may be achieved, for example medical consultations, or job interviews.

Healthcare settings such as hospitals offer profuse quantities of these crucial and critical sites of engagement as numerous encounters occur within them daily, each harbouring rich veins of discourse (Scollon 1998: 147). A&E departments provide excellent examples, as life and death are present in their most extreme forms, and a constant stream of interactions takes place between professional and lay people as they navigate emergency situations, high emotion, and uncertainty. It is in such interactions, which have been a focus of interest for linguists such as Sarangi and Roberts (1999a), that identities of individuals, professional roles, organisations and structures are produced and reproduced discursively, giving rise to and reiterating power relations. Spoken communication between health professionals and patients at these sites of engagement has been examined in detail. I propose that by paying attention to the semiosis of the tools and artefacts deployed by medical organisations

to further their work with citizens, namely published health promotion and information texts, we will find that they are also instrumental in producing and maintaining this power.

Smith (2005: 120) believes that institutional documentation is key to establishing institutional order through terms and accountability, and that for people to act on texts 'somehow they have to be brought into the same dimension as that of people's everyday doings'. She explains that 'text-reader' conversations take place with institutional texts, and that the recipient interacts by reading the text and 'activating' the discourses therein, then responds by acting appropriately. This viewpoint allows the text to be considered as an actor, or at least as 'playing a part in organising definite sequences of action'(ibid.). The idea is reinforced in the following internal communications advice from NHS England, for producers of NHS information, which suggests that readers will interact with the information as if they are holding a conversation:

> If you are writing to patients and the public, make sure your style is both personal and direct. Your written communication should be capable of being spoken out loud and sound as if it is being addressed to an individual.
>
> When communicating about difficult subjects, your tone should communicate genuine understanding and respect. The listener or reader should feel empowered and informed (NHS England, 2019).

If we view texts in this way, we may consider the moment of interaction with the text to be comparable to a site of engagement. Each genre of texts is similar to a 'nexus of practice' (Scollon 2001: 150), so that although the content of each leaflet or TV ad may be different, the reader has expectations because of their pre-existing knowledge of the genre. Hence the viewer of an advertisement expects to be sold something, and the reader of a health promotion poster expects to be given health advice of some sort.

Previous investigations into other genres of public information texts suggest that, power relations are enacted even though such texts are now subject to simplification

and ‘easification’ (Fairclough 2015: 219), and that the convolution of health with other discourses such as marketing serves to obscure but not to diminish the power relationship (Ledin and Machin 2016a and b). It has further been shown that multimodal texts can be harnessed to tactically foreground and naturalise neoliberalist discourses proffered by elites (Brookes and Harvey 2016). Until now, although plentiful and clearly important to the NHS in discharging their responsibilities to the population, there has been little work on the discourses and ideologies encoded in health promotion and patient information materials.

Although A&E departments have been the subject of studies in a number of disciplines including sociology and ethnography, I have not identified any CDA studies into discourses in public information about emergency healthcare, although a growing number of papers have critically analysed the websites of health-related organisations including NHS trusts, charities and health related products (Brooks and Harvey 2016; Harvey 2013b for example). None of these studies have investigated the production of the model citizen as a discursive strategy. A recent study on an anti-obesity campaign (Mulderigg 2017) investigated the ‘nudge’ process used to shift citizens into healthy behaviours, but focused on this process rather than the shaping of the citizen identity. My objective is to explore and to critique the ways in which the model citizen construct is employed in a range of multimodal texts from different corners of the NHS, which seek to influence different people at different moments or sites of engagement. This investigation into a selection of hitherto uninvestigated health promotion and public information texts is therefore timely. As I have said, however, such discourses do not simply ‘appear’. To understand the semiosis of these texts it is necessary to return to the topic of extextualisation and recontextualisation, and consider the processes taking place in the design, production and distribution of these data, as it is through these processes that discourses become realised into the expressive forms—the modes and media—that the real citizen will receive (Kress and van Leeuwen 2001: 4).

2.5.1 The role of communications teams in (re-)producing power

The authority of doctors as realised in discourse is almost taken for granted (Lupton 2012: 105ff), and it has been shown that nurses (S. Candlin 2002), and medical receptionists (Cicourel 1999) also wield some level of power. But does power sit with frontline staff working for the NHS, or is it distributed through the whole medical establishment? Although, as I explain in Chapter 4, in some cases they harness the authority of doctors, nurses and other medical staff, the texts in this thesis are produced far from the healthcare frontline, in the communications teams of national and local NHS departments and trusts, and sometimes, with external design or marketing companies, as in the case of the *Stay Well* campaign and the A&E banner. The production of these campaigns and other texts are examples of the 'discourse technologies' described by Fairclough as 'more or less self-conscious application of social scientific knowledge for purposes of bureaucratic control' (2015: 211). The discourses used to produce and reproduce the citizen have been developed over time and now are 'more or less consciously' crafted by specialists deliberately producing texts for this purpose.

Each of the trusts referred to in this study has a communications team producing information for the public. Such teams are likely to house staff with competencies in public relations, reputation management, marketing, design and copywriting. They are typically responsible for information to staff too, and often control access to distribution channels and media outlets. The communications team at NUH, for example, lists eight team members on its web page, and is the contact point for media enquiries, permissions for filming and photographs, and advertising on NUH trust premises (Nottingham University Hospitals [NUH] 2020). Communications professionals working in the NHS are also in a special position of power. Although not medical practitioners, by association with the NHS, and separate to their professional expert knowledge about production processes, information professionals acquire some of the power of the medical profession. In some ways they are akin to the receptionists in an outpatient clinic, described by Cicourel (1999: 184), whose 'gatekeeping activities … calls attention to a form of bureaucratic discourse by which the least knowledgeable personnel in health care delivery acquire power over the way patients enter the health system.' However communications officers are likely to

be skilled and knowledgeable workers in their own field. They are gatekeepers to medical knowledge and arbitrators between medical staff and the public. Not only do the public need the information which they control, but medical staff view them as having the necessary skills to interpret and prepare medical content in a suitable format for the public to digest. Communication teams do of course work with, and take advice from, medical staff, but budgets are provided to marketing and communications teams in order that they will apply their skills in copywriting, design or marketing. Yet they also have their own 'expert systems' (Giddens 1991: 18, 31) and therefore wield their own form of 'sapiential' (Woods 2006: 118-119) or 'expert' power (Holmes and Stubbe 2003: 4). They are specialists in an area which medicine has historically been bad at, and their control of knowledge and resources is quite separate from medical power. However they generally have access to and influence on senior management, so in a business-focused NHS (Pollock 2005: 1) they may wield at least as much authority as medical staff, if not more so. In the NHS then, the authority of medical staff and communications teams reflect each other dialectically. The products of the communications teams, which rely on medical power, are used and distributed by medical professionals, which in turn reproduces and augments the power of communications teams.

The role of communications teams is not just to embellish the content of a text with logos and pictures. They are responsible for the recontextualisation of texts into new formats, for rewording into plain language, and for 'targeting' the look and feel and content of a text to its proposed audience. This includes reframing to reflect the viewpoint of their organisation, so that public information texts are an important part of the process through which discourses of control become actions. The recontextualisation of discourses allows communications staff to be creative and innovate, sometimes with novel media, techniques and formats more often found in commercial advertising texts. The use of advertising formats to convey messages from government bodies allows for flexibility in format, as opposed to the constraint of bureaucratic forms (Sarangi and Slembrouck 1996: 23), easing the colonisation of new spaces, and placing the content in competition with other advertising. Adoption of novel formats has been one of the mechanisms which has enabled encroachment into other discourses, partially because it allows their apparent debureaucratisation

(Sarangi and Slembrouck 1996: 19). Machin (2007) and Ledin and Machin (2015, 2016a) have demonstrated some of the techniques employed by communications teams to ease the assimilation of discourses of neoliberalism into organisations. I develop this line of enquiry by showing that these techniques and others are used in texts destined for citizens and potential users of health services.

The UK government has developed a substantial body of guidance for public sector communicators, and all those producing information on behalf of the NHS and other government agencies are expected to comply (HM Government 2018). NHS England has built on this guidance by publishing many pages of more detailed communications policies for its constituent organisations. These cover everything from use of the NHS logo and identity, to currently acceptable terminology (NHS England 2019). The production of public information on behalf of the NHS is a collaborative process, and is likely to involve subject specialists and communications specialists, each of whom has authority only at a specific level within a certain area of what is a complex bureaucratic and hierarchical organisation. Text producers are constrained by their place in a management structure which consists of many layers of decision-making or delegation. They will also need to rely on others internal or external to the NHS to disseminate the information. Staff are expected to be creative, but within a highly controlled scope. So whilst possibly contributing to 'debureaucratisation' through use of plain language and simple, accessible messages, the communications staff of the NHS are also subject to 'bureaucratisation' of their work processes and creative aspects of their jobs (Sarangi and Slembrouk 1996: 33).

2.5.2 Information, or manipulation?

As we have seen, and as I shall elucidate through this thesis, health promotion consists of much more than simply transactional data. Influencing a citizen to alter their behaviour, may be viewed as persuasion, but could also be considered to be manipulation, defined by Van Dijk (2006: 364) as 'discursive power abuse' taking place through text and talk. He distinguishes it from 'legitimate' forms of mind control including persuasion and information provision by stipulating that manipulation occurs when control is exercised against the best interests of the receiver, whether or

not one or both parties are aware that the phenomenon is taking place. Recipients of manipulative discourse can be considered victims, if they 'are unable to understand the real intentions or to see the full consequences of the beliefs or actions advocated by the manipulator', because the 'ethics of discourse' are being contravened. He points to a particular genre of domination of populations against their best interests, via resources controlled by 'symbolic' elites or 'between members of a 'dominant collectivity', such as politicians, journalists, scholars, writers, teachers and so on. Social power is related to access to resources, including 'a preferential access to discourses and communication' such as the mass media (van Dijk 1996: 85),

> In order to be able to manipulate many others through text and talk, one needs to have access to some form of public discourse … since such access and control in turn depend on, as well as constitute, the power of a group (institution, profession, etc.), public discourse is at the same time a means of the social reproduction of such power (van Dijk 2006: 362).

So this type of manipulation of large numbers of people contributes to the reproduction of social inequality. There are some who resist manipulative discourses (van Dijk 2006: 375), although this may prove fruitless if they have little power. In attempting to change the way citizens think 'the general goals of manipulative discourse are the control of the shared social representations of groups of people because these social beliefs in turn control what people do and say in many situations and over a relatively long period' (ibid.: 369). Manipulators may place emphasis upon positives or negatives in various ways, with focus on attitudes, qualities and values. A variety of techniques and devices can be used to effect thought by influencing the short or long term memory. Machin (2007) has demonstrated that manipulation can be carried out through numerous techniques effecting the representation of participants and processes, including multimodally via pictures, films or other media. It may be difficult for readers to spot as reframing and recontextualisation may involve very simple techniques such as deletion or choice of speech reporting verb (Kress 1993). In texts these can be discursive, or involve physical aspects of the type and layout.

The discursive-semiotic phenomenon of manipulation does not use different discourse structures to other types of (legitimate) communication, and does not have anything particularly different in terms of lexis or parts of speech. This means that the context category of the discourse, such as its emplacement or the social practices of which it is a component, is more relevant than its textual structure, when establishing whether manipulation is occurring (van Dijk 2006: 372). It would be controversial to argue that all health promotion materials carry messages which are against the best interests of the recipients. However, as this thesis will evince, they are strongly biased towards the best interests of the information producers. One of the goals of CDA is to denaturalise or expose this abuse of power, which is dependent upon social context. Whether the data are manipulative will be a line of enquiry in this thesis, which I address by asking why particular choices have been made, and in whose interest.

2.6 Conclusions

'Health' is a prime site for the study of governmentality in action. The NHS budget is measured in hundreds of billions of pounds per year, yet availability of health services is not keeping pace with demand and there is a requirement for resources and services to be rationed. So those in control of resources have attempted to control demand by various means including education of the public in new, 'correct' ways of using services such as A&E. Health is also a current locus of attention for those advocating and those opposing neoliberalist policies as recent legislation allows increased privatisation and relocation of public money into the pockets of commercial businesses (Pollock 2005; Brookes and Harvey 2016).

Health promotion policy 'reflects and reinforces the prevailing political ideology of neoliberalism' (Ayo 2012: 100ff), and also works in a way that can 'facilitate the making of the "good" and "healthy" citizen'. As we have seen, healthiness has become one of the duties of the responsible citizen, and this is reinforced and fed by the 'burgeoning health industry propagating throughout nearly every realm of society at an ever increasing pace'. The activities we carry out to become 'healthy' are linked through discourses as the way we can practise 'prudence, hard work, responsibility

and asceticism' so that rendering our bodies healthy and beautiful becomes a moralistic lifestyle. 'This principle of personal responsibility is not only a matter of economic efficiency, but it is also highly value laden and situated as a code of ethics, an obligatory duty of citizenship' (ibid.: 103). There is a risk that if obligations to be healthy and co-operate with the procedures, tests, and commercial requirements of healthiness are now part of the requirement of citizenship, those who do not co-operate may be seen as 'bad' citizens with negative consequences accompanying this status. As I will demonstrate, if not following advice, citizens can be blamed for their own action, or inaction. Worse still, the very existence of services such as ambulances and emergency departments depends, it seems, upon the behaviour of citizens.

Discourses are the language element of how we understand our existence and navigate our world, how we achieve things or stop things from happening, how we explain ourselves and how others explain themselves to us, how we know what to do in different scenarios, and how we understand or relate structures, actions, and knowledge of subjects. It is this 'stuff of life' quality which makes discourses so inherently interesting and worthy of investigation. My aim, in this thesis, is to investigate the construction of the model citizen in health communication, and I will operationalize this by conducting multimodal discourse analysis upon materials produced for users of A&E services, to reveal and critique the discourses entrenched within them. This will enable me to identify the contribution of such discourses to the identity of the model citizen. My study will examine materials employing a range of semiotic communicative modes, produced by people who work within the NHS. Further, there is 'close association between the production and reception of texts with the disciplinary or organisational practices of institutions and their members' (C. Candlin 2002: 186) which makes it necessary to study such practices alongside the texts. Cicourel (1987: 225) also emphasises that it is almost impossible to analyse the meaning in a text without studying the 'structural and processual aspects of social organisation and reasoning during interaction'. For this reason, studies of this type are often at least to some extent interdisciplinary, because it is necessary to understand some of the context in which the discourse is located. In any given situation there are a variety of alternative discourses which may be employed to articulate various versions of 'the truth', so extricating the ideologies from the

discourse in order to understand their meaning and origins is an important part of this research.

Governmentality needs discourses to do its dirty work. The discourses employed in public texts will vary depending on the politics of the government, but similar discursive practices are engaged whatever propaganda the government of the day is proposing to promulgate. Documents and texts are part of the work of institutions and contribute to the 'technologisation of discourse' (Fairclough 2010: 126), which is required to transform ideologies into actions. They are tools used in the training of citizens to become more civilised, take on responsibilities and act in ways consistent with the requirements of governments. This thesis explores the discourses used to address patients of the NHS and members of the public, in relation to health services. The many interactions between individuals and health services provide useful insights into the ways in which the behaviour of citizens is managed by governments, in this case via the actions and messages of a government organisation, namely the NHS. It is from this juncture that I will begin my investigation into the construction of the model citizen.

3. Methodology

3.1 Introduction

This chapter introduces and give reasons for the choices of method, tools and data used in the thesis. It explains how, in order to answer my research questions, I apply established CDA methodologies to datasets composed of materials from the NHS, to investigate and critique the construction of the model citizen and related discursive strategies. I begin, in 3.2, by establishing for my subject matter the context of emergency healthcare in England, which due to its relationship to government and the public, is highly political and requires a critical methodological approach. I then, in 3.3, give background to Critical Discourse Analysis (CDA), explaining the appropriacy of Fairclough's (2015) dialectical-relational approach to Critical Discourse Analysis (CDA) for this study, and defining the terms power and ideology, which are central themes in this approach. Multimodal CDA (MCDA) methodologies are increasingly used to investigate texts which consist not only of lexical content but also non-lexical semiotic communicative modes, and in 3.4 I explore relevant MCDA tools and techniques for this data. However, no method is without its criticisms, and I list these in 3.5, explaining how I attempt to mitigate such issues in my study. In 3.6 I set out my framework for analysis, which is based upon a semiotic framework using the concept of strata introduced by Kress and van Leeuwen (2001). I explain my approach, which involves ascertaining which discursive strategies are present in datasets, and is a novel application of MCDA, combining existing tools and techniques to investigate large quantities of data in an uncharted subject matter. In 3.7 I introduce the data for the study, explaining the structure of the analysis chapters, giving reasons for choices made in the selection and organisation of data, and providing background and context for each dataset. Finally in 3.8 I list some issues of specific relevance to my data.

(M)CDA, and therefore this thesis, is positioned within the wider field of Applied Linguistics, in which linguists aim to make practical use of analytical tools and linguistic knowledge by applying them to real-world situations. Based upon materials found in use in healthcare settings, the study is driven by ‘naturally occurring’ data

(Silverman 2006: 393) collected from live healthcare locations. The term 'naturally occurring' here refers to artefacts which are not generated by the researcher for research purposes, but are produced for and used by ordinary members of the public as entextualised discursive elements of social practices. I therefore operationalize this approach by investigating three specific but inter-related datasets using a social semiotic framework for multimodal analysis and range of technical analysis tools demonstrated by Kress and van Leeuwen (2006) Machin and Mayr (2012), van Dijk (2006, 2016), Scollon and Scollon (2003) and others, as discussed in this chapter.

3.2 The importance of a critical approach

Critical Discourse Analysis (CDA) was chosen as the methodological approach for this study because as health promotion materials, the texts constitute artefacts of the semiotic and largely discursive practices in which NHS policies are recontextualised as actions by citizens. Choices about allocation of resources to the NHS and within the NHS are always political (Clarke et al 2007: 41) because of its relationship to government. For this reason, decisions made about, and within, the NHS must be judged to be ideological, and in order to be understood, should be investigated using methodologies which are able to root out ideologies rather than simply to discover and name discourses. A critical approach is therefore required to reveal the reasons why the model citizen construct is being invoked.

Like many approaches to discourse analysis, which are by no means confined to Linguistics, CDA is essentially cross- or multi-disciplinary, and looks outwards from academia at issues affecting social actors in a given setting. Discourse studies are applied to selected texts rather than theoretical use of language or invented utterances generated by the researcher to illustrate a point. Though they may investigate reasons behind discursive phenomena, many approaches seek to analyse, describe and understand discourse. CDA however aims to progress from this position to one which challenges the discursive production or perpetuation of societal injustices. I expand on this below. 'Critical', in many disciplines, refers to 'the use of rational thinking to question arguments or prevailing ideas' although others take it to mean that the researcher is 'positioned on the side of dominated and oppressed

groups and against dominating groups' (Fairclough, Mulderigg and Wodak 2011: 358). CDA tends to align itself with this latter interpretation of the term.

3.3 Critical Discourse Analysis

CDA as a school of thought emerged in the 1990s through the individual and collaborative effort of a network of academics from varying areas of study. Particularly influential has been the work of Norman Fairclough, Ruth Wodak, Teun van Dijk, Gunther Kress and Theo van Leeuwen who between them have shaped the concept of CDA, which has been developed in several different directions in various institutions. Indeed, its approaches and philosophies have since been built upon by many, and continue to be developed and debated.

Fairclough (2010: 234) and Wodak and Mayer (2016: 5) point out that CDA and MCDA are not methodologies but rather approaches, in which a range of methods are possible, with the researcher selecting the most suitable tools to analyse any given dataset, and often combining methods. Such methods may overlap at times but have distinct defining features, although there is no consensus about the number of these, nor whether each has equal status as a research approach. There is, however, a unifying principle of 'demystifying ideologies and power through the systematic investigation of semiotic data, be they written, spoken or visual' (Wodak 2004: 185-186) which applies to all CDA methodologies. Several writers advise caution in choosing the method of analysis too soon, stressing the importance of understanding the data before choosing the most appropriate methods for their analysis (for example Widdowson 2017, Fairclough 2010: 234).

My methodological approach is based upon the dialectical-relational CDA variant expounded by Fairclough in *Language and Power* (2015), in which focus is placed up on the 'power behind discourse', elucidated in the subsection on power below. Fairclough's model of CDA has undergone revisions over time, but rather than rejecting earlier variants he sees them as shifts of emphasis 'not in a way that discards earlier concerns, but rather in a cumulative way that incorporates them into new theoretical and methodological syntheses' (2015: 2). Built upon theoretical

approaches to discourse from Foucault and Marx, Fairclough's CDA work is particularly focused upon the dialectical nature of the relationships between social practice, including discourse, and social structures, in which organisations such as the NHS are positioned. His theories about the role of organisations in producing and reproducing 'common sense' discourses, which are the manifestations of dominant ideologies (see Fairclough 2015: 101-127) are particularly relevant to this thesis.

The various approaches within CDA share a common agreement that discourse is the central point, or starting point, of research, and is a 'social practice' which is both produced by and produces institutions, situations and social structures (Fairclough 2003, 2010; Wodak and Meyer 2016). What sets it apart from other approaches to discourse analysis is the 'critical impetus' (Wodak and Mayer 2016: 6), a commitment to draw attention to injustices which are encoded into discourses and the texts into which they are recontextualised. CDA has been strongly influenced by Halliday's (1985) systemic functional grammar (SFL) in which he developed ideas linking the form or structure of language to social meaning. Emerging from this work is the presence of three 'metafunctions' of language: the 'ideational' metafunction of representation, the 'interpersonal' metafunction responsible for social interaction and the 'textual' metafunction which ensures the coherence and cohesion of the text (Halliday 2014: 30-31). Linguists working in CDA have developed these ideas into 'Social Semiotics' (Machin and Mayr, 2012: 17) and have applied them to real-world texts in order to investigate social issues including immigration (for example KhosraviNik 2009; van Leeuwen and Wodak 1999; Wodak 2013) and literacy (Kress 1997; Rogers 2002), as well as challenges to social order such as the commercialization of universities (Fairclough 2010; Zhang and O'Halloran 2013). Social Policy has received a significant level of attention (Fairclough 2010; Mulderigg 2011), as have political speeches (Hansson 2015; Reyes-Rodrígues 2008; van Dijk 2006) and management discourse (Bargiela-Chiappini 2004; Ledin and Machin 2016a, 2016b). Media texts have also seen a considerable number of studies (Vaara 2014), as has advertising (Machin and Mayr 2012). The social semiotic approach allows linguists to analyse and demonstrate the 'work' being undertaken by the component semiotic resources in the language of any given text.

CDA has proved particularly useful in studying health care communication. Early studies focused on interactions amongst medical professionals or between them and their patients (Mishler 1984; Fox 1993b; Sarangi and Roberts 1999b; Slade et al 2008), but in their 2002 review of applied linguistics research into health communication, Candlin and Candlin noted a 'gradual shift ... toward analyses that locate such encounters within a complex institutionally governed framework of social interactions, relationships, and situations' (143). Academics have turned their attention to policy documents (for example Hunt, Koteyko and Gunter 2015) several studies have analysed data from health-related internet forums (Fox, Ward and O'Rourke 2005; Harvey, Mullany and Locher 2013). Corpus-based approaches have been combined with CDA in a number of health-related studies, blending the capacity of corpus tools to analyse very large quantities of data with CDA's critical stance. For example, Baker and McEnery (2014: 478) looked at representations of foreign doctors in a corpus of around half a million words taken from the UK press, identifying likely reasons that a moral panic surrounding these doctors was linked to concordance with 'problematic constructions relating to terrorism, AIDS and an "invasion" metaphor'.

While a few papers cover related areas and include some analysis of discourse (Dixon-Woods 2001; Makoni 2012; McManus 2009; van den Berg and Parastou 2009) there have been few 'traditional' CDA studies of health promotion materials. This is despite the wish of health authorities to engage more with the academic community and use evidence to inform their communications (PHE 2015), and calls from academics such as Sarangi (2006: 212-3) for applied linguistics research to tackle a wider range of health communication sites including those in which 'language and communication issues play an even more significant role'. Of particular interest to all branches of CDA is the overt or tacit encoding of power relations into texts and the relationship between power, ideology and discourse. In this respect CDA also owes its heritage to the 'legacy of enlightenment' (Wodak and Meyer 2016: 8) via Marxist and Frankfurt School Critical Theory (Fairclough, Mulderigg and Wodak 2011: 358). In common with other forms of critique, CDA claims that 'social theory should be oriented toward critiquing and changing society as a whole, in contrast to traditional theory oriented solely to understanding or explaining it' (Wodak and Meyer 2016: 6).

3.3.1 Power

Power, and its relationship with, and enactment through, discourse is a central theme of CDA, because discourse is a particular and essential element in relations of power. It is, however, a conceptually disputed term with many definitions, and applied linguistics distinguishes between several different types or functions of power. Power can be wielded in many ways by those in control of financial resources, political control, expertise, or other scarce commodities, and is one element of the interpersonal metafunction of communication. It may be seen simply as 'a relative concept which includes both the ability to control others and the ability to accomplish one's goals' (Holmes and Stubbe 2003: 3). However CDA tends to work to expose complex relations of power, including overt or 'oppressive' power and covert or 'repressive' power found, for example, in the workplace between managers and their subordinates (ibid.: 100). Medical encounters are acknowledged to be sites of power inequality (Jones 2013: 68) in which 'oppressive' power, enhanced by the specialist knowledge and high social status of doctors can be observed constraining the nature of conversation by causing interactional asymmetries (Sarangi and Roberts 1999c: 7, 21). However, overt expression of power has been declining in recent years, both in the workplace (ibid.) and in public discourses, such as those emanating from government bodies, and a more insidious, coercive kind of power, which explains actions, using simple language, as common sense, has emerged (Fairclough 2015: 14). As I shall show, this repressive power is present in discursive strategies of ideal citizenship which model preferred behaviour rather than the issuing of direct instructions.

Although power can in many instances have positive effects, it is the illegitimate or unjust application of power which is often targeted in the debunking of texts through CDA. Fairclough (2015: 26-28) distinguishes between 'power in' and 'power behind' discourses, which are both matters of 'power over' discourse. Power in discourse describes the control of the discourse by a participant, which may be evident in many face-to-face exchanges, but less so in written texts as the writer and the reader can be separated by time and space. Indeed the producers and recipients of the texts in this study may never meet, despite their mutual participation in the perpetuation of model citizen discourse. Those who hold information are always in a position of

power—they have something that other participants do not, and the way this information is shared, and what is withheld, is part of the expression of that power. In media texts 'producers exercise power over consumers in that they have sole producing rights and can therefore determine what is included and excluded, how events are represented and ... even the subject positions of their audiences' (Fairclough 2015: 79). The technologies used to produce public information about health services are similar to those employed by media companies, and although the decision-making processes and provenance of discourses may be quite different, for the most part public health information materials are a normalised route for NHS services to deliver information to their users. Perhaps it is also true that the reader retains some power in an interaction of this type. They may sometimes have a choice of media through which to receive information, or they can choose not to interact, to switch off the TV, stop reading the brochure, or turn away from the poster. However, the status of the NHS as unquestionably the nation's most significant healthcare authority ensures that 'power-holders' within the organisation are able not only to control resources and practices of health in the UK, but also to influence and control discourses. This influence extends to the positioning of NHS staff in relation to patients or potential patients, the various ways in which communication takes place between them, and indeed, as I shall illustrate in the next chapter, the range of topics which can be considered to be part of the field of 'health'. This 'higher level' control which sits outside individual interactions and specific institutions is what Fairclough calls 'power behind discourse' (ibid.: 83). Fairclough has also explored the concept of 'simulated egalitarianism' (2015: 67) which he claims is instantiated with simple language and increased use of first and second person pronouns in government communications. He considers this to be a symptom of 'the increasing reliance on control through consent' rather than through coercion (ibid.).

In this thesis I am interested in the complex, related to governmentality (see section 2.3.3) in which power is exercised over citizens by the state, including institutions such as the NHS. The NHS provides large numbers of leaflets, web pages, posters, booklets, TV advertisements and other materials on a range of health-related subjects. Much of this content is informative, but in addition, many NHS publications use techniques aimed at persuading members of the public and potential NHS user to

change their behaviour (McIntosh 2014; Mulderigg 2017). Furthermore, the NHS, though highly political and politicised as mentioned above, always presents itself as non-partisan. The UK's NHS occupies a unique position as it embodies both the power of the state and that of the medical profession. The subtle exertion of this power in the data is exposed in the analysis chapters, where I identify discursive strategies to produce and maintain power in each dataset. I explore the ways in which the model citizen is manipulated as part of an effort to control or change the behaviour of actual citizens.

3.3.2 Ideology

As with power, there are many differing views on what constitutes ideology. It is 'the way that we share broader ideas about the way the world works' (Machin and Mayr, 2012: 25), it is a belief system shared by members of a social group (van Dijk 2011b: 382) and it is a 'representation of aspects of the world which contribute to establishing and maintaining relations of power, domination and exploitation' (Fairclough, 2003: 218).

CDA is often used to root out 'hidden and latent' ideologies in discourse and the texts in which they are embedded (Wodak and Meyer 2016: 8). Ideologies may come in the guise of 'common sense', an 'important factor for social change' (Fairclough 2015: 13) which is open to manipulation by politicians if they are able to articulate ideology in such a way that it is accepted by the population at large (ibid.: 13-14). This is particularly the case when a dominant ideology (Fairclough 2010: 26-27) becomes naturalised so that it is no longer seen as ideology. Naturalisation is the process by which certain ideological frameworks and related discourse types become accepted to the point that they are no longer perceived as ideologies, and are accepted as 'natural' or just the way things are (Fairclough 2015: 113). In this way dominant discourses are added to the canon of 'common sense'. Health promotion discourses are examples of these naturalised discourses. Because they are produced within a field viewed as beneficial and perhaps 'scientific' but not ideological, they are less likely to be challenged. Another example might be the existence of the NHS itself, which was born out of ideological belief that healthcare should be free and available

to all. The paradigm of the NHS is now seen in the UK as natural and fair, although it is clearly not the only possible model of healthcare provision.

It is this disguising of ideologies as common sense, or at least as something which is not ideological, which is of particular interest in CDA. In particular those discourses which embody capitalist ideology but in which lexical and non-lexical choices mask their true meaning and implications, through naturalisation (Fairclough 2015: 113). Discourses represent what we know about social practices, and can be used by powerful elites to influence or effect change to such practices. Recontextualisation of the discourse around a particular practice is a selective process which effectively changes the dominant discourse through new representations of reality. Whilst social participants are often not aware that the naturalised discourses in which they participate are ideological (Fairclough 2010: 44), nonetheless they reproduce power relations through their use and reuse of such discourses. Applied linguists have found that 'one way to draw conclusions about the macro level is to examine micro discourse events' (Sarangi and Slembrouck 1996:11). As such, studies using CDA methodologies often seek to de-naturalise discursive formations and discursive practices which have come to be accepted, and to reveal the true ideological positions of texts. This involves the unmasking of these ideologies, through explanation, or, through comparison with alternative ways of saying or seeing. Machin and Mayr (2012) provide examples of techniques for denaturalising ideologies, particularly in relation to the ways that actors and actions can be represented. They identify, for instance, the 'quoting verbs', such as *insisted*, *grumbled* or *conceded* chosen in newspaper stories to position participants, and the inferences hidden in these verbs. They then replace these verbs with the alternative, and more neutral quoting verb *said* to demonstrate the effect these choices have on the readers' perception of the participant. De-naturalisation also involves attention to 'absences and taken-for granted assumptions' (Machin and Mayr 2012: 10), as ellipsis, or what is unsaid is 'indicative of shared knowledge and interests' (Cook 2001: 173) that can be used as evidence in unearthing hidden ideologies. Throughout the analysis chapters I provide similar comparisons to illuminate the ideological stance taken by the writers.

Generally speaking, the population of the UK is equivalent to the population of NHS users, so this study is premised on the view is that any member of the public could be

a target audience member for information about universal services such as A&E and ambulances. For the purposes of this study I also assume that a citizen who is the target of communications materials, i.e. the data for this study, is an appropriate person. They are a resident of, or possibly a visitor to, the location in which the text is accessed. This is a simple definition, but as explored in Chapter 2, there are many definitions of the 'citizen', and it is not my intent to enter into a debate about this term and its meaning. The recipients of the information are participants in the production of meaning, as are the producers of the texts (see 3.6). The model citizen construct can also be considered as a participant. This is easy to recognise in texts where citizens are depicted visually, but is also the case in other texts where the citizen may be invoked in other ways, through personal pronouns, for example.

The model citizen is an ideological construct produced as a discursive strategy in the texts in this study in order to effect behaviour change. In my analysis I explore the various ways in which the actual citizen, patient or member of the NHS-using public, is entreated to change their behaviour in relation to certain NHS services. Although the model citizen in public health campaigns has not, until now, been investigated, Van Leeuwen (2008: 23-54), lists many techniques used in the construction of social actors which I draw upon in my analysis. Other studies have looked at the juxtaposition of health discourses with commercial ones (Brookes and Harvey 2016; Harvey 2013b; Koteyko and Nerlich 2007), and these examples all critically examine the ideological concept at work in public health texts, particularly those appearing online.

3.4 Multimodality

> What may be the most important question ... may be more to do with what we can accomplish as communicators through different kinds of communicative resources, such as images, colour, material and gesture, than whether these can be described and accounted for in the same manner as language (Machin 2013: 349).

CDA tends to focus on language, and many scholars use CDA to study purely spoken or written language, but it is also widely acknowledged that meaning resides also in many other communicative resources (Jaworski and Coupland 2014: 6-7, Fairclough 2015: 59, Wodak and Mayer 2016: 2). MCDA is a version of CDA which examines the semantic dimensions not only of written and spoken language, but also of the other communicative modes in given texts. It can be argued that all texts are multimodal, as however simply or conventionally presented, written language is always accompanied by graphological style, positioning on the page and the materiality of the medium. Spoken language is likewise accompanied by facial expression, bodily stance and gesture etc., but in 'traditional' or 'monomodal' CDA, and in many other approaches to discourse analysis, these other modes of communication are often disregarded. Work on semiotic 'visual' modes of communication has been pioneered by academics such as Robert Hodge, Gunther Kress and Theo van Leeuwen. The 'still fledgling, movement' (Kress and van Leeuwen 2006: 6) of MCDA endeavours to apply principles based upon Halliday's SFL (1985) and social semiotic theory to semiotic resources other than language. For example, relations of power may be represented, not only through lexis but through the positioning of the viewer in relation to the depicted participants in a photograph (Kress and van Leeuwen 2006: 140-142). The ideational, interpersonal, and textual metafunctions may all be realised through a combination of communicative modes.

Although semiotic resources are used to communicate meaning, whether their meanings can be categorised or described in similar ways to linguistic resources, in other words whether there are 'grammars' and potentially taxonomies for the non-lexical modes, is still under investigation. However there are, at least, systematic codes for some visual semiotic modes, such as colour, linked to culturally-established meanings. Using the example of colour, Kress and van Leeuwen (2001: 59) observe that 'the discourses which exist in the domain of the specific design practice shape the meaning of the colour sign' with colour potentially signifying different meaning in different contexts. For a resource to be considered as a mode of communication both the sender and the receiver must have an understanding of its 'grammar'. It must be 'a resource for making signs' capable of being articulated and interpreted (Kress and van Leeuwen 2001: 42, 58). So, for example, for the colour red to be a signifier for

'stop', both the producer of the text and its reader must share this understanding of its meaning. I draw attention to many instances in the data where the producers assume that readers do understand the 'language' of each mode. The rules of such a grammar, like the grammar of spoken and written English, are established over time and are fairly fixed, but may sometimes be flouted, and can also be changed over time and replaced with other conventions (ibid.: 42). While I engage with the above definition of modes, I am less concerned with their classification, and more interested to discover which communicative resources can convey meaning. I therefore refer to any resource which does so as a communicative mode.

The texts in this study all have lexical content, but they also encompass pictures and logos, colour, graphical devices such as arrows, voice, music and other communicative resources including labels, lists and boxes. In analysing the meanings of these semiotic resources I draw upon the extensive work of Kress and van Leeuwen in this field, in particular *Reading Images* (2006), which, they acknowledge, derives from Barthes' (1977) work on visual semiotics. Timeliness and the location of the reader in relation to the location of the texts also contribute semiotically to our understanding of their meaning so I consider these to be communicative modes and have included then in my analysis. My observations about these modes develop ideas discussed by Scollon and Scollon (2003), in which they analyse the contribution of place to discourses, and to some extent temporality also. In this way they expand the understanding of texts by considering 'the meaning systems by which language is located in the material world' which they term 'geosemiotics' (ibid.:x). Indeed multimodal studies need not stop at the edge of the page or screen. There are a growing number of studies into 'place semiotics' (Scollon and Scollon 2003:8) and 'linguistic landscapes', such as Adami's (2017) investigation into multimodality in the stalls an indoor market which looked in particular at the meanings of cross-cultural signs. In common with Kress and van Leeuwen, Scollon and Scollon are interested in the positioning of the lexical and non-lexical elements of a text in relation to each other, but they also analyse many other material qualities of texts including the medium of inscription (2003: 135-6, 145ff) and their emplacement in the world, which may be situated, decontextualised or transgressive.

An analysis of the verbal language within a text includes paying attention to the choices made by the producer in respect of grammatical features, vocabulary, style, register, nominalisations, pronouns and many other features which are conspicuous either by their presence or by their absence. Likewise with other modes, choices are made from the range of possibilities or meaning potential (Kress and van Leeuwen 2001: 59; Machin and Mayr, 2012: 51) within the affordances of each mode. A critical multimodal analysis considers each of these choices as semiotic. Although I consider any communicative resources to be relevant and contributory to the discourses present in the text, this does not detract from the contribution made by lexical content, which is often the most important communicative mode in terms of articulation. In order to consider the contribution of non-lexical modes to the model citizen construct I have selected texts from a range of genres which use various different communicative modes (see 3.7.3).

To focus purely upon the verbally expressed meaning, and investigate these texts without employing multimodal analysis, would have produced quite different results, particularly in those texts which rely upon a visual element. The video and audio elements of television advertisements are key to their decoding as they communicate not only the NHS locations and staff, but also register and vocal features. The producers of websites often make full use of the array of modes available, combining them in new ways when technological development allows this. Communicative modes may also be combined ineffectively. In McIntosh (2014: 22-23) I provide several examples in which discursive strategies of the text producers in a public health campaign are disrupted through ineffective deployment of resources, or through combinations of resources which were likely to bewilder the reader, reduce modality and hence limit the effectiveness of communication. For example there is incongruous use of animated slapstick comedy in a serious message about the harms of drinking), as the campaign uses PHE's Change4Life brand, which is really designed to appeal to young children. There are also an overwhelming number of advice and information points, which are undifferentiated and could have been made more accessible and comprehensible had resources such as typeface, and framing through use of colour, been more effectively deployed.

Kress and van Leeuwen (2006: 155ff) have focused their work particularly upon visual images of all genres, ranging from children's drawings to commercial brochures, and have demonstrated how meaning can be represented without the use of words. They show, for example, how the recipient of the meaning in a message can be conditioned to accept new information through careful positioning on a page in relation to known or 'given' information, and how visual framing devices using borders or colours can group ideas together or distance them from each other in similar ways to lexical cohesion. They also point out that the modality, or level of realism or believability, can be effected through visual means too, using a 'social theory of the real' to explain that our perception of the 'truth' of an image depends upon a range of factors relating to the colour of the image, the detail of the representation, the depth of perspective, illumination and brightness of the image. Machin and Mayr (2012) provide commentary on analysis of multimodal media texts, as does van Dijk (2006, 2016), with a strong focus upon the cognitive aspects of manipulation. Although in these useful handbooks for multimodal analysis, there are few references to the analysis of information about health, the techniques deployed are transferable and appropriate for my work. However no overall framework for this type of study with such a wide range of media has been demonstrated and I want to analyse each text in ways which will most effectively illuminate the model citizen construct. The nature of multimodality, with its attention to many different semiotic resources, is that a variety of tools are needed to gain an understanding of texts. As this study incorporates various communicative genres or channels including tv advertisements, web pages, posters and leaflets, each of which employs several semiotic communicative modes (colour, layout, audio, images etc.), it is necessary to adopt a 'mix and match' approach to the analytic techniques used. Precise analytical frameworks will vary and will not be applied consistently to all data as this may limit the thoroughness of the analysis.

Multimodality raises many issues which are not problems for the analyst of purely linguistic texts. The boundaries of the sign (Kress 1993: 184) and its location in time and space (Scollon and Scollon 2003: 166 - 196) must also be considered, as these contribute to the meaning for the recipient. So, for example, it is necessary to decide whether to consider the surface upon which the poster is fixed as part of the sign, and

whether the area of a web page which does not fit onto the screen should still be analysed. Each stage in the generation of a text offers options to the author, maker or producer, so there are moments at which the meaning of the text can be influenced. In order to appreciate the 'multiple articulations' of meaning added to texts, Kress and van Leeuwen (2001) refer to these as 'strata', of multimodal practice, namely discourse (as sociocultural practice), design, production and distribution. These strata do not necessarily have any hierarchy of importance or a set order of occurrence, but are a useful way of organising the many ways in which meaning is produced and added to the multiple strands of multimodal data.

The Design stratum involves 'the organisation of what is to be articulated into a blueprint for production' (Kress and van Leeuwen 2001: 50). It is the stage at which choices are made about which modes to use to articulate a message. Choices about discourses may be made consciously, but in some cases because they have been naturalised into the culture and practices of the organisation the choices made are seen as common sense or the way that things are done. The design stage does not involve only those we think of as 'designers', although in terms of the texts examined in this thesis, graphic designers are likely to be involved. But there are also a plethora of others who contribute to the design of the text. For example, in the health service the requirement for a publication may well originate with clinical staff who have identified a piece of information which may be usefully entextualised, and may already have ideas about the best way to do this. The production stratum covers all of the physical and electronic processes through which designs are turned into texts, or the 'organisation of the expression' (Kress and van Leeuwen 2001: 6). For multi-media campaigns this involves numerous processes, and in some cases the demarcation between design and production is fuzzy, see for example Goffman (1981: 143-146) on production roles, or the 'product' may be returned to the design stage for further work. Distribution involves all the processes and practices involved with delivering the text to its intended audience. Distribution 'tends to be seen as not semiotic' (Kress and van Leeuwen 2001: 6) but the distribution or emplacement of a text in relation to the recipient adds meaning and is the beginning of the interaction between the reader and the text (Smith 2005: 108). I will return to this model in my framework for analysis (below). I also draw upon my background in printing and

communications roles in a field related to health for my working knowledge and understanding of the processes of development and production of texts.

Kress (1993: 173-176) reminds scholars of MCDA that all signs carry ideological meaning because the production of each sign is premised upon choices made by the producer which are always motivated by their interest in certain features of the signified. Furthermore, signs do not have static meaning, but are remade each time they are used, with meaning compounded and accumulated to on each occasion. Therefore they are not 'natural' or arbitrary, and can all be considered to be metaphors for 'an object or an event in the physical or in the social/cultural, semiotic world'. For the researcher, what this implies is a consideration of the reason for choice of each sign, as each will in some way 'realize the social, cultural and therefore political position of their producer' (Kress 1993: 174). Of course semiosis is not only added to the sign by the producer, and recipients will also bring their own 'interest' to a text in terms of experience and context. In terms of public information from the NHS, the 'interest' of the producers may be organisational rather than individual, although each contributor to the design and production processes will also bring their own social and cultural experience.

It is important to bear in mind that although choice within the meaning potential is exercised in these texts, that this is not completely free choice. When considering public information we may be dealing with text producers who have a relatively limited range of signs from which to choose. Communicators choose specific channels such as leaflets, web pages and posters because of their affordances, but financial restrictions or time constraints may mean that a stock image must be used rather than a bespoke one, or organisational policy may restrict the typeface, layout or colours of a publication, for example. Teams may also be limited by competing priorities, their own technical skills, or by the technology available to them, and the producers of web texts are further limited, when complying with the latest standards for web accessibility, by the affordances of the receiver's interface.

3.5 Criticisms of (M)CDA

Many of the main proponents of CDA have stated that it can be used to 'contribute to addressing the "social wrongs" of the day' (Fairclough 2010: 231), but there are various criticisms levelled at CDA and (M)CDA approaches. Firstly, Chilton (2005: 21) doubts this initial premise, and has said that CDA has not yet been demonstrated to be effective in changing societal injustices. Applied linguistics prides itself upon studying real world issues or problems, and is effective in rooting out hidden ideologies buried in discourses produced by those with power for consumption by the masses. This in itself is not the same as solving these issues, but it is likely that CDA and MCDA can generate solutions or suggestions for improvement or other ways of being, which may, in turn, be the beginning of a change. The dichotomy is that those with power have to be persuaded that alternative framings of social practices are possible or necessary. If (M)CDA can demonstrate that public information is having effects which are different to those desired by the producers, it may be that they will be open to alternatives.

Another major criticism of CDA and MCDA is that 'analyses are often restricted in scope, focusing on only a few texts and examples' (Wright and Brookes 2019: 63). Critics claim that 'cherrypicking' of specific texts which suit the interests of the researcher takes place, and that this is not a scientific, or even objective method of text selection. Widdowson (2004: 109), for example, asserts that critical discourse analysts pick and choose which elements of a text prove the point they want to make, ignoring those which do not. A number of writers have addressed this thorny issue, but it is almost impossible to refute a claim that a researcher has cherrypicked their data, particularly if it is interesting and does provide many discussion points. Baker and Levon (2015) concluded that ideally more than one method of research should be applied to the same research question, in order to 'triangulate' results. Angermuller (2020) however, argues triangulation is unnecessary, because it prioritises the methodology over the importance of the text. Indeed Silverman (2010: 141) advocates 'purposive sampling', allowing the researcher to 'choose a case because it illustrates some feature or process in which we are interested'.

Although they are indeed interesting, the texts I have chosen for the study are unremarkable in that they are similar to many others. For the most part they were selected because they were hard to ignore, rather than hard to find, being placed in public spaces or widely advertised to the population. All were published on the internet, broadcast on national TV, or found in locations local to me. I began by collecting a range of texts which related to emergency services, with the objective, initially, of presenting a range of genres. When a choice between more than one similar text had to be made I considered which was the best or most appropriate one to use, to investigate the model citizen construct in the widest variety of data. I attempt to mitigate the cherrypicking issue by looking not only at those communicative resources which contribute to a discursive strategy but also those which disrupt it.

Machin and Mayr (2012: 207-218) list several other issues that have been raised regarding analyses, including rarely consulting real readers of the texts in question, failing to give clear and precise descriptions of discourses, and not sufficiently considering text production. CDA has been accused of 'pay(ing) lip-service to the importance of textual production and reception', and its generally introspective approach has been viewed as a weakness because,

> (i)n order to know what meanings signs may carry in the social domain, we need to know more about how and why they are made, with what intentions, beliefs and ideologies, and how they are read, with what interests, interpretations and discourses (Pennycook 2009: 304).

Specifically regarding multimodal studies, Bateman (2011: 17) criticises the failure to satisfactorily pin down the definition of a mode, and Forceville (2010: 2607) claims that multimodality is too large a subject to be useful, and should be subdivided. MCDA also needs to become more coherent as a discipline, offering clear benefits and usefulness (Machin 2013: 349). Finally there is a charge that sometimes CDA runs the risk of outcomes 'becoming too remote and abstract, almost bordering on non-applicability' (Sarangi 2006: 202).

I have attempted to avoid these pitfalls as far as possible in this study. Production is one of the four strata proposed by Kress and van Leeuwen (2001: 4ff.), which

contribute towards the meaning of each text, and is considered in my analysis. While it is not possible to totally avoid the 'researcher's bias' I have attempted to mitigate this by choosing, as described previously, a diverse range of texts. I outline below my reasons for selecting specific texts over others, but in general there are so many texts produced by NHS trusts in which some form of the model citizen is evident that for this thesis it became more of a question of narrowing down the scope to a coherent range of texts of a suitable volume. Certainly, those who claim to be practitioners of (M)CDA are passionate about the issues highlighted by their work, but it is another matter to make changes to social policies and practices. By focusing on texts which are in everyday use, and in such an important area of social life, I anticipate that my research will have some impact and may be applied to real world scenarios where public information texts are being produced.

3.6 Framework for analysis

I follow the MCDA approach described by Machin and Mayr (2012) which develops the concept of ideologies concealed in texts by giving examples and demonstrating many techniques. To inform my analysis I draw upon Kress and van Leeuwen (2001, 2006) who provide many useful tools and techniques for the analysis of visual communication. I also look to Scollon and Scollon (2003) in considering the temporal and spatial positioning of texts. Taking account of all this guidance I conduct a multimodal critical analysis of discourses and discursive strategies present in the datasets. Considering that all modes can be semiotic, and taking on board Kress' statement that every sign is ideologically motivated, I examine the work carried out by the choices made within the meaning potential of each mode, and consider the contribution of each mode to the ideological work embedded in each text.

In the same sense that sentences contain subjects, objects and verbs, texts of any type contain social actors or participants, and actions or processes. Depending upon the text and the medium, the producers have various modes which they may use to represent participants and the processes in which they are engaged. Kress and van Leeuwen distinguish between 'represented participants' which are those depicted in a given text and 'interactive participants' who are the people using the text as a

means of communication, namely all those involved in the production of the text, such as the writer and designer, and all those who are recipients or readers of the text (2006: 114). Texts may depict processes, but they may also be an integral part of processes in themselves, for example an information leaflet or web page may contain a form which must be filled in to receive a service.

Koteyko and Nerlich (2007: 23) propose a social semiotic framework for multimodal analysis, which, following Kress and van Leeuwen (2001) considers that four strata: discourse, design, production and distribution, are fundamental elements to the analysis of multimodal texts. The framework has so far been used to conduct analysis of websites, so has been tested on texts which encompass a number of semiotic resources, but are of the same genre. However it does not appear to apply only to online materials, and could be used for other multimodal texts. My texts are collected from a wider variety of genres, so I have maintained the focus on the strata introduced by Kress and van Leeuwen, but adapted this framework to meet the requirements of my research questions and data, specifically:

i. Discourse Design

Representations: what participants and processes (and also concepts, such as model citizenship) are represented using the various communicative modes used in the texts? How are they represented? What themes emerge from the text?

ii. Production

What does the medium of production of each text contribute to its meaning? What aspect of meaning is added, subtracted or altered through the process of mediation which necessarily takes place in order to recontextualise a discourse to suit the communication needs of the producer or receiver? The various media employed in the entextualisation of health-related messages each bring their own affordances, or special features, and enable them to capture certain elements of a discourse, yet the media themselves also leave their trace in those discourses. The choice of communicative modes used in the text is dependent upon the medium used, so that the meaning potential, or range of options available to the text producer is also restricted.

iii. Discourse distribution, reception and audience

How are recipients positioned? What benefits or obligations are conferred upon producers of the texts, their recipients or other actors? Put another way, what actions are carried out through delivery of the texts, for example, are they location-specific? Does the way in which the discourse is distributed impact upon its reception by the citizen?

iv. Discourse as Sociocultural practice

What do the various communicative modes employed in the texts reveal about the underlying ideologies of their producers? To what discursive strategies do they contribute, and what actions might they invoke? How are these ideologies recontextualised in the texts?

3.6.1 Discursive strategies

I consider the construct of the model citizen through each of these strata: its discursive production and its integration into the text, its positioning in relation to recipients, and whether it is central to or peripheral to discursive strategies. Koteyko and Nerlich used their framework to deconstruct the ways in which commercial producers of probiotic dairy products and dietary supplements were able to recontextualise discourses of health and illness in the interest of selling their products. Their framework has also been adapted for use in other health-related studies such as Harvey (2013b) and Hunt et al. (2015). In my analysis, I use this framework to understand how the model citizen construct is realised, by analysing all the modes present to discover and critique the ways in which discursive strategies are produced.

The identification of discursive strategies is a feature of my analysis which links the work of individual and combined semiotic resources to the purpose of the texts. A discursive strategy is a 'more or less intentional plan of practice' which can be 'located at different levels of linguistic organization and complexity' (Reisigl and Wodak 2016: 33). The concept of discursive strategies, as used in this thesis, is equivalent to the macro-strategies described in detail by Reisigl and Wodak (2001:

33ff) in their study, using the Discourse-Historical approach. Reisigl and Wodak refer to the micro elements making up these strategies as 'means of realisation', a wide range of lexical devices and techniques which do not exclusively serve one type of strategy. The means of realisation in the texts in my study are not only lexical but also multimodal, achieved through a range of choices made within the meaning potential of a diverse variety of semiotic communicative resources or modes (Kress and van Leeuwen 2001: 21-220) including their interaction with one another.

While it is true that these strategies could also be referred to as discourses of model citizen construction, they are, at least, a special category of discourses which appear to 'serve certain purposes or help to achieve a particular objective' (Reisigl and Wodak 2001: 32). I distinguish them from discourses and identify them as discursive strategies because they appear to have objectives which can be described as strategic, such as construction and normalisation. The discourses, and inter-relationships between discourses of model citizenship are complex, and for this reason I have identified several strategies in each dataset, named to describe the actions they are carrying out. Like Wodak and colleagues, I do not impose categories of strategies on the data but derive them through conducting an abductive analysis (Wodak and Meyer 2016: 18) in which each semiotic communicative mode is considered first individually, then in combination with other modes. By asking by asking of each mode present 'what work is being carried out by this resource?' I aggregate these tasks into strategies.

Through further iterative analysis I evaluate whether these modes are contributing to the discursive strategies or whether they actually disrupt the enactment of a strategy. Although I identify several strategies in each dataset, these are by no means discrete and they overlap in many ways. The texts can rarely be broken down into sections which are dedicated to one strategy, so it is not until the multiple modes in a text have been analysed that the strategies present can be ascertained. Indeed communicative modes are likely to contribute to several strategies. While some discursive strategies are overarching and encoded into many texts, others may be specific to the purpose of one dataset. I begin each analysis with a description of the texts in that dataset, as Machin (2013: 348) has noted the importance of description in MCDA.
Notwithstanding the differences between the texts, and the various analytical tools

used, in each of the analysis chapters I follow the same route of identifying strategies and key themes. This allows for comparisons to be drawn in the discussion chapter, where strategies of constructing the model citizen are contrasted and explored in more detail. To illustrate the ways in which NHS trusts employ discourses of model citizenship to influence the behaviour the public, I now turn to my data.

3.7. Data

What follows in Chapters 4, 5 and 6 is my detailed multimodal critical discourse analysis, conducted in line with the analytical framework described above. Here I introduce the data analysed in the study and describe the selection and collection of texts, issues and obstacles encountered during this process. I begin with an overview of the context in which this data is situated.

3.7.1 Context

It is not difficult to find public information about NHS services. Leaflets, posters, and information booklets abound in waiting rooms and clinics around the country. Each NHS trust has its own public information website, and there are TV campaigns, smartphone apps, and other creative communications such as the 'A&E banner' featured in Chapter 5 (Figure 4). According to the *NHS Constitution for England*, the NHS pledges to 'inform you about healthcare services available to you' and 'offer you easily accessible, reliable and relevant information in a form you can understand' (DH 2015). For example Derby Hospitals website lists 64 pages of downloadable publications relating to health conditions, medical procedures, equipment and medication (Derby Teaching hospitals 2018).

While my analysis does not comment upon the 'quality' of communication materials, NHS England is committed to providing 'impartial' information to patients and the public, and in 2009, was the lead partner in the publication of 'The Information Standard'. This is a self-imposed quality mark which was developed by the NHS and other public organisations such as local authorities, as a response to the proliferation

of online information about health, much of which did not originate in the NHS. One of the objectives of the information standard is to 'reduce health risks that may be caused by misinformation' (NHS England 2018a). NHS Choices and NUH are 'certified organisations' which have achieved the standard, and both make the claim that they will produce 'impartial' information, which is also accurate up-to-date, evidence-based, and accessible (NHS Choices 2016a: NUH 2017: 6, 20). Those trusts which have not yet achieved the Information Standard nonetheless endeavour to publish and disseminate good quality information which is accessible to all (for example Derby Teaching Hospitals 2017).

3.7.2 Structure of the analysis chapters: The 'journey to emergency care'

In considering the construction of the model citizen within health communications materials I have sampled texts for analysis from three stages of what might be considered a 'journey to emergency care'. Through collecting and analysing texts for potential patients of NHS services it became evident that the texts were intended for people at different stages or moments in the decision-making process about using emergency health services. So, in each of my analysis chapters I consider texts from a different 'stage' of the patient's 'journey'. In the first analysis chapter I look at texts from a preventative campaign which aims to avoid the need for citizens to use A&E and ambulance services by providing information about ways to avoid serious illness. My second analysis chapter focuses on examples of texts addressed to people who may be considering or about to use A&E or the local ambulance service. The 'choosing' texts seek to keep people away from emergency services unless they can meet certain criteria, and to signpost them to other services or other courses of action. The third analysis chapter considers texts found within A&E waiting rooms, and displayed to people who are already 'in the system' at an A&E department. There are many different messages and discourses messages at this third 'stage' of the journey, and I focus upon one of these messages, completion of the Friends and Family Test survey, which is the subject of numerous texts. In selecting these data I am not claiming that they are comprehensive, or even representative, but through this collection of texts I investigate how the model citizen is produced throughout an

array of materials for the public relating to emergency health care. Through the choice of data sources for my study I have endeavoured to exemplify different stages at which patients might find themselves. I present my data in three chapters, relating to these three stages.

3.7.3 Selection of texts

> Which text is ideologically the most effective: the text which overtly declares its ideological constitution and intention, or the text which does not? Which is the most in need of critical analysis? (Kress 1993: 190).

(M)CDA is generally applied to real-world texts in order to expose the ideologies behind the discourses of which these texts are constituent. Often these are overtly political texts where one would expect to find ideology (e.g. Fairclough 2010: 380-389) but many other genres such as advertisements (e.g. Kuhn and Lick, 2009), and media stories (Machin and Mayr 2012) have also been analysed using (M)CDA. As Kress (1993: 190) suggests (above), those texts which are overtly ideological, do not necessarily need critical analysis as they encode an acknowledgement of the ideological standpoint of the producer. Although of course they may not always include a statement of their true purpose, the receiver is, at least, alerted to the political or other ideological origin. It is those texts which are presented as neutral, non-partisan or apolitical which it may be more valuable to investigate, and which are most deserving of critical analysis.

The texts in my study are not overtly political. They do not name ideologies, or cite government ministers and their decisions about healthcare spending. However these seemingly innocuous-looking texts are interesting and worthy of sustained critical investigation because political ideology is present but masked, working insidiously on readers. All texts are suitable for critical analysis (Kress 1993: 174, 190), and it may be that the covert ideology behind the discursive strategies in the texts are deliberately hidden from view in order to mislead or manipulate the reader. It is important, therefore, to analyse texts such as these which are very prevalent and are increasingly incorporated into public and private spaces. They are 'everyday' texts;

produced and disseminated using public resources by privileged employees of trusted organisations, and presented as unequivocal truths, including the positioning of the model citizen in relation to health discourses. It is not only appropriate and legitimate that this work of social meaning-making through discursive strategies should be scrutinised, but also important to do so using practical examples of texts which have been deployed to transmit these discourses to the public and patients of the NHS.

Few studies in MCDA so far, have analysed public health information. Although there are a growing number of multimodal papers about health-related websites, they have tended to cover sites for commercial products (Koteyko and Nerlich 2007, Harvey 2013), web pages about NHS trusts (Brookes and Harvey 2016) and health related charities (Brookes and Harvey 2015). The wider, multimedia nature of health-related materials for the public, and campaigns, is still widely un-tapped. However, there are a few recent notable exceptions in which multimodal analysis of health promotion is tackled. These include my investigation into discursive strategies in an alcohol reduction campaign (McIntosh 2014), a study on health information leaflets for people with intellectual disabilities (Chinn 2017) and one on 'nudge' tactics in health policy using a corpus of NHS Change4Life advertisements as its data (Mulderigg 2017), so it may be that this little–visited genre has begun to draw some interest. Also of relevance to my study are multimodal studies on public signs (Mautner 2014) and warning notices (Spinzi and Terminiello 2010) Scollon and Scollon (2003: 97). Brookes and Harvey (2015) have conducted multimodal analysis of large format posters and Sarangi and Slembrouk (1996: 22) have considered billboard advertisements. All of these studies, however, look at a single genre of text rather than a multimedia campaign or a range of text types. There is still therefore, a gap, which this thesis fits: the NHS public information gap. In considering this project I narrowed the scope from health in general to emergency health, in order to focus on a specific area which is somewhat discrete yet available in some form throughout the country. This subject matter covers concepts which are familiar to the public and within the experience of many.

For ease of reference and comparison the characteristics of the data are presented in Table 1, below, but I expand here upon the choices made and reasons for those

choices. To test the prevalence of the model citizen construct I introduced a number of variables to my data. My first analysis chapter, for example, looks at a national campaign, the second covers texts produced for local use by individual NHS trusts, and the third looks at posters on display in the waiting room of individual hospital departments. Also represented are different channels of communication, each with varying requirements for design, production and distribution. They include traditional and newer media: TV advertisements, web pages, banners, posters and leaflets. Whilst it will not be possible from this selection of data to show that the model citizen is present in all public health materials, I investigate the presence of this construct in a wide range of NHS communications regarding emergency care. The target audience and selection criteria for the texts in each dataset are also listed in Table 1. The texts were collected at various times during 2016 and 2017, and specific details are given below. All materials were on current display or available free of charge to members of the public at the time of collection. Some data have particular relevance for certain groups of people who might be more vulnerable, such as older people or people with existing medical conditions, or may be specific to the location in which they were found. I collected only data items relating to emergency health services for the first two analysis chapters, but for the third, in order to record the semiotic environment as best as possible, I photographed all materials on display in the A&E waiting rooms of two hospitals. Details of the specific texts, locations, and relevant dates are given under the chapter headings in section 3.7.4. My selection criteria for texts were as follows:

First dataset (Chapter 4):

Produced by an NHS agency

Covering a large geographic area

Drawn from a multimedia campaign

Available free of charge to large numbers of people

Second dataset (Chapter 5):

Produced by an NHS trust in the East Midlands

Covering the geographical area of the relevant NHS trust

Available free of charge to large numbers of people

Third dataset (Chapter 6):

Displayed in A&E waiting rooms at Lincoln County Hospital (LCH) or Queen's Medical Centre (QMC).

Available free of charge to those using the facility.

Later narrowed down to texts produced by an NHS organisation on the subject of the Friends and Family test.

The data for Chapters 5 and 6 were chosen from sources local to me in the East Midlands for practicality and ease of access. Similar materials are available in other parts of the country, however, and this study could be replicated by collecting texts from another NHS region. Chapter 4 texts were published or broadcast nationally, and were chosen as relevant to the research question and widely available to the public throughout England.

In any qualitative study it is difficult to be sure that a suitable quantity of data has been analysed, and as there is no standard method of data collection in CDA, the researcher must decide upon the most suitable approach (Wodak and Meyer 2016: 14). Studies in (M)CDA often focus upon a single text to illustrate a point, or upon a set of texts which have features in common, in order to provide comparisons or arrive at generalisations about certain categories of texts. To answer my research questions about the phenomenon of the model citizen construct using the framework outlined above, I continued to collect and analyse texts until I had a sufficient body of evidence concerning the model citizen construct in my area of study. In terms of the generalisability of the study, and in considering the prevalence of the model citizen it was important to study a range of texts. Narrowing my area of study from 'the field of

Table 1. Characteristics of data included in analysis chapters

	Chapter 4 ***Stay Well this Winter*** **campaign**	**Chapter 5:** **'Choosing' texts**	**Chapter 6:** **Waiting room materials**
Geographical reach	National (England)	NHS trusts within East Midlands (local/regional)	Individual hospital A&E departments (specific)
'Stage' of decision-making	Preventative: aimed at preventing emergency	Pre-emptive of decision to attend A&E/call ambulance	In A&E department
Media	TV ad and booklet	Web pages, banners and posters	Posters, leaflets, notices and signs
Target audience	General public, especially vulnerable categories of people	General public, particularly those about to use emergency healthcare	A&E patients and carers
Selection criteria for texts	Produced by NHS England Relating to preventive healthcare (avoidance of emergency health scenario) In use at the time of collection. Made available to the general public	Produced by an NHS trust in the East Midlands relating to emergency healthcare in use at the time of collection Made available to the general public	Produced by an NHS organisation relating to the Friends and Family Test in use at the time of collection made available to visitors, patients and carers at A&E
Collection dates and locations	Leaflet collected from GP surgery in January 2017 Advertisement accessed on *Stay Well this Winter* website during April and May 2018	A&E banner: QMC, Nottingham, photographed 8th June 2016. Ambulance poster: outside Kings Mill Hospital, Sutton in Ashfield, photographed 12th November 2017. Derby Hospitals website accessed March - May 2017.	Photographs taken and other materials collected at LCH, 17th May 2016 and QMC, Nottingham, 8th June 2016.

health', to public information about emergency health services has created a more focused and manageable scope whilst still allowing for the analysis of a wide range of media. However, there are still many other texts which could have been considered for this study. For ease of access and to avoid repetition I have narrowed the number of possible texts by taking one iteration of a national campaign for Dataset 1, materials of different types from trusts in the East Midlands for Dataset 2 and texts found in two A&E departments for Dataset 3.

3.7.4 Collection of data, recording and monitoring websites

Specific details of the collection of materials for each dataset are listed below, including dates of collection and locations where relevant. All images of web pages were captured using Apple Macintosh OS X Grab software, and all URLs are listed in Appendix 1. All photographs were taken using the camera on my Apple iPhone6. Those used in the thesis are listed in Appendix 1, and a log of all photographs taken is available. Hard copies of publications are also available, and scans of these are in Appendices 2-5. Appendix 1 also lists all supplementary files and materials for each chapter.

3.7.4.1 Data: Chapter 4

The data for my first analysis chapter are texts from the *Stay Well this Winter* campaign jointly published by PHE and NHS England which is distinctive in its use of genuine NHS staff as actors. The dataset consists of an A5 leaflet (Figure 2, Appendix 2), and a TV advertisement (Figure 1) which are described in detail in Chapter 4. Initially launched in October 2015, and with the intention to 'ease annual pressure on NHS urgent care and emergency service' (PHE 2017b), this campaign ran over the winter months, and was updated and aired again during the following two winters. Several versions of the *Stay Well this Winter* TV advertisements were aired, featuring similar settings and messages, and largely the same cast. Certain of the campaign elements were targeted at different demographic groups, and the two texts examined in this chapter are aimed at the largest of these populations: people over the age of 65 or younger adults with existing medical conditions, comprising around sixteen million people. The version I analyse in Chapter 4 was first shown in December 2016,

when PHE estimate that around 65% of the target population of over 65s and people with long-term conditions saw the advertisement at least three times (PHE 2018a). Of the variants available I analysed this version as it was the one featured most prominently on the website as well as being aired on national TV. It was shown on seven commercial TV channels including ITV, Channel 4 and Sky. (See supplementary information Appendix 1). It was shown again in December 2017, and also appeared on the *Stay Well this Winter* web pages, where, for example, between 1 October 2017 and 26 March 2018, it was played 2,322 times (PHE 2018a). In addition the ad was posted on the YouTube video 'channels' for PHE and NHS England. Advertisements in the form of short video broadcasts are therefore a flexible genre which can be shown and viewed on a number of platforms, and are likely to be seen by large numbers of people if shown at the right times.

Leaflets and booklets of various sizes are a very common format for public health information and can be distributed in a number of ways. They allow for more detailed information to be shared, and are generally intended to be given away to the user, sometimes as part of an interaction with a health professional. Compared to TV ads, they provide something tangible, portable and relatively cheap to produce, particularly in such large quantities. The *Stay Well this Winter* leaflet analysed in Chapter 4 was collected from a GP surgery in Nottinghamshire in January 2017. It

Figure 1: Opening scene from Stay Well this Winter TV advertisement



was first published in 2015, when 11 million copies were posted to individual households in postcode areas with above average levels of people aged 65 years or older (PHE 2018a). In both 2016 and 2017, 1.4 million copies were distributed through the Department of Work and Pensions as part of their 'Warm Home Discount' mail out, and they were also placed in leaflet racks in GP surgeries, chemists and other NHS locations.

Stay Well this Winter is a fairly 'traditional' multimedia campaign using well established media (print and TV). In addition to the texts included in the analysis, *the Stay Well this Winter* Campaign included posters with a similar layout to the front cover of the leaflet. There was also a self-contained *Stay Well this Winter* web area (see Figure 3) on the NHS Choices website. Visitors until 2019 would find four pages, branded in a similar way to the ad and leaflet, complete with photos of NHS staff and blue concentric circles. These included specific advice for certain sections of the population (NHS Choices 2018), and two of these links, 'Living with a long term health condition' and 'Ages 65 or over' led to pages upon which the TV ad analysed in Chapter 4 could be found. The site is not analysed here because it carried no additional information, repeating the content of the leaflet and TV ad. Visitors to the site in 2020 will find that the *Stay Well* content has been 'debadged', and incorporated into the main NHS website, although some of the leaflets are still available to download. PHE also have a 'Campaign Resource Centre' (PHE 2017b). This is a website from which organisations which register with PHE can order or download resources such as the posters and



Figure 2: Front Cover of *Stay Well this Winter* leaflet

leaflets, and access guidance on using the *Stay Well* logo and visual identity for their own publications.

The cost for the whole campaign, of which the leaflet and advertisement are just two elements, was £3.64million in winter 2015/16 and in winter 2016/17, £4.18million. This represents a significant investment, and reflects the obligation on the organisation to produce high quality public information in line with public expectations. PHE estimated that 'the campaign drove an additional 1.85 million visitors to pharmacies for advice at the first sign of a winter illness'. This claim is based on 'modelling of campaign awareness and reported actions' (PHE 2018a). They do not, however, claim that it has reduced the number of A&E attendances.

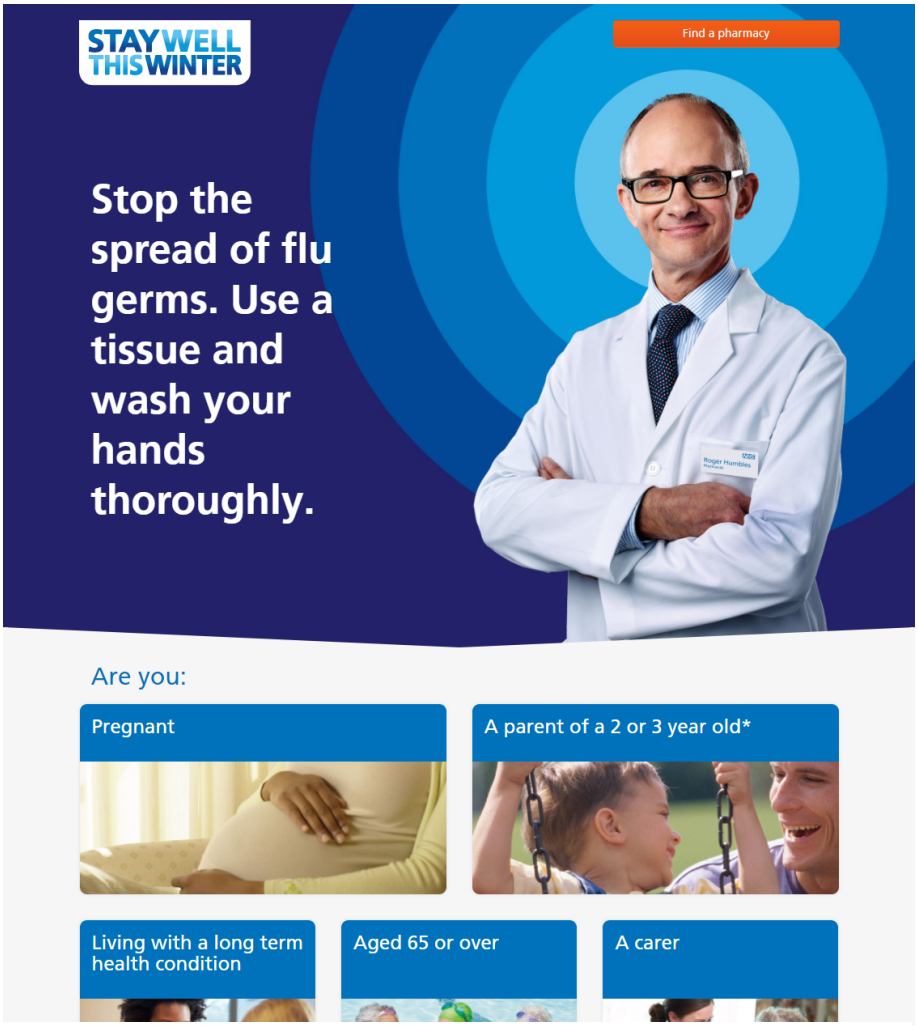


Figure 3: Screenshot from the *Stay Well this Winter* website (20 April 2018)

3.7.4.2 Data: Chapter 5

The data for Chapter 5, my second analysis chapter, were produced by NHS trusts based in, and serving the populations of, the English East Midlands. The materials relate mainly to A&E services for the Nottingham and Derby Areas; services which are being promoted as alternatives to A&E; and ambulance services which cover the whole region of the East Midlands. These texts are published by several different NHS trusts (named below) and are brought together for this chapter because of their common purpose. The materials were all produced with the aim of shaping the behaviour of the public by informing or reminding citizens about 'correct' use of emergency services, in particular A&E departments and the 999 emergency ambulance telephone number (Door 22 Creative 2017, Ionescu 2013, Derby Teaching Hospitals 2018). The examples analysed in Chapter 5 are as follows:

- A banner situated outside the entrance to the Emergency Department, Queen's Medical Centre, Nottingham (Figure 4)

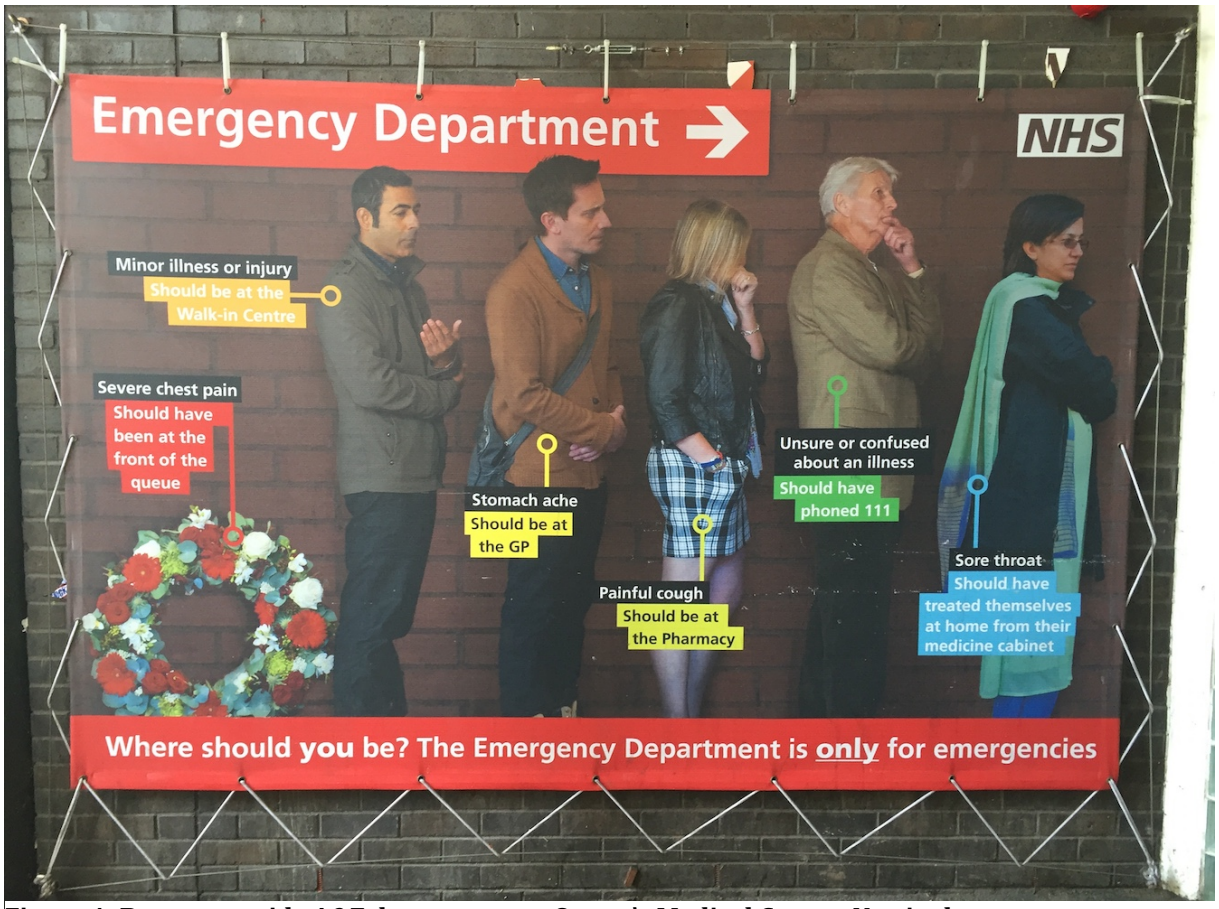


Figure 4: Banner outside A&E department at Queen's Medical Centre, Nottingham

The banner is 1.9m high and 2.85m wide, and was photographed on 8th June, 2016 at QMC. It was produced on behalf of NUH by Door 22 Creative Ltd., a UK design agency which has developed several campaigns for the NHS and various charities. The banner was part of a campaign:

to educate the community that there are many other excellent services and professionals equipped to deal with less serious conditions and to make people understand the role of the A&E and the very real and possible consequences of its misuse (Door 22 Creative 2017).

Large format banners such as this one are more often employed for commercial advertising, but their potential for impact has not gone unnoticed by public sector organisations who have begun to use them. They are fairly weather-resistant and can be attached to a variety of surfaces, so are available to be applied in unusual and unexpected settings, where the surprise factor might mean that they are more likely to be noticed.

Originally commissioned by NHS Leicester City, the banner has been adapted for several other A&E services in England including Sussex, Devon and Suffolk. On their website the designers describe the campaign as 'hard-hitting' and 'a no-holds barred approach' (ibid.). When I contacted the Communications Team at NUH in April 2018 for information about the banner I was told that it was part of a 'four–year old campaign', and had been in position since 2014. Although the campaign was no longer active, the banner had been left in place as it was seen still to be relevant. Between April 2014 and March 2017 over 400,000 patients attended the Emergency Department at QMC, with the number per year ranging from 194,000 to 203,000 patients (Supplementary information is available—see Appendix 1). Although approaching 30% of patients arrived by ambulance or air ambulance so will have been taken in through a different route, and some may not have used the main entrance, hundreds of thousands of patients, plus those accompanying them, will have passed by this banner on their way to or from A&E. It is therefore a significant item of communication between NUH and the public.



Figure 5: EMAS Ambulance pictured outside Lincoln County Hospital

- A poster observed on ambulances from the East Midlands Ambulance Service NHS Trust (Figure 5).

  Figure 5 below was taken outside Lincoln County Hospital (LCH) on 17th May, 2016, and the photograph of an ambulance in Chapter 5 (Figure 16) was taken outside Kings Mill Hospital, Sutton-in-Ashfield, on 12th November 2017, although I have observed ambulances bearing the same posters on several occasions at different locations around the East Midlands. The posters are also publicised and referred to on the East Midlands Ambulance Service NHS Trust (EMAS) website, and EMAS use the same wording in tweets from their Twitter account.

  EMAS provides ambulance services within Derbyshire, Leicestershire, Lincolnshire, Northamptonshire, Nottinghamshire and Rutland and operates over 300 emergency ambulances, in addition to a number of other services including transporting infirm patients to hospital appointments. Posters in

prominent places are one of the ways health authorities have traditionally attempted to engage audiences and disseminate messages (Cooter and Stein 2010: 174-179), and I shall return to the proliferation of posters in certain NHS locations in Chapter 6. Posters on ambulances, however, are a recent phenomenon. Previously ambulances were simply seen as public service vehicles, and the wording thereon would be for identification purposes. Communication teams are becoming more creative and have harnessed an existing resource in a new way to expand the reach of their message.

Of the ten NHS ambulance trusts in England, most have started to place messages on their ambulances about when to use their service, although there is significant variation in the content and design of communications using this channel. The poster I focus on in this study reads Y*ou wouldn't call the coastguard if you fell in a puddle,* alongside a photograph of a puddle. It is one of a series of three posters, the other messages being *You wouldn't call the fire service to blow out a candle* and *We risk our lives to save yours.* 250 posters, spread equally over the three designs, were produced by a creative agency based on ideas from EMAS staff, and were attached to EMAS ambulances starting in October 2015. Posters were added gradually to the ambulance fleet, as the vehicles came into the depot for service or repair, and this continued until they were used up. The posters will remain on the vehicles until they are replaced. The 'coastguard' poster was chosen for analysis because it was the first of the three that I had the opportunity to photograph. These vehicles are constantly out and about within the East Midlands, so again, the posters are seen by large numbers of people, and must be considered as significant and worthy of analysis.

- Pages from the Derby Hospitals website, and Derbyshire Community Health (DCHS) website (Figures 6-7). These sites were monitored from 1st March until 31st May 2017, during which time I visited the sites at least four times each week, at various times of day. Screenshots from this site were captured on 22nd March 2017. The pages relevant to this chapter are those which relate to or carry significant content about A&E, so I focus upon elements of three in particular.

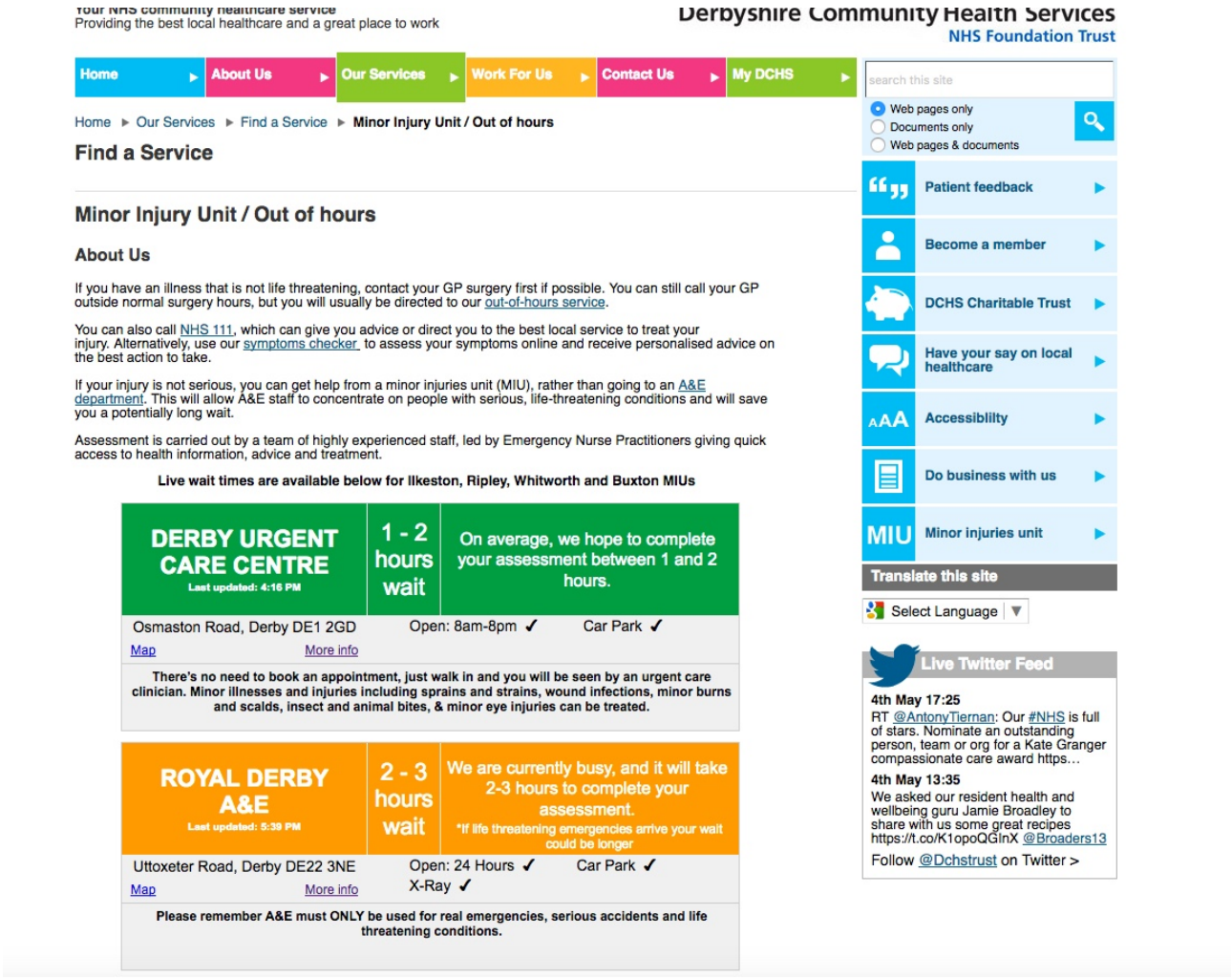


Figure 6: Part of the *Minor Injury Unit / Out of Hours* page of the DCHS website, showing the live wait times feature

The Derby Hospitals website is similar to many other NHS websites in that it aims to provide large quantities of information about a range of services, policies, news and public health information. It also attempts to provide differentiated information for several different audience groups, and to direct these groups to the information they should most appropriately access. The site contains over 1,200 pages, and links to hundreds of documents, such as policies, procedures and patient leaflets. The website, and even the home page itself, contain so many elements that any kind of comprehensive study would be impossible unless perhaps this were the only text under consideration. Instead, I follow Johnson et al. 2010: 226) in focusing upon the 'purpose and the potential ideological effects of particular semiotic choices' of certain important elements of this and other pages. I analyse elements of the home page and the About Live Wait Times page.

The screenshot of the DCHS Minor Injury Unit / Out of Hours page (figure 6) was captured on 5th May, 2017, and is the only page I have analysed from this site. It was chosen because it is linked directly from Derby Hospitals site via a hyperlink, and because it features the same live wait times app found on the Derby Hospitals site. DCHS are responsible for the Minor Injuries Units and out-of-hours services in Derbyshire, and manage community healthcare services for Derbyshire, as well as eleven smaller hospitals which do not have A&E departments. The website, again, carries pages of information about services run by the Trust, links to other NHS services, opportunities for users to get in touch in various ways, and documents relating to the governance of the organisation, such as management board minutes and annual reports. The site has over 300 pages, plus links to hundreds of documents such as patient information sheets, policies and procedures.

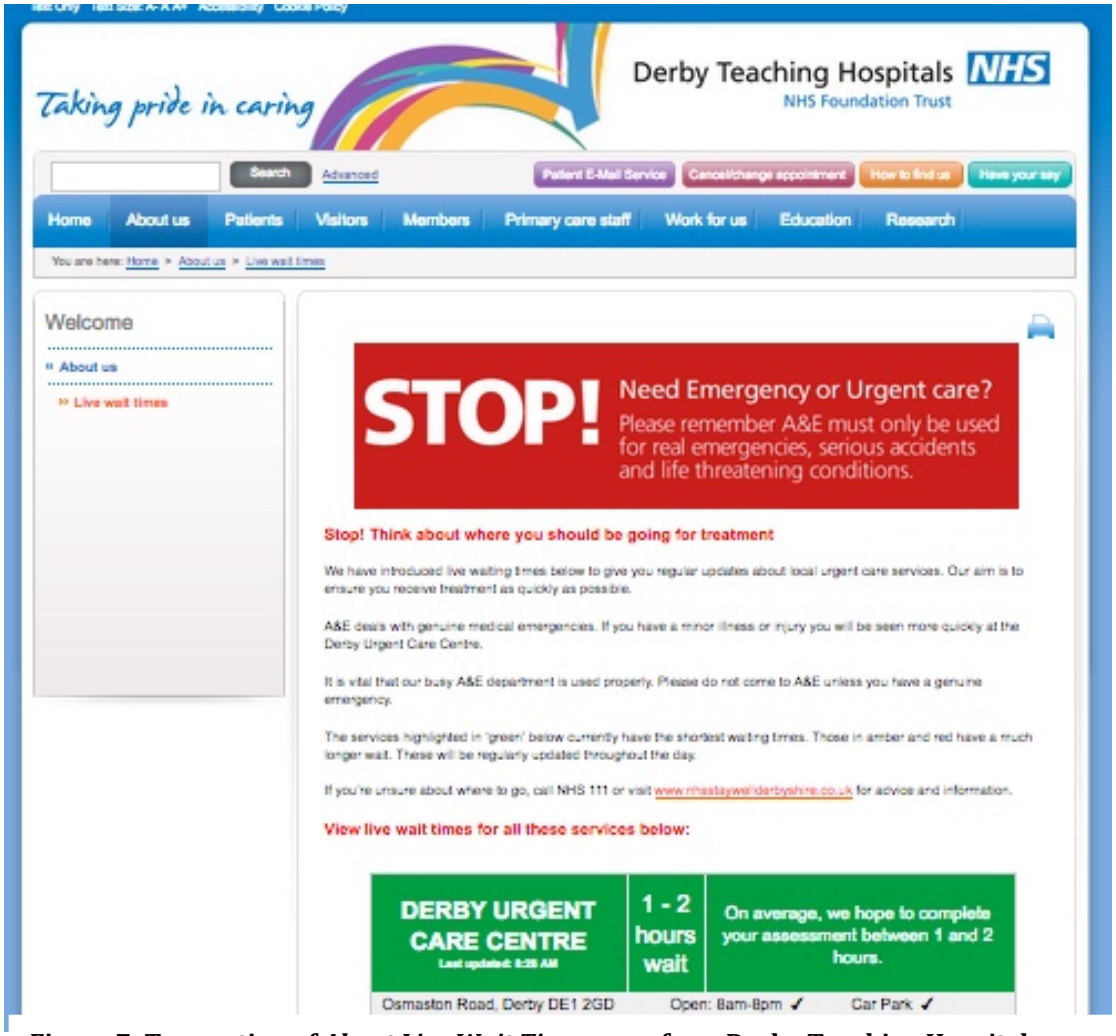


Figure 7: Top section of *About Live Wait Times* page from Derby Teaching Hospitals website.

With such volumes of information to impart, the web content must be arranged in a suitable way, and there are many sources of advice for web editors in how to achieve this (see for example Neilsen and Tahir 2001). As part of the process, policies and guidance are rewritten, re-organised and simplified into palatable chunks of text. As in printed publications, illustrations or diagrams are added, but in addition, web formats facilitate the inclusion of audio and video, and hyperlinks, which connect the text being viewed with other texts on pages of the same, or any other website.

As of 1st July 2018, Derby Teaching Hospital NHS Trust merged with Burton hospitals NHS Foundation Trust to form the University Hospitals of Derby and Burton NHS Foundation Trust, and accordingly altered their website to reflect the new name. The site has been completely overhauled since and no longer has a live wait times page, however as of July 2020 these are still available on the DCHS site. All data for this study were collected before the merger, so I continue to refer to Derby Hospitals Trust by their name at the time of my data collection. The view in Figure 7 shows the top part of the *About Live Wait Times* page, captured on 4th May, 2017. I have included old and new URLs in Appendix 1.

3.7.4.3 Data: Chapter 6

The texts for the third dataset were collected from the A&E departments of two hospitals in the East Midlands. Photographs of LCH were taken on 17th May 2016, and those at QMC, Nottingham, were taken on 8th June, 2016. I initially photographed all of the materials on display in the main waiting area of each A&E department. In addition to taking photographs in both waiting rooms I also collected copies of leaflets and other publications which were made available to the general public in leaflet racks, on tables and reception counters, and anywhere that was openly accessible to visitors in the waiting room. My initial criteria were to collect only leaflets from the NHS or other public authorities, not charities or commercial organisations. In addition I did not take the last available copy of any leaflet, as this would have left none for the intended recipients!

LCH is the largest of four hospitals run by the United Lincolnshire Hospital NHS Trust, which between them serve a resident population of 720,000 people. Situated

approximately one mile outside Lincoln city centre, it serves the city and parts of North Lincolnshire. On my visit I was given permission take photographs inside the waiting area of A&E, and around the exterior of the department, provided I did not include any people in my photographs. I originally took 66 photographs at this location, and collected 9 leaflets. QMC is one of two hospitals managed by NUH, and its only site with an A&E department. At QMC I was accompanied by a nursing sister and was able to take photographs in additional areas of the A&E department including treatment areas and the entrance used by ambulance crews to bring patients into A&E. In total I took 69 photographs here, and collected 11 assorted leaflets.

There were very large quantities of materials displayed at both sites, and I describe the waiting room environment in more detail in Chapter 6. Most photographs captured posters and signs on the walls, although I also photographed some additional items with semiotic content. Not only were there numerous texts, but having carried out an initial categorisation of the materials collected, I ascertained



Figure 8: A corner of the A&E waiting room at Lincoln Hospital

that there were also many categories of texts. Most, but not all of these categories were present in both waiting rooms. To narrow down the quantity of texts to a manageable number for analysis, I first conducted a categorisation exercise.

Categories were allocated based on my understanding of the meaning of the texts and knowledge of the organisations involved, and are not all of the same order. They were applied to leaflets and photographs. Many items fell into more than one category, particularly where I had not photographed all items individually but in groups. In all I sorted the content into 25 categories, as follows:

1. Direction signs
2. Signs restricting access
3. Behaviour in the A&E dept:
4. Staff notices
5. Payment for or access to NHS services
6. Redirection to other services
7. Information about non-NHS services
8. Quality ratings and inspections
9. Customer satisfaction, complaints, comments, Friends and Family Test etc.
10. Patient Advice and Liaison Service (PALS)
11. Translated items of all kinds
12. Miscellaneous items, e.g. water fountain, bedpans, vending machines.
13. 'Welcome' messages
14. A&E Processes
15. 'Statutory' notices about fire safety, danger, energy rating
16. Choice
17. Information for children and young people
18. Research, audit, surveys
19. Abuse

20. Cleanliness, infection control
21. Organ donation
22. Paintings!
23. Communication
24. Public health: smoking, falls, vaccination.
25. General views for context.

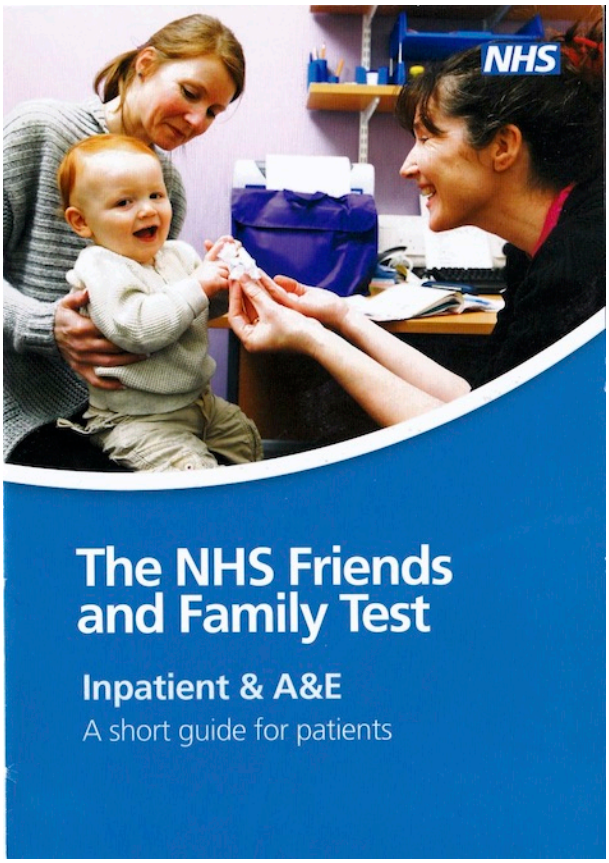


Figure 9: Front cover of the 'national' Friends and Family Test leaflet analysed in Chapter 6

I further narrowed down the selection to include only photographs which were of sufficient quality to be legible, for practical purposes, and texts produced by the NHS, in order to maintain consistency with the other datasets. Of these, 'feedback' was the most frequently occurring category, and FFT texts by far the most numerous within this category. I was therefore able to narrow down the initial large set of texts to a more manageable three texts for detailed analysis. The main text, which I call the 'national' Friends and Family leaflet, was the only text present in both settings. In the chapter I make reference to two other printed texts, and a wider set of related texts.

3.7.5 Ethical issues

As I had no intention of collecting any personal data at any point in the study no ethics approval was required. However the environment in which some of the data were collected included the interior and exterior of hospitals, namely the A&E Departments of LCH and Nottingham University Hospital. Staff and patients were present in these locations, and as A&E departments are open round the clock it was not possible to arrange to visit when the space was unoccupied. Photographs of the interiors and exteriors of hospitals were taken with the permission of the communications manager of each hospital trust. On asking permission to take

photographs I stipulated that no photographs of people would be taken, and that I would delete any photographs which they did not wish me to keep. At the end of my visits I asked senior A&E staff to check that they were happy with all of the photographs I had taken. In each case I was told that all the photographs were permissible. No patients or staff were in the ambulances at the time the photos were taken, and the texts do not include any personal information.

3.7.6 Permissions

The data for this study consist of materials which were produced by NHS trusts and other organisations for the intention of communication with the general public, or those using NHS services. As such they were in the public domain at the time of collection.

- Materials collected for Chapter 4 are jointly published by NHS England and Public Health England.
- Materials photographed and reproduced for Chapter 5 were published by the following NHS trusts:

  Nottingham University Hospitals NHS Trust

  East Midlands Ambulance Service NHS Trust

  Derby Teaching Hospitals NHS Foundation Trust

  Derby Community Health Services NHS Foundation Trust
- Materials photographed for Chapter 6 were published by a wide variety of organisations from the public, charity and private sectors. All were photographed or collected in A&E departments as explained above. Leaflets reproduced in Chapter 6 were published by:

  NHS England

  Nottingham University Hospital NHS Trust

  United Lincolnshire hospitals NHS Trust

Posters, signs and other materials reproduced for Chapter 6 were published by the following:

United Lincolnshire hospitals NHS Trust: Figures 23, 26, 27, 30, 31, 32, 33, 34, 36.

Nottingham University Hospital NHS Trust: Figures 25, 28, 29, 31, 32, 34, 37, 40, 41.

NHS England: Figures 24, 31, 35.

Care Quality Commission: Figure 38.

Department for Communities and Local Government: Figure 39.

Where items do not display an imprint or logo I have attempted to ascertain and include the publisher, although this was not possible in all cases.

All publications from the NHS and the other listed government bodies are subject to Crown Copyright (National Archives 2018) under the Open Government Licence for Public Sector Information, and my use of the materials published by the above organisations, solely for research purposes, is permitted. I was fortunate to have the full co-operation and help of all NHS staff I contacted including the communications teams at Public Health England who provided me with a high quality copy of the TV advertisement, and communications staff at NHS England, East Midlands Ambulance Service, United Lincolnshire Hospitals Trust, Derby and Burton NHS Foundation Trust and Nottingham University Hospitals NHS Trust.

3.8 Issues encountered during the process of analysis and writing up

In conducting my discourse analysis I have tried to travel the most appropriate path between the 'micro elements of discourse' which make up its 'textual dimension' and the 'contextual dimension' of 'topics and themes ... with particular attention to the reproduction of ideology and hegemony' (Lupton 1992: 145). Whilst I was keen to analyse a wide variety of data for this study, the large volume of qualitative data, resulting from the analysis of a diversity of sites, media and modes, raised issues for

the organisation and presentation of results. With a matrix of modes, themes and discursive strategies I finally settled on the current format of three analysis chapters after much wrestling and reorganising. There are, of course, challenges associated with the collection of any data, but the main ones facing me related to their 'live' status as they were contemporary texts, still in use on the day they were collected. Multimodal texts also pose some issues. In addition, as all researchers, I was aware that my position as a researcher may compromise or alter my data. A brief summary of these challenges is set out below:

1) Challenges of 'liveness'

The NHS websites I studied were interactive and were often updated overnight with news items and additional features. Some of the pages included panels with scrolling information or other constantly changing features. Several of the pages featured 'live wait times' which were dynamic, and changed according to inputs from staff at several NHS settings in Derbyshire. There were issues regarding when to capture data from these pages, and how to respond to this live and constantly changing data, including ways to demonstrate its 'live' nature, as after the moment of capture the texts become (albeit recent) historical snapshots. Contemporary texts such as these are prone to being updated, so this was also an issue with other data, although to a slightly lesser extent. For example the Stay well this winter campaign has been run over three years and each time several versions of the advertisements and posters have been produced, resulting in a number of similar texts from which to select an example for analysis. When taking photographs in A&E waiting rooms, the decision about when to capture the images was not completely my own. My visits to LCH on 17th May 2016, and the QMC on 8th June 2016, were timed to suit the hospital staff at each location, and to cause the minimum of disruption. The photographs had to be taken within a short time window, sometimes in less than ideal lighting conditions, which meant that some photos were not of suitable quality and there were some duplicates. Because of the stipulation that photographs should not show real patients or staff at the hospital sites it was not possible to take wider shots which might have given more detail on the positioning of the texts in these locations. Showing the whole waiting area in either setting, would have included waiting patients and would therefore have required additional clearance.

2) Challenges of multimodality

Another issue is the challenge of multimodality, particularly in the representation of multimodal texts in a two-dimensional document which relies almost entirely upon the written word, albeit with the inclusion of a few photographs. One point to note regards the use of photographs in this thesis: while I have, at certain points, described and analysed photographs which are incorporated into texts, and consider them as a communicative mode, I have also photographed texts in order to analyse them, and reproduce them for illustrative purposes in the thesis. These should not be considered to *be* the texts themselves, nor are they true copies of texts. In this sense, photographs can never be copies of texts as they can only reproduce certain aspects of a text (Tinkler 2013). I cannot use them to reconstruct a hospital waiting room, or a moving ambulance, for example. So in these cases I provide photographs as evidence of the texts, rather than claiming that they are the texts.

3) Difficulty of identifying who is a reader

The issue of knowing who reads texts such as these is also faced by their producers. The only way for NHS communications teams to find out whether those for whom the information is produced have actually read it is to conduct some kind of time consuming survey, or to install registration for user of web resources, which may have the effect of deterring readers. I have therefore to presume that if a text is widely available, fairly easy to access, free of charge, and placed in appropriate locations, it will be accessed by some of those to whom it is directed.

4) The researcher's position

As a researcher, who could also potentially be a user of emergency healthcare, conducting this study has required me to consider my position in relation to the texts I am studying. Fairclough cautions that through studying discourse and applying CDA we create discourse and perpetuate or erode contemporary iterations of discourses. Researchers should also be aware, whilst studying power relations in discourse, of the power status of academia and its impact on participants in research (2015: 9). 'Researchers, scientists and philosophers are not situated outside the societal hierarchy of power and status but subject to this structure. They have also frequently occupied and still occupy rather superior positions in society' Wodak and Mayer (2016: 7). I am aware that, as Wodak and Mayer have said, academics may be high-

handed about decisions made in relation to the production of texts. For applied linguists to understand the professional context being studied sufficiently thoroughly to understand and make comment upon it, linguistic knowledge needs to be 'supplemented by the knowledge/experience of a given profession in its organisational environment' (Sarangi 2006: 202). As a former communications professional in the public sector I have been able to appreciate the circumstances affecting the producers of texts in the NHS, such as constraints on spending, a bureaucratic decision-making process, and difficulty in reaching disadvantaged audiences. Yet I have also attempted to ensure that this knowledge does not impact upon my critical stance as a discourse analyst by keeping my distance from the text producers and only approaching them when I could not progress my research without information which only they could provide.

3.9 Conclusions

This chapter has explained the methodological approach of my thesis, highlighting pertinent points relating to the tradition of CDA, with its central themes of power and ideology. It has introduced the multimodal approach which I will pursue, and has described my analytical framework. I have also used this chapter to discuss my data, including its organisation into three datasets with criteria, reasons for selection and methods of collection. In the following three chapters I will analyse my data using the framework described above.

My research questions call for a qualitative method which will both identify discursive strategies and delve deeper into the semiosis of such strategies. In adopting a critical multimodal approach to a varied set of data I test the suitability of the methodology for larger datasets, demonstrating a method which retains rigour and accountability to the discipline whilst effectively expanding the boundaries of its work. I also aim to show that MCDA is a useful approach for a thematic study, and apply it to the as yet, under-investigated field of health promotion and information. My further findings about the nature of this construct are set out in the following chapters.

4. First Analysis Chapter: Stay Well this Winter

4.1 Introduction

In this first analysis chapter I analyse two texts from the NHS campaign *Stay Well this Winter,* to show how the model citizen is produced via a series of discursive strategies (see 3.6.1). I will first describe the data before moving on to examine the discursive strategies and the multimodal resources harnessed to produce them, integrating into my analysis the four strata of design, production, distribution and social action. In my Literature Review I explored the concept of governmentality (Foucault 2007), which expounds that government agencies require citizens to act in particular ways, and that they influence them to do so using the various technologies available. This is done partly to ensure public order, but also as I will show here, to enable the enactment of new social practices (Fairclough 2010: 444). As I have explained in Chapter 2, public information produced by the NHS is one of the technologies employed to influence citizens.

As detailed in section 3.7.4.1, the *Stay Well this Winter* campaign, covering the geographical region of England, was jointly produced by Public Health England (PHE) and NHS England. In the campaign background materials for NHS staff and partners, the stated objective for the campaign was '(t)o ensure that people who are most at-risk of preventable emergency admission to hospital are aware of and, wherever possible, are motivated to take, those actions that may avoid admission this winter' (PHE 2018b). Reasons given for this include easing 'seasonal pressure on NHS services ... to reduce the number of people, who become so ill that they require admission to hospital'. Importantly, these reasons are not included anywhere in the campaign or shared with the general public.

NHS England and PHE have significant resources at their disposal, but their objective of behaviour change in millions of people is quite a substantial task. It requires the public to accept the authority of the NHS, whilst trusting that the advice given is authentic and beneficial. It is also important that the audience understands what they are required to do to become model citizens. With the *Stay Well* campaign the text producers attempt to address each of these requirements via deployment of a variety

of communicative resources, and astutely, to cement these strategies, they also deploy their own staff in front of the camera as participants in the work carried out by the texts. Through analysis of the lexical content and the semantic contribution of what is depicted through each communicative mode employed in the campaign (Kress and van Leeuwen 2001: 21) it was possible to aggregate these meanings into the following four discursive strategies. In order to maintain control of the field of health, the NHS is proactive in **(i) (re-)establishing the authority of the NHS** to give advice and instructions to citizens. They further cement their authority and ensure that it extends to acceptance of a particular set of instructions relating to the target audience by **(ii) developing the authenticity of the *Stay Well this Winter* campaign**, and **(iii) establishing the 'correct' use of NHS services**, particularly in relation to the shielding of busy services. These subsidiary strategies work simultaneously, building up layers of meaning around the texts, and contributing to an overarching strategy of **(iv) constructing the model citizen.**

Discursive strategies are realised in a variety of ways, sometimes through specific linguistic devices, or though semantic choices in non-verbal communicative modes, and also at times through symbolism or semiotic emplacement (Scollon and Scollon 2003: 142) of texts. Although I address the modes and other elements individually, the true picture is an integrated one in which all communicative resources work together in complex ways to achieve the strategic and discursive objectives of the campaign. I give examples in this chapter, identifying a number of salient elements for each strategy, and analysing the ways in which they combine and contribute to semiosis in the example texts. As every communicative mode contributes to several strategies, I address them below under the most apposite heading, and alongside these communicative resources, I also consider the materiality of the media channels used, and the significant polysemous contribution made to the campaign by the inclusion of NHS employees. This campaign presents the opportunity to show how the text producers not only exert their power in discourse (Fairclough 2015: 73) through the content of the campaign, but also use the unique operating position of the NHS to reach the masses, and to wield power over discourse (ibid: 83). Before proceeding with the analysis I provide a description of the texts (Machin 2007: xi).

4.2 Description of the texts

The two texts analysed in this chapter are part of a suite of materials produced for the *Stay well this Winter* campaign, and targeted at people over the age of 65, or younger adults with existing medical conditions:

i) A 30-second TV advertisement titled 'First Signs'.
A copy is provided, see file [1_StayWellFirstSignsTV.mp4)]

ii) An eight-page A5 (210x148mm) booklet with the title *Do you have a long-term condition or are you 65 or over*?
This booklet is attached as Appendix 2.

Supplementary files and information are available, including transcripts of the texts (see Appendix 1). Lines in this leaflet are referred to throughout this chapter as L1, L2 etc., and lines from the advertisement as S1, S2 etc. Background information about the campaign was provided in the Methodology (3.7.4.1) so here I simply give descriptions of the two texts, which will be expanded upon in this chapter as I develop my analysis.

The ***First Signs* TV Advertisement** opens with a scene in a GP's surgery (Figure 10). The GP, Ranjan Dass, speaks from his desk, and establishes whether the viewer is a



Figure 10: Still taken from surgery segment of *Stay Well* TV advertisement showing Ranjan Dass, GP.

member of the target audience by listing the groups for whom the information is relevant. The setting then jumps to a generic waiting room (Figure 13), where a nurse named Kate Bulmer expresses concern that cold weather can *make you more likely to catch a winter illness that could become very serious* (S4). This is followed by the reassuring advice from Mary Oaiya, pharmacist, speaking from behind her pharmacy counter (Figure 14), to 'get help from your pharmacist before it gets more serious' (S6). The threats of serious illness are countered at the end of the advertisement with a very short return visit to Ranjan Dass, who states *We're all here to help you stay well this winter* (S7-8) as the *Stay Well this Winter* logo appears on screen at the end of the advertisement, accompanied by uplifting music. The advertisement text is much shorter than the leaflet and contains only a few specific 'facts' which we must presume, as they have been selected for inclusion, are considered by the producers to be the most important ones.

Although the leaflet is from the same campaign, with the same target audience and has ostensibly the same planned outcome, its content is very much extended. It consists of eight pages. The front and back, and centre spread are printed in full colour, and the remainder of the booklet is in black and blue only. There is a picture of Nurse Cheril Sowell, on the front cover (Figure 11), and a question 'Do you have a long-term condition or are you 65 or over?'. The cover also sports the NHS logo, a *Stay Well this Winter* logo, a statement that the document includes 'some important information from the NHS', and an instruction to share this with anyone else who might need it. Behind these elements is a series of concentric circles in progressively darker shades of blue, which appear to emanate from behind Cheril Sowell's head and reach to the edges of the paper. These circles appear several times in the booklet, and also in the advertisement, where they are animated. Inside the booklet, page 2 introduces the idea that 'winter conditions can be seriously bad for our health', and covers information about immunisations for influenza (flu) and pneumococcal diseases. Page 3 is about keeping warm, and highlights several actions to be taken, with a graphic of a thermometer. Page 4 advises the reader about getting advice from a pharmacist quickly in cases of illness. Page 5 is about medicines, and also includes a stylised graphic of a snowflake, along with more concentric circles. The centre spread of pages 4-5 also features a photograph of Roger Humbles, a pharmacist, placed in the



Figure 11: Front cover of A5 *Stay Well* leaflet.

centre of two blocks of text (Figure 12). Page 6 explains how the reader can 'look out for other people' and instructs in the many ways they should offer assistance to others, and page 7 is headed 'Five things we recommend you do'. It summarises the content of the leaflet into a checklist, with boxes to tick when the items are complete. There are also spaces to 'write down your local pharmacy number' and 'things I need to remember to do for winter', along with more graphics. Finally, the last page of the leaflet contains a list of services which are 'here to help you stay well this winter'.

I now move on to discuss the discursive strategies enacted through the texts in this dataset. I begin my analysis by looking at the first of these: (Re-)establishing the Authority of the NHS.

4.3 (Re-)establishing the authority of the NHS

The first of these strategies is one which must be achieved for all of the others to succeed, namely the legitimisation of authority (van Dijk 1998: 255; van Leeuwen

2007) of the producer, or sender, in this case the NHS. As already established, the NHS wields considerable power in the domain of health, yet this power must be continually re-negotiated and re-established in order to assert the status of the organisation, and its commensurate right to control. I begin by discussing the primary linguistic means by which this power base is secured before moving on to talk about other modes involved in the execution of the strategy.

Much of the power in the campaign is realised through choice of verb forms, as with very few exceptions all 'advice' in the campaign is given through the strong deontic force of the many imperative directives (see Appendix 7). For example, a list on page seven of the leaflet reads:

L63 Make sure you get your flu jab.

L64 Keep your home at at least 18°C (65°F) if you can.

L65 Take advantage of financial schemes and discounts to help you pay for heating.

L66 Visit your local pharmacist as soon as you start to feel unwell.

L67 Look out for other people who may need a bit of extra help over the winter.

Imperatives such as these are at the disposal of those who do not need to use politeness to get things done because of significant social distance (Fowler and Kress 1979: 29). Through its appropriation of this 'order-giving' form of verbs, the NHS demonstrates that it has the authority to issue instructions to the reader or viewer (Fairclough 2015: 83. The Stay Well texts also contain many 'information items' mostly in the form of declarative statements (see Appendix 6), such as:

L7 Being cold can raise the risk of increased blood pressure, heart attacks and strokes.

L38 Pharmacists are fully qualified to advise you on the best course of action.

L55 Icy pavements and roads can be very slippery and cold weather can stop people from getting out and about.

In several cases these instructions and the 'fact' which justifies them, or possibly 'problems' and 'solutions', are organised in adjacency pairs where the information item is followed by a suggested remedy in imperative form, following the pattern:

A: assertion about a presumed issue, or risk (justification, declarative)

B: suggested remedy (instruction, imperative)

For example:

L19 Keeping warm over the winter months can help to prevent colds, flu and more serious health problems such as heart attacks, strokes, pneumonia and depression.

L20 Heat your home to at least 18°C (65°F).

These pairs of justifications and instructions can be likened to the arrangement of content into 'given' and 'new' (Ledin and Machin 2016b: 464), where declaratives represent the 'given' facts of the matter, and imperatives represent the 'new' — or what is to be done because of the 'facts'. Sometimes the order is reversed, with the instruction preceding, followed by the justification:

L26 Wear several layers of light clothes.

L27 Because they trap warm air better than one bulky layer.

Although much shorter, the ad follows the same format:

S4 Cold weather can make you more likely to catch a winter illness that could become very serious.

S5 So, at the first sign of a winter illness, even if it's just a cough or a cold

S6 get help from your pharmacist before it gets more serious.

This directive language aligns the texts with the discourse of the traditional medical interview, rather than the more conciliatory and non-directive 'counselling' style in which patients play a larger part in choices of care or treatment (Mishler 1984; Fairclough 2010: 135). The asymmetric power dynamic in this directive style may limit the healthcare choices of the reader, by allowing only certain courses of action. Pairs such as these are also frequently found in advertising discourse (Cook 2001: 175), where they are used to justify buying choices, and here they are employed in a similar way, in an attempt to influence the receiver of the information to carry out certain actions. Particularly when used repeatedly as in the leaflet text, the 'given' and 'new' pairing also has the effect of simplifying concepts and appearing to present logical solutions out of what is not, in reality, alethic. The claims made and the 'facts' used to back them up are not reinforced by any evidence, references to studies, or examples. This implicit understanding that the source is trusted further endorses the

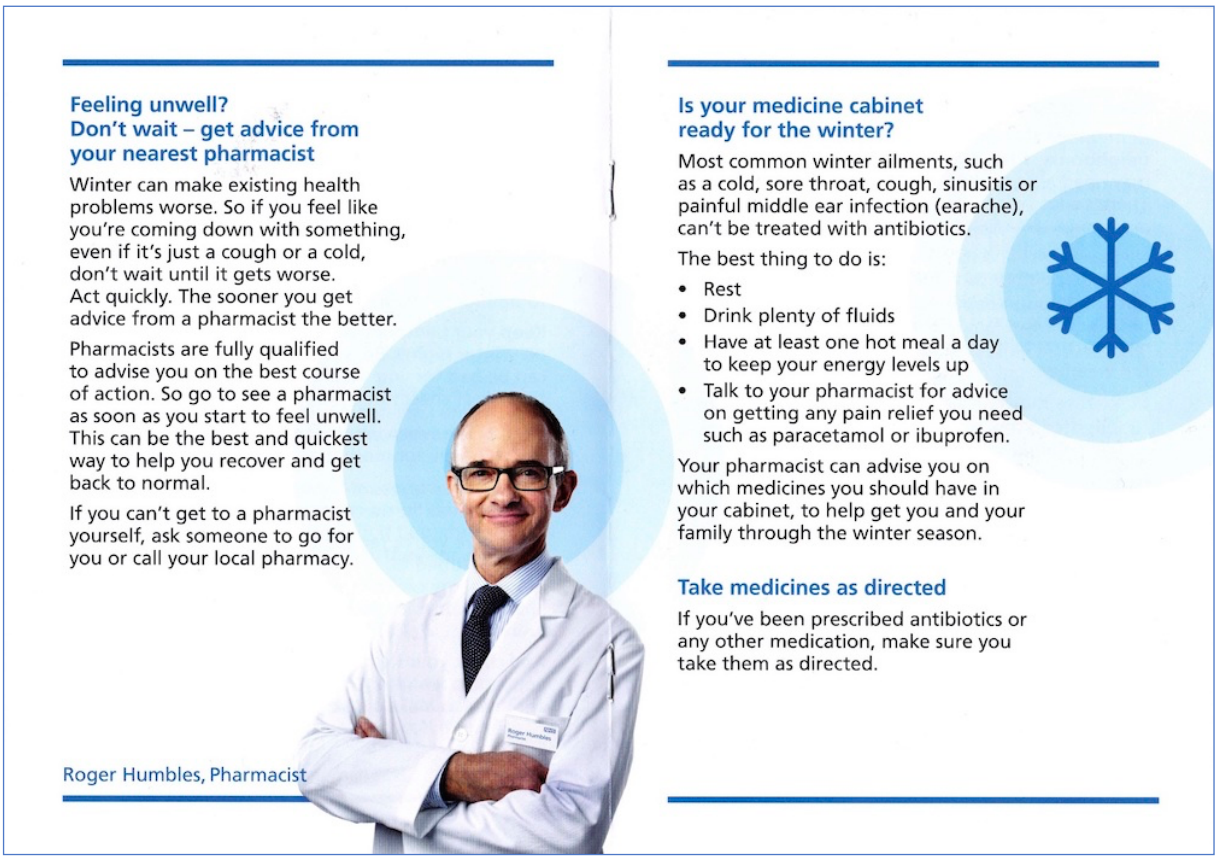


Figure 12: Centre pages of the *Stay Well* leaflet

authority of the NHS, as it is expected that these assertions will be accepted as truth because of the 'impartial' and authoritative source from which they are issued.

The 36 imperatives and 34 information items place an excessive burden upon the reader through deontic obligation, but the NHS also demonstrate their authority to control healthcare in the UK through the form of the campaign. This can be observed in their tight regulation of its visual features, many of which function individually or collectively as semiotic communicative resources. For example, predominant in the campaign, and therefore significant in the NHS's efforts to assert its authority, is the communicative mode of colour which can 'carry a set of affordances from which sign makers and interpreters select according to their communicative needs and interests in a given context' (Kress and van Leeuwen 2002: 355). The NHS brand guidelines state that 'core NHS colours' are 'NHS blue' (Pantone 300) and white. The NHS logo appears in the top right corner of the front cover of the leaflet, as per NHS publications guidance, and is reproduced repeatedly throughout the campaign, always in these corporate colours. This extremely well established and recognised

logo is a trusted 'brand' which brings with it the authority of the medical profession, and also of government. A study commissioned by NHS England in 2015 (Research Works 2016) reported that public and patients found the NHS logo 'instantly recognisable, delivering strong associations with service quality, expertise and accountability' (11) and evoked feelings of pride, fairness and a high degree of respect (15-16). This included the blue and white colour of the logo, which 'brought associations with the nursing uniform, and of calm and cleanliness' (11) and was spontaneously recalled by 87% of people when asked about the NHS Identity (NHS England 2018b).

The NHS brand guidelines also allow four other specific blue shades to be used in publications (ibid.), and all of them appear in this campaign. Looking particularly at the leaflet, the five shades of blue 'rhyme' (Ledin and Machin 2018: 67) with almost every element. On the cover, the nurse's uniform is a much darker shade of blue, but the difference between the two shades is bridged by the concentric circles motif. These circles step through five stages from a shade paler than the NHS logo, to a blue slightly darker than the nurse's uniform. In addition to the NHS Logo, the relatively new *Stay Well this Winter* logo appears on all materials in the campaign. It consists simply of a white box with the words *STAY WELL THIS WINTER*, graduated from NHS Blue through to a dark blue close to that of the nurses' uniforms. Introduced in 2015, *Stay Well this Winter* is one of a limited number of brands developed by NHS marketing teams to group and draw attention to linked issues seen to be relevant to certain audience segments. There are few of these brands because the NHS is aware of the power of its own simple logo (ResearchWorks 2016) and its internal communication guidelines warn against diluting the brand by using a profusion of logos because 'it creates confusion, mistrust and concern' (NHS England 2018b). The repeated use of blue and white, is a powerful cohesive device for the various texts of the campaign and creates a visible association between the NHS logo and the *Stay Well* logo, giving it credence. The graduated tint of the *Stay Well* logo links to other shades of blue in the type and graphics thus contributing to this cohesion. White also plays a part in this cohesion, as the blues which cover most of the front and back covers are broken up by the reversed out white type, rhyming with white piping on Cheril Sowell's dress, and her white badge. The back page is similarly dominated by

blue with white text. Roger Humbles' white coat blends into the white centre pages (Figure 12), and his shirt, tie and badge are all blue and white. On the inside pages of the leaflet 'NHS blue' is used for headings, subheadings, header and footer rules, and sentences deemed to be very important are picked out in bold type and coloured blue, as are graphics the internet references in the text. As the majority of the type is black, the colour draws the eye to these items.

The use of blue and white is also noticeable throughout the TV advertisement. The NHS logo, in a prominent top right corner position, is superimposed upon the picture so that it is, symbolically, the one visibly constant element throughout the whole ad as the scenes change. The logo is small but rhymes with several items in each setting—the blue paper towel, stethoscope and poster in the surgery, Kate Bulmer's dress and the posters and leaflets in the waiting room—reinforcing the presence of the NHS in the text. The final screen features only the colours blue and white and the two logos. Other items in the ad scenes sporting logos, such as medicine packets, are blurred into soft focus so the branding on them is obscured (see also section 4.4). As a result the NHS and Stay Well logos are the only two which can be distinguished, their clear and prominent reproduction signifying to the viewer high modality (Kress and van Leeuwen 2006: 161) in relation to any potentially competing messages. The Stay Well



Figure 13: Still from waiting room segment of *Stay Well* TV advertisement showing Kate Bulmer, Nurse.

this Winter brand name is also used as a slogan and appears at lines 2, 8 and 70 of the leaflet, and in the final line of the ad, reiterating the message and its meaning within the campaign. The long-standing association of blue and white, possibly with health in general, but certainly with the NHS, may also relate to the discourses of 'reflection, science and objectivity', which blue has been used to communicate (Ledin and Machin 2018: 102). The colour blue is important to the perceived neutrality of the NHS, as well as its recognisable brand and is thus 'able to realise discursive meanings which writing or speech could not' (Kress and van Leeuwen 2001: 29). Blue has semantic links to cold, and white to winter, so the designers may also be making reference to these other colour meanings when linking the NHS with winter in a campaign.

Control and consistency, through strictly enforced adherence to NHS corporate style guidelines, are also evident in many other elements of design. For example the only typeface appearing in the campaign is Frutiger, which is used throughout the NHS for publications, but also for hospital signage, stationery, vehicles, and more. It 'is a contemporary and flexible sans serif font, which was designed to be clear and easy to read at a distance and in small sizes' (NHS England 2018b). Frutiger as a semantic choice for the typeface mode operates surreptitiously, and because of its ubiquity becomes unnoticed. It can be said to function in a similar way to naturalised language because although not particularly distinctive, due to its omnipresence it is very familiar to users of NHS services although they may not know it. Its use communicates adherence to NHS policy, and if an alternative typeface was used they would be likely to notice, and may have less trust in the origin of the content, so its presence reassures and quietly contributes to maintenance of the status quo. The concentric circles motif, which may be an attempt to generate some kind of identity for the campaign, possibly disrupts this discursive strategy through lack of clarity in meaning. It is prominent and repeated, indicating that it is likely to be important, and appears throughout the campaign, sometimes centred on the faces of actors, but at other times drawing the eye away from important facts in the text by centring on less important graphics. The intertextuality of the circles creates cohesion between the texts, and because of their prominence the viewer may attempt to attach significance to them, but if they do have a deeper meaning this is obscure. This is, however, but a small distraction from the discursive reproduction of power.

Having considered several of the linguistic and non-linguistic modes which contribute to the re-establishment of NHS authority, I turn now to the role of symbolism in this discursive strategy, and will discuss the methods by which the existential qualities of NHS staff are transformed into a communicative resource to cement the strategy.

Advertisements are populated by a plethora of people who might or might not be real customers endorsing products (Schimmelpfenning 2019), including 'celebrities', who it is sometimes hard to believe, are users of a particular product or service. They also often feature 'health experts' who are so enthusiastic about the products they are advertising, that it is difficult to be sure they are genuine dentists, doctors, etc. The actors in this leaflet and advertisement though, are bona fide NHS staff employed in the roles in which they are depicted, although the settings shown are staged. The main participants were recruited from the NHS workforce to appear in the campaign, and we are told their real names and occupations, via captions on the screen. They therefore represent themselves, but also stand for the whole NHS workforce, and in particular some of the NHS roles that are familiar to the general public. The participants depicted visually in the advertisement are as follows: Ranjan Dass, GP (Figure 10), who wears dark trousers and a light coloured shirt. He is seated at a desk, with his face turned to the right, as if swivelling away from his computer to



Figure 14: Still from pharmacy segment of the *Stay Well* TV advertisement, showing Mary Oaiya, pharmacist.

speak to a patient, and he looks directly into the camera. His hands are clasped in front of him, and as he speaks his face and hands move slightly, in a natural fashion, including slight nods, raised eyebrows, and, at the end of his second sequence, a smile. Nurse Kate Bulmer who, wears a nursing sister's uniform, with name badge, and a security tag (Figure 13) stands in the middle of the waiting room, hands clasped in front of her. Mary Oaiya, Pharmacist (Figure 14), is dressed in a white shirt and smart cardigan, with a name badge. She stands behind a pharmacy counter so we see her from the waist up. She tilts her head to the right a little, and nods and smiles as she speaks. The only other represented participants in the TV ad are two women who appear in the waiting room setting, serving merely to sit in the background of this scene. Unlike many public health films there is no separate voice over in the ad, and between them the three main characters read all the lines in the script.

The leaflet contains two photographs, each of which pictures one member of NHS staff. On the bottom right of the front page, Cheril Sowell, Nurse, is pictured in a close shot, from just above the waist. On pages 4 to 5 Roger Humbles, Pharmacist, is depicted similarly, although he stands with his arms crossed (Figure 12). Again, there are captions to tell the reader the characters' names and job titles, and in the leaflet, these details are also visible on their name badges. The foregrounding of the names and jobs of all these characters makes it clear that they are real people doing real jobs in the NHS, and some participants are additionally identified by their clothing, such as dark blue dresses of a specific type, which are familiar as the uniform of nurses, or the pharmacists' white lab coat. In most contexts NHS staff are positioned as dedicated and genuinely caring about their patients, so their depiction here implies that the viewer can trust the message that these medical professionals are purveying. Not only are the staff included because they are the human face of the NHS, but they are also well placed to explain how to be healthy and how to use services. Importantly however, they also very much represent the authority of the NHS, because this authority is embodied in its medical staff. It is through its workforce that the public interact with and experience the NHS, including its power in relation to themselves (Lupton 2012: 24). These depicted participants are in a position of power because of their status as medical practitioners and their employment within the NHS, and are also positioned as experts who know more than the recipient of the information.

There is little physical movement in the advertisement, with the stillness of the actors contributing to the construction of their professionalism, and avoiding distraction from the message. The single camera zooms in slowly, at approximate walking pace, towards the central actor in each scene, focusing more and more closely upon the speakers, and in particular upon their faces. The GP, nurses and pharmacists gaze ahead, out of the ad and the leaflet, directly into the eyes of the viewer, in what has become known as a 'demand' image. This 'creates a visual form of direct address' (Kress and van Leeuwen 2006: 117) in which a vector is produced between the participants in the image and the real participant who is viewing it, creating a relationship of sorts. The viewer of the advertisement can therefore be considered as a participant in the text (Kress and van Leeuwen 2006:118), and becomes involved in the production of its meaning. Kress and van Leeuwen (2006: 140) have further proposed that the direction of gaze indicates the nature of this relationship, and that in such a demand image, the real participant may be obliged to look either up or down at the depicted participant, depending upon the simulated power dynamic. A patient viewpoint in the GP segment of the ad is filmed with a camera placed at the doctor's head height and angled on a level with him with the viewer looking straight at Ranjan Dass. He is seated, so the point of view must also be that of a seated person. We see his body from the knees up, in a medium shot (Ascher and Pincus 2007: 324) and are drawn even closer in his second segment. The viewer is, therefore, intended to feel that they are close by (Kress and van Leeuwen 2006: 124-126) probably sitting on a chair next to the doctor's desk, as in a typical GP appointment. This 'point of view' camera angle, a type of shot used by filmmakers to show the vantage point of an actor in a narrative (Ascher and Pincus 2007: 324), is used so that imagined participants, the viewers, can picture themselves interacting face to face with a health professional in a medical encounter. The other two settings involve slightly longer shots, but again the viewer is positioned at eye level with the speakers Kate Bulmer and Mary Oaiya. The point of view here imitates the viewpoint of a participant, a patient or customer, walking towards each actor who, perhaps we can imagine, is a busy NHS worker taking a few moments out of her day to give us advice. Alternatively we can view this as a potential 'site of engagement' (see 2.5).

In the leaflet, the nurse gazes directly at the reader in another demand image, as does the pharmacist. These demand images mimic direct one-to-one contact with health professionals, the eye-level camera angle indicating, according to Kress and van Leeuwen (2006: 140) that 'the point of view is that of equality and there is no power difference involved'. However, as I have already argued, a power imbalance is realised in the verb forms of the texts. Although the camera angle indicates that the power position of the viewer is equal to that of the professionals this is clearly not the case, and it could be said that the viewer is being misled by the producers. Later in this chapter I refer to Fairclough's (2015: 205-206) notion of synthetic personalisation, which he explains as a discursive practice intended to give the reader the impression that there is a reduced power imbalance between the sender and receiver of information, and to deceive the receiver into thinking that they are on an equal footing with the writer. The representations of equality here can be seen as a visual form of synthetic personalisation, wherein an artificial relationship with depicted characters is developed. The realism of the encounter, particularly in the film, but also to some extent in the leaflet, is intended to persuade the reader that they are on an equal footing, when, for reasons I have already discussed, they are actually in a subordinate position in relation to the medical professionals.

Authenticity is an important theme in this campaign which I will explore in detail in the next discursive strategy of **Developing Authenticity**. In relation to the NHS actors, I have already discussed several factors which contribute to their authenticity, and hence to their symbolic power. This authenticity also extends to the (stereotyped) demographic mix of the participants with both genders, and a mix of ages, ethnic backgrounds, and regional accents represented. The text producers have been careful to index diversity in the staff of the NHS and indeed the population of the UK, in their choice of actors, who are likely to be seen as typical NHS staff. In addition to their visual appearance the actors' voices demonstrate to the listener, not only that they represent the whole NHS workforce, but also that they are more like him or her than members of 'the Establishment', who might be represented by a middle class white man in a suit speaking in Received Pronunciation. This is another modality marker, demonstrating that the workers of the NHS are drawn from across the UK and beyond.

The deployment of these staff in the campaign is powerful and semiotic on many levels, and they can almost be seen as a 'secret weapon' of the NHS. Although we know the names of the characters, and they are indeed genuine NHS staff, they are presented to us as idealised representatives of the NHS workforce, stereotyped and iconic. This is done to win the trust of the reader, and to place them in a defined subject position as the patient in a medical interaction (Fairclough 2015: 78). The choice of real NHS workers to front the campaign augments the deontic force of the instruction to *get help from your pharmacist,* increasing the modality of the script (Kress and Van Leeuwen 2006: 155). This is not just because the actors are able to look and speak with the humanity and demeanour of medical staff, but also through the viewers' understanding that the messages are endorsed by people working in professions considered to be trustworthy (Goffman 1981: 147), and whose instructions the citizen is accustomed to obeying. These staff are not speaking their own words however, but are the 'animators' of a script, or bluntly put, the 'sounding box(es) in use' (ibid.: 144). Their message is the message of the establishment, albeit delivered by the friendly face of the NHS.

4.4 Developing the authenticity of the *Stay Well* brand

I have shown that the NHS uses certain communicative modes in re-establishing its authority to advise and instruct the public and I now move on to the second discursive strategy of Developing the Authenticity of the *Stay Well* brand. These first two discursive strategies are closely and dialectically related, and repeatedly reinforce each other, in particular through the presence of NHS staff, already mentioned. As I will show below, authenticity is also used to reproduce and reinforce power relations between the citizen and the NHS. With *Stay Well this Winter*, the NHS are attempting to establish a regular campaign which can encompass a number of ideas, such as encouraging the uptake of flu vaccinations and early treatment of symptoms, to effect a reduction in the number of emergency admissions to hospital. To ensure that *Stay Well* is a trusted and believable brand which delivers relevant messages to its target audience, several communicative resources are mobilised, and the strategy is enacted almost entirely through non-verbal modes. It is mostly

concerned with building a relationship with the reader, that will allow for acceptance of the correct use of services and shaping of the citizen.

Important to this strategy of authenticity in the campaign are the audio modes of voice and music. In addition to the accents already mentioned above, the inclusion of authentic NHS staff brings to the TV advertisement all the paralinguistic qualities of the voices of the speakers, including warmth, reassurance, familiarity and concern. As with such modes as colour, there is no fixed meaning that can be attached to a particular voice quality, yet such attributes are undeniably semiotic (van Leeuwen 1999: 129). The social or physical distance indicated by the voices also reinforces the positioning of the viewer as a patient listening to each speaker. The speakers' register is one of quiet concern, as if having a private conversation with the listener; they each talk slowly, quietly and calmly, with authority and without hesitation. The speakers enunciate carefully, to make their voices clear to older listeners who may have hearing difficulties, although this overt effort at audibility may be interpreted by the audience as patronising register, as it can mimic the way adults sometimes speak to children. The voices are smooth and relaxed, with the exception of Kate Bulmer's words *sign of a winter illness* (S5), for which she increases the tension in her voice (ibid.: 131), speaking more loudly to draw attention to the importance and urgency of the phrase. After this, the return to soft, slow and relaxed speech by Mary and Ranjan is an audible signal that despite the risks, there is no need to panic and all the citizen needs to do is follow advice in order to be well.

Although the script is short, it contains a question, a warning, advice and reassurance. These allow the actors to use modulation effectively, and to introduce the realistic 'bedside manner' in which medical professionals are practiced. Although he refers to sound fluctuation as a signal of modality, Van Leeuwen (1999: 175) does not discuss this feature of speaking, and refers to voices as if they are constant. It is, though, a marker of humanity, and makes another contribution to the realism of the scenarios in the ad. The voices do not seem in any way forced or false; indeed at certain points the GP and Nurse speak in a slightly stilted manner indicating, perhaps, that their words do not come naturally and that they are reading a script. Unusually for actors, this increases their modality because they become more obviously NHS staff than professional actors. The connotations of these voices are an important aspect of their

meaning, and listeners' perceptions of the truth of the message will be calculated in part on the modality of the voice (ibid.: 141).

Music is another communicative mode which, particularly because of its 'simultaneously powerful but indeterminate' (Cook 2001: 51) affordances in meaning-making, is used so often in TV advertising. The ad has a background music track which starts very quietly as a sequence of regular strummed guitar chords, at a low pitch, with a little harmonic detail of individually picked notes. As Kate Bulmer begins to speak, a keyboard instrument is added, playing a simple, repeated melody in the same key, and the music becomes slightly, but noticeably, louder. In Mary Oaiya's segment, more instruments are added to create an orchestral sound, including a crash of cymbals, with the volume again increasing in relation to the voice of the speaker. Finally, just before, Ranjan Dass' second appearance, (at 0.21), the pitch, which has remained low and constant throughout, rises in a triumphant crescendo, before descending to a slightly lower pitch and ending on a single note played three times as the final screen is displayed. In his last sentence the rhythm of the music is synchronised with Ranjan's speech. He slows his speech to a slightly less than natural speed to coincide neatly with the final notes, so that these two audio modes resonate together with visual modes, and reinforce the words in the *Stay Well this Winter* logo which simultaneously appear on screen.

The music serves several purposes, providing continuity between the scenes as they switch from each location to the next, in the same way that colour runs throughout the leaflet. It also probably contributes background noise to compensate for the absence of naturally occurring sounds in the depicted settings. Although the music does not make a major statement as it is 'quite subtle and nondescript' (Ascher and Pincus 2007: 636), in this ad the steady and repetitive beat could be seen as a metaphor for the continuous work of the NHS and reiterates the calm steady voices of the participants in reassuring the listener, possibly mitigating the fear-inducing discourse of the script. Van Leeuwen (1999: 92) has described 'sound acts' as the sonic equivalent of speech acts. The raised pitch and volume, accompanying Mary Oaiya's smile and the assertion by Ranjan Dass that *we're all here to help you stay well this winter,* and the crash of symbols could be seen as such. They fashion the NHS staff as the triumphant heroes of the ad, and the uplifting end to the music subconsciously

signals a conclusion and happy ending. It is likely then, that this music, however innocuous, communicates with us on a subconscious level. In this text it also contributes to commercial production values, turning a public health message into an ad because it creates intertextuality with the consumerist texts of TV advertising, and forging links with capitalist discourse.

As the receiver hears the text other stimuli are added multimodally. The realistic settings for the TV advertisement are another contributory factor towards authenticity in this campaign. The scenes are set in generic health locations representing places likely to be familiar to the UK television viewer: a GP's surgery, an NHS waiting room reminiscent of those found in hospitals and clinics, and a pharmacy counter. The first and last scenes are set in Ranjan Dass' surgery (Figure 10). On his desk are a computer, and a stethoscope—the tools of the trade of the modern GP—and he is surrounded by various trappings often observed in such places. For example there are charts and NHS posters on the wall, a trolley with dressings and packs of disposable gloves, an examination couch, a telephone, personal touches such as a coffee mug, to remind the viewer of his humanity, and other props which create a realistic impression of the location. We can tell that the setting for Kate Bulmer's segment (Figure 13) is a waiting room because there are people waiting, but there are also chairs and a small table, signs and notices, and an electronic display giving the name of the next patient and the doctor they are seeing. We also see a water cooler and a painting, and there is intertextuality here too, as copies of the *Stay Well* leaflet are displayed on the reception desk in a dispenser (at 00:19), and a poster featuring Cheril Sowell is on the wall along with other posters from the *Stay Well* campaign.

The setting in which we find Mary Oaiya is a pharmacy (Figure 14). She stands behind a cash register and a wide counter, surrounded by shelves filled with packets of medicines and the small bags used for dispensing medicines. Again, this is likely to be a familiar encounter for many adults. All of the settings have bright and naturalistic lighting, with typically institutional, neutral-coloured walls and other surfaces. These settings increase the modality of the simulated encounters with the NHS participants by adding another layer of realism and providing the characters with context. In combination with the modes already mentioned their authenticity is intended to

evoke recollections of encounters with nurses, doctors or pharmacists. Kress and van Leeuwen (1996: 166) list 'representation' as one of the 'key markers of visual modality' meaning that more detail increases credibility, whereas more abstraction allows for doubt to be introduced about the reliability of the message. The generic settings contain enough props and medical references to enable us to recognise what they are, without needing to know their exact location. They could be described as stereotypical settings for health encounters in the same way that the characters found in them are stereotypical NHS workers. Like the staff featured, all the settings are clean, tidy and modern. This is an idealised and iconic NHS, and we see only the relevant part of the setting in which the speaker is placed, from the point of view of the patient or customer—for example just the pharmacist's counter, not the whole shop.

The scenes are filmed in realistic full colour with a shallow depth of field, so that the characters in the foreground are thrown into sharp focus, whereas, as I have said, the backgrounds, whilst recognisable, are slightly less clear and somewhat fuzzy (or abstracted). This technique is used by filmmakers to direct the attention of the audience towards certain objects of the screen, and away from others (Ascher and Pincus 2007: 86). The effect is such that the character in the centre of each scene has the highest modality, along with the NHS logo, making it clear to the viewer that although they contextualise the speakers, the settings are less important than the characters. In combination with the vector connecting the actors' gaze to that of the viewer these settings bring medical locations into the home via the TV set, taking further the concept of synthetic personalisation by placing the reader or viewer in a simulated setting in which a conversation might take place with a real health professional. Although the scenarios are presumably intended to help the viewer feel that they are in a familiar and unthreatening location, they also depict and represent sites of medical encounters in which they, imagined as participant, are subject to medical power (Lupton 2012: 96).

Bringing the GP's surgery, waiting room and pharmacy counter into the living rooms of the nation as part of a multimodal discourse, and simulation of a medical encounter, ensures that the medical professionals depicted can act upon the recipient in the home, exercising power in a location where the citizen usually has some

authority. This TV ad can therefore be seen as an encroachment into the private space by the NHS, or an expansion of its realm of control. Conversely, the leaflet appears not to continue this authentication of settings. In it the actors are photographed in full colour, and with good studio lighting, achieving similar effects to the advertisement participants, but they are decontextualised from their workplace settings. Several locations are referred to in the leaflet, including pharmacies and other NHS services, as well as the reader's home, and presumably it would have been possible to photograph Cheril and Roger in NHS locations like the staff in the film, but this is an unexplained inconsistency in the campaign.

4.5 Establishing the correct use of NHS services

Moving on from the multimodal strategies of authority construction and authenticity building, in this section I show how the correct use of NHS services is established as a discursive strategy in the *Stay Well* campaign. Although they are purportedly about staying well, the texts can be more accurately described as belonging to a discourse of illness. The leaflet contains many names of diseases and conditions, as well as negative expressions such as *aggravate, serious, painful* and *life-threatening* which dominate the text. In contrast, the only terms relating to healthiness, apart from *stay well* are *recover and get back to normal* (L41). According to this campaign, being over the age of 64 automatically places citizens into a category of people who are vulnerable to certain dangers, along with people of all ages with a wide range of medical conditions. Particular threats emanate from *winter conditions* (L5), *Winter* itself (L34), and *being cold* (L7), which also have agency and can affect body and mind. *Cold and damp weather, ice, snow and high winds* (L6, S4) and *breathing cold air* also pose risks. The hazards involved range from the mild *bad for your health* (L23) and making us *more vulnerable to illnesses* (L6), to the *risk of increased blood pressure, heart attacks and strokes.* (L7) Flu takes the danger to a new level, we are told, as it *can lead to serious complications such as bronchitis and pneumonia, and it can be deadly* (L11).

Several lines on page 2 are concerned with persuading the reader to have an influenza vaccination or 'flu jab', with the added incentives that it is free of charge,

and simple to arrange — 'just speak to your GP' — although no other suggestions for avoiding flu, or reducing its spread are given. As an effect of these discourses of winter and illness the many instructions in the texts are transformed into a fear-inducing discourse and, combined with neoliberal notions of risk control (Rose 2007: 70 - 73), become akin to warnings. The construction of citizenly behaviour here includes to some extent the sanctions on those not following the official advice. If the various tasks are not completed then the reader becomes *more likely to catch a winter illness* (S4), thus encoding failure (Johnson and Murray 1985: 152) and allowing for blame to be attributed to the citizen if they have become ill.

From these texts though, emerges an unlikely new hero to assist the reader. In addition to the named NHS staff pictured in the leaflet several other NHS 'actors', with whom the reader is expected to interact, are invoked through exophoric reference. These include GPs, nurses, hospital specialists and NHS 111 call advisors, but by far the most frequently mentioned, with more than double the total mentions of all the other health professionals, are pharmacists. Formerly understood to be qualified specialists in medicines, in the *Stay Well this Winter* campaign pharmacists are reinvented as the first port of call for many areas of healthcare. The level of repetition clearly indicates that the reader is being diverted to them, rather than other NHS services. The reader is told that pharmacists are not only *able to advise you on which medicines you should have in your cabinet* (L49), but also *fully qualified to advise you on the best course of action (L38),* and *highly trained healthcare experts on everything from colds to long-term conditions* (L76). The importance and status of pharmacists is augmented in the text; the reader is exhorted to *go to see* (L39), *get to* (L41) *visit* (L66) *call* (L41) or *ask* (L75) a pharmacist, as well as writing down the number of the local pharmacy (L68). However, very limited claims are made about the services they can actually provide. They give *advice* (L33, L37, L48,) or *advise you* (L38, 49) and in the TV ad, the very generic *help* (S6, S7), which in this context is likely to be a synonym for advice.

Advice, here, is constructed as a kind of commodity which changes hands. It is already in the possession of pharmacists, and is needed by the recipient of the information who is instructed to obtain it. As the directions to seek advice are so prevalent in this campaign it becomes a critical aspect of self-care, and those not complying again

leave themselves open to be blamed, not only for getting ill but also for not obtaining advice before taking action. There is also a focus on speed. Readers are urged:

L33 Don't wait - get advice from your nearest pharmacist

L37 The sooner you get advice from a pharmacist the better.

L39 go to see a pharmacist as soon as you feel unwell

S6 Get help from your pharmacist before it gets more serious.

Of course, urgently contacting a pharmacist might be the right course of action, but most pharmacies are only open during normal shopping hours. An anxious citizen struggling with symptoms at night may be faced with a dilemma about appropriate use of NHS services as it is unlikely that an emergency duty pharmacist could be called out for *just a cough or a cold* (L35, S5). This promotion of pharmacists by NHS agencies is part of a neoliberal discourse of productivity in which health services are viewed as 'economic units' which must be used to maximum efficiency (Pollock 2005). This ideology allows pharmacists to be viewed as an underused resource, and GPs and A&E departments as overused ones, justifying the redirection of patients to pharmacists, whether or not this is the most appropriate service.

In addition to expertise, the properties of pharmacists and pharmacies which are stressed are semantically linked with nearness and belonging. Of the 13 occurrences of *pharmacist(s)* and *pharmacy* in the text, eight collocate with the possessive *your,* and three also collocate with *nearest* or *local.*

L33 get advice from your nearest pharmacist

L66 Visit your local pharmacist as soon as you start to feel unwell

The repetition of these terms implies a sense of belonging and encourages the idea that going to the pharmacy is the easiest option because it is nearby. The collocates also suggest a welcoming place which is part of the community, and perhaps indicate that the reader should develop a relationship with a pharmacist. This is reinforced multimodally through the facial expressions of the actors depicted in the campaign, in contrast with the more neutral or solemn expressions of the nurses and doctor. Mary Oaiya the pharmacist is particularly welcoming with her smile, quiet voice and

reassurance that you can 'get help from your pharmacist', and Roger Humble, the pharmacist in the leaflet, also sports a broad grin. There is a sense though, that the movement of the citizen is being curtailed. Most of the information and advice is oriented around the home, with references to various rooms in the house. To *Stay Well* the model citizen must maintain a stock of medicines to get them through the winter (L49) and when ill must treat themselves by resting, drinking fluids and eating a hot meal every day (L45-47). This depiction of home-based self-care as correct behaviour appears also to be part of the plan to keep the citizen at home, venturing only as far as their 'local pharmacy', and well away from the A&E department.

Pronouns in the texts also play a part in the construction of correct behaviour for the citizen. In the ad, and most of the leaflet, the audience is addressed directly with the pronoun *you*. Used repeatedly, and in combination with the demand images of the campaign, *you* involves the recipient in the texts so that they become a participant, and can be acted upon by the depicted actors. Fairclough (2015: 205-206) has noted that this aspect of synthetic personalisation is common in communications from public authorities to citizens, and I have already highlighted a multimodal equivalent in the 'point of view' filming and photography of the campaign. Whilst the footing of the reader as *you* remains relatively stable throughout the texts and occurs many times, along with the possessive *your*, this is not the case with the first person pronouns *us* and *we*, and *our*. These are used very sparingly, with *we* appearing only once in each text:

S7 We're all here to help you

S8 stay well this winter.

L62 Five things we recommend you do:

Us and *our* also each occur once, and only in the leaflet:

L5 Winter conditions can be seriously bad for our health

L6 The cold and damp ...make us more vulnerable to illnesses ...

These second person pronouns are of importance as their meanings are not fixed, and '(t)here are few words in the language that may be as socially and ideologically "loaded" as simple *we*' (van Dijk 1998: 203). In line S7 of the ad *we,* spoken by Ranjan

Dass could indicate the three depicted participants, but as they are representatives of the wider NHS and its workforce, it is most likely to imply 'we the NHS', or at least 'we the doctors, nurses and pharmacists of the NHS'. At L26 of the leaflet, *we* may have a similar meaning, although as it is printed rather than spoken, it could be taken to mean 'we the writers of this booklet' or 'we the managers and policy-makers of the NHS'. *Us* and *our* in L5 and L6 of the leaflet refer to a completely different and inclusive 'we, the recipients of this campaign' or even 'we, everyone'! These fluid pronouns, with which 'group identity, identification and ideology' are closely intertwined, allow the text producers to manipulate and position the reader into and out of groupings of participants (ibid.: 119) in relation to the NHS. This meaning of *we* is reinforced through the form of the advertisement, in the turns of the actors, who pick up and continue each other's narrative. However the message that *we're all here to help you* is contradictory as the only option given is to *get help from your pharmacist.* Implied in the ad is that there is agreement between all of the professionals, who are united in purpose, chorusing that *you* must go to a pharmacist. An alternative reading of this campaign is that there is no choice, and no escape from this discourse of individualistic health. If the GP, the nurse and the pharmacist collude, telling the reader to get a flu jab and ask the pharmacist for advice, then it is difficult to argue that one might really need a GP appointment, or might really need to go to A&E. For the viewer this could mean that trying to see a doctor, or attending A&E will be a hopeless trip as they will not be seen but will be sent to the pharmacist instead.

Aspects of the leaflet layout contribute to the establishment of correct use, and link the texts to a neoliberal discourse of preparedness. The lexical attempts to focus the mind of the reader upon planning, organising and risk management are augmented through lists of tasks with bullet points or checkboxes, which 'claim to present the core details of a process' (Ledin and Machin 2016b: 454) by simplifying tasks down to a few words. On page 7 the user is entreated to interact with the leaflet by recording a plan for staying well. A checklist of recommended actions, boxes to tick and blanks to fill, are provided to assist the citizen to manage the project of their own health. Here, the reader may add further tasks to those already allocated to them, and produce in their own words, their personal script of model citizenship. Such lists organise and

break down the required actions, suggesting that they are discrete and straightforward, and linking the content to business or project management discourses (Ledin and Machin 2016a: 9) and hence to the commercial world. Apart from pharmacists, NHS services that the reader can use to 'stay well' are not described fully in the leaflet, but are mainly confined to a list on the back page, and their use only permitted in certain circumstances. If, for example, one has *minor illnesses and injuries* it is possible to *visit a walk-in centre*. GPs, usually thought of as the first port of call for non-emergency healthcare (Talbot-Smith and Pollock 2006: 49), are briefly referred to on page 2 of the leaflet. But they are not mentioned again until the last page, where they are relegated to fourth on the list of people and places to contact for help with staying well.

Lists such as the one on the back cover offer certain affordances to the text producer (Ledin and Machin 2015: 469) and can be used in manipulative ways, often appearing in texts associated with neoliberalist discourses (Ledin and Machin 2016a). The ordering of items in this list is a subtle attempt to influence the reader away from emergency care, and also away from their GP, presumably because GPs are also reportedly 'overloaded' (Reynolds 2018). The items on the list are presented as equivalent to each other and discrete, suggesting that the reader has a range of options. The list is not numbered, and there is no statement that the actions thereon should be considered in a certain order, yet they are organised from top to bottom in order of increasing cost to the NHS, with *Call 111* placed at the top and A&E at the bottom. Because lists generally work in a vertical fashion, and would usually be read from the top, this can be seen as a deliberate ploy to influence the order in which the reader will consider using these services. Further, the conditions placed on usage of the listed services limit the choice, and the reader must make decisions based on the information provided, which is heavily skewed away from A&E services and towards pharmacists.

A striking feature of this campaign 'aimed to ease seasonal pressure on NHS urgent care and emergency services' (PHE 2018b) is the almost complete ellipsis of emergency services from it. The aims of the campaign include reducing the number of unnecessary visits to A&E, but the public watching the ad or reading the leaflet are not told this. The emergency telephone number 999 does not appear at all, and A&E

departments are underlexicalised, appearing only once, in the very last paragraph of the leaflet. Neither service appears in the script of the ad. When mentioned, it is in the context that the reader is unlikely to be in genuine need of emergency services:

L82 A&E departments.

L83 They're for life-threatening emergencies.

L84 But if you're not sure whether it is an emergency, call 111 first.

The strategy of establishing correct behaviour in relation to A&E appears to be to deflect people away from this service by almost ignoring it. Rather than explaining the concerns about pressure on A&E, and clarifying when it *should* be used, the writers have presupposed that the reader is likely to misuse the emergency services, and also that they are unlikely to know what constitutes an emergency. This strategy of establishing correct use works to constrain the actions of the reader through direction to pharmacists but also through the omission of other relevant information.

So we can see that this strategy to establish the correct use of NHS services is achieved not only through the previously mentioned instructions in the leaflet, but also through fear inducing discourses of illness and winter, and through overlexicalisation of the benefits of consulting pharmacists, who are developed as a major source of help through linguistic construction of their expertise. As choice is a main tenet of neoliberalism (see 2.3.4.), including the freedom to choose and determine one's own future, readers are led to believe that there are many sources of medical help available to them, whilst they are manipulated into 'choosing' to stay close to home and seeking advice. Common sense 'is not something rigid and immobile but is continually transforming itself' (Gramsci 1971: 326), and actions relating to self-care are presented in this campaign as common sense with little or no evidence of their effectiveness. Critically, what counts as common sense is open to manipulation in order that the ideologies of the elite can be accepted by the masses (Fairclough 2015: 14), and the necessity of compliance is encouraged through exaggeration of the 'harms' caused by winter weather.

4.6 Constructing the model citizen

So far, I have explained how layers of meaning are built up in the texts through three discursive strategies, but I view these strategies as supplementary to the ultimate aim of the campaign which is to produce a citizen who behaves in a certain ideal way. It is only when the framework of these strategies is in place that the model citizen can be formed, as citizens must learn to respect the authority of the NHS, recognise that the *Stay Well* campaign is a trustworthy representation of the truth published by the NHS, and also understand the correct way to use NHS services. Production of the correct subject position for the model citizen is important so that the NHS can implement its policies in the desired way, so I now discuss the means by which discourses are deployed and combined to shape the model citizen.

In section 4.3 I focused on the imperative framing and paternalistic nature of instructions and advice given to the reader, and I return to them here to examine their subject matter. The ad contains only one health-related instruction, but the material qualities of the leaflet afford space for much more linguistic content. As a result, we can see an example of the divergence of meanings in the two texts, and although it purports to be about staying well in winter, the leaflet directs its audience on a much wider range of topics. Advice from medical sources is usually representative of the dominant biomedical norms (Mishler 1984: 63), and medical discourse appears throughout the leaflet, but when it comes to illness-prevention advice the medical terms are outnumbered by non-medical terms, including colloquial expressions such as *bad for your health* and *coming down with something.* Many of the instructions in the leaflet would not normally be associated with healthcare at all, and certainly without any substantiating evidence might appear more like 'lay' advice than medical wisdom, yet they are included in a list of duties the model citizen must make sure they have completed. For example, the leaflet explains how to dress warmly:

L26 Wear several layers of light clothes.

L58 wear ... a scarf around the mouth

and other ways to keep warm such as:

L24 Keep active when you're indoors.

L25 Don't sit still for more than an hour or so.

The leaflet also includes instructions on using heating systems, including energy efficiency and gas safety, and even debates the temperatures that the reader might prefer in various rooms of their house:

L20 Heat your home to at least 18°C (65°F).

L21 You might prefer your main living room to be slightly warmer.

L22 Keep your bedroom window closed on winter nights.

The issuing of all of these pieces of advice is predicated on the assertions that keeping warm 'can help to prevent' the serious conditions that being cold can cause. This medicalisation (Conrad 2007: 3) of temperature management by PHE and NHS England is just one example of health colonising tangentially related discourses (Brown and Baker 2013: 114), and evidence that the remit of health promotion is continuing to expand. No explanation is given for the inclusion of these particular pieces of advice rather than others, but the text producers have used their position of power to select topics and classify them as 'health' information, controlling the order of discourse (Fairclough 2015: 60) and claiming these formerly non-health related discourses as part of their 'domain of relevance' (Mishler 1984: 70). The production of the model citizen relies upon the obedience of the reader in following the advice and information of health professionals in order to stay well, but apart from the repetition of some 'facts', such as the importance of acting quickly (L34, L35, L36), there is no attempt to identify for the reader which of them are the most consequential for wellness. Even when they fall within this newly expanded canon of health topics, close links are forged between health and obedience of the instructions. Not only will the reader who has not had a flu jab invite blame because they have knowingly increased their risk of getting ill (L9-11) (Webber et al. 2015: 6), but likewise they will also now be implicated in the cause of their illness if they have allowed their heating to break down (L29 -31).

Conflicting discourses relating to the mental processes of the reader suggest that the footing (Goffman 1981: 128) of the model citizen in the campaign may be

problematic. In places the leaflet text suggests that the recipient is a capable adult who has a good appreciation of social interactions such as health encounters. It is presupposed that the reader understands the science of vaccination, can take responsibility for their own household, and is able to interact with a multitude of organisations and their websites. Evidence for this can be found in the tasks required of the citizen. For example they are viewed as able to undertake intellectual work such as learning, and developing their financial acumen:

L29 learn how to make your home energy efficient

L65 Take advantage of financial schemes and discounts to help you pay for your heating.

This can be contrasted with other lines of the text where the reader is seen as ignorant of even the most rudimentary measures needed to keep warm and cope with winter weather. They need training in how to avoid illness, and are, unsure or untrustworthy in regard to use of NHS services, and in need of reassurance. The reader's capability to perform simple actions is doubted, and their modality as a competent adult, particularly when relating to intellectual actions is reduced by the inclusion of such uncertainty markers as *remember*, *check* and *try not to*. Table 2 lists all of these uncertainty markers, with the most prevalent *make sure* applied to seven actions, including *Make sure you get your flu jab* and *make sure you take* (medicines) *as directed*, with this verb phrase implying that the reader might forget or easily be

Table 2: 'Uncertainty markers' in the leaflet text

make sure	L9, 28, 31, 51, 57, 59, 63
learn	L29
check	L30
remember	L53, 69
don't forget	L16
But if you're not sure	L72, 84
try not to	L25
might	L3, 21
write down	L68
if you can	L64
if you can't	L41

distracted. *If* and *might* also put in appearances, among other terms indicating that actions may not be carried out.

These uncertainty terms are another indicator of the power imbalance between the writer and the reader, who is presumed to know very little. The implication is that the actions of the reader, as encoded by the writer, carry a lower modality than those of the medical professionals (McIntosh 2014). Doctors in the leaflet don't *try to* give flu jabs, and pharmacists do not *make sure* they offer advice. These terms are reserved for the actions to be taken by the reader, whom, the writer suspects, is unsure or hesitant, relying on feelings rather than knowledge:

L84 But if you're not sure whether it is an emergency, call 111 first

L35 if you feel like you're coming down with something

The frequent references to not forgetting and making sure, along with instructions to carry out simple tasks, construct the perceived reader to be an adult with unreliable memory or reduced mental capacity. Some of the instructions, such as *take prescription medicines as directed* (L50, 51) are particularly patronising. The switch to the first person in line 69: *Things I need to remember to do for winter*, is reminiscent of instructions given to primary school children, and the verb constructions diminish the power position of the reader, who is belittled and positioned as ignorant, forgetful and unable. Elsewhere in the text the imagined audience are assumed to be badly informed:

L10 The flu virus ... can be far more serious than you think

L43 Most common winter ailments, such as a cold, sore throat, cough, sinusitis or painful middle ear infection (earache), can't be treated with antibiotics.

Lupton (1995: 120) describes a similar construction of subjects of health promotion as less privileged than those who hold the information, with the subject treated like a child 'needful of training to become a citizen'. The ad and most pages of the leaflet construct a citizen who needs help and advice in order to survive.

Presuppositions of ignorance are applied to the reader, but in addition, a discourse of uncertainty pervades the whole campaign. Non-specific phrases such as *long-term condition* and *all the help you are entitled to* do not appear to contribute any accurate information, and beg further questions about their meaning. *Coming down with something* (L35) and *feeling under the weather* (L56) are clichéd metaphors, and probably contribute to rapport-building with the reader, but are unhelpful and vague for a person attempting to decide whether their illness is severe enough to warrant seeking help. It can be seen that this campaign foregrounds its intended readership as older or made vulnerable to serious illnesses through a pre-existing health condition, but encodes a number of presuppositions about them, including their knowledge, understanding and resources. The prevalence of such discourses demonstrates that age and disability are conflated with ignorance, uncertainty and senility in the minds of the writers. The campaign projects a sadly non-progressive stereotype of adults who are older or disabled as lacking knowledge and initiative, and dependent on advice, without which they are unable to act. It is likely to offend some, and may render this model citizen construct less useful. Indeed, comments from the public added to online press releases from PHE about *Stay Well this Winter* bear this out (see Appendix 8). Although they do not point to specific language features, the general themes are very similar to those raised above. Several respondents were offended or angry at being patronised and demeaned, and treated like children or 'imbeciles'. One called *Stay Well* 'the most offensive and patronising NHS campaign to date', and another described it as a 'self-righteous, mish-mash of verbiage'. Others took issue with the accuracy of the 'facts' in the campaign, or cautioned that bad advice, or not enough detail to be useful was being given. Two writers attempted to raise the issue of poverty and its negative impact on health, including one who said that 'a lot of us who are chronically ill are not able to heat our homes at 18 degrees… We can't afford to!' Two also brought up limitations on access to NHS services.

The NHS has delineated the target audience of the *Stay Well* campaign so in this case it is only those targeted sectors of the population who must conform to this version of the model citizen. In the advertisement, and until page 5 of the booklet, the subject position of the reader is that of a vulnerable adult who is over 64 or has a long term condition. However, on page 6 (L52 - L59) an intriguing change takes place, in which

the reader becomes enlisted as a volunteer for the *Stay Well* campaign and instructed that they should provide help to *people who are more frail than you*. Entitled 'Look out for other people', this section puts aside previous notions of self-care, and engages instead with a discourse of caring for others. The footing of the reader switches from vulnerable and passive recipient of services and information, to capable care and support provider. Still addressed as *you,* the reader is instructed to carry out a range of tasks for other people, who could be neighbours, friends or family members (L53). These include offering practical help and emotional support (L56), ensuring that they have enough food in the house (L57), encouraging them to *wear shoes with a good grip and a scarf around the mouth* when going outside (L58) and making sure that they have collected their prescriptions (L59).

Having read the leaflet, the citizen appears to be newly qualified to give advice so should share information with 'anyone who might find it useful' (L3), but bearing in mind that this campaign is aimed at the over 64s and those who already have a health related condition, the list of tasks is rather strange. There is plenty of mention of giving help to other people, but no suggestion that any of this help will be reciprocated. With the single exception 'if you can't get to a pharmacist yourself, ask someone to go for you' (L41), readers are encouraged to seek help and advice from 'professional' sources (Brown and Baker 2013: 97) but should only offer help, not ask to receive it, from friends and neighbours. Self-control is also required, in stopping oneself from carrying out certain actions, such as going to A&E or taking antibiotics. The foregrounding of these actions as something *not* to do implies that older people and people with conditions are constantly bothering the NHS by turning up at A&E or asking their GP for antibiotics.

Another peculiar aspect of this page is that none of the tasks that one is expected to do for others, are on the list of instructions that the readers should do for themselves, although surely they are important for anyone, and particularly those who may be older or in poor health. How this page is meant to be read is unclear as it certainly breaks from the previous flow of directions to stay meekly at home, work on the self and ask advice from pharmacists. The citizen is empowered somewhat as a person able to assist others, although the relentless list of instructions continues, but in this section acts as an agent for the NHS, relaying their advice and instructions to a third

party. It might be assumed that this particular page has a different intended reader, that the subject position of the model citizen has shifted and that *you* now has a different referent, a carer perhaps. However, line 54 *There's a lot you can do to help people who are more frail than you,* makes it clear that the writer is aware that the reader is frail. Notwithstanding this, they are told to help others who are even frailer! There is no advice, however, on how to judge whether someone is more frail (or more deserving of care) than oneself. An alternative reading of this page might be that perhaps the writers think that this information is too difficult for the reader to accept, so it much be couched in terms of 'asking for a friend'. In any case it appears that carrying out one role is not enough, and the responsibilities of the model citizen do not end with one's own wellbeing. Through this discourse of caring the reader is shaped not only as a model user of NHS services but also as a model neighbour, friend or family member who should provide care for others, even when they themselves are a vulnerable person. The reader suddenly becomes able to provide a lifeline to 'more frail' neighbours, friends and family members, and also advocates for the NHS by passing on advice.

Importantly, and although medical professionals and other experts are invoked in both texts, selection of the active voice, with the reader as the subject of sentences, ensures that instigation of almost all action depends upon the individual, and must be initiated by them. Although 'fully qualified' (L38) only at one point in the leaflet do the pharmacists actively 'advise you on what medicines you should have in your cabinet', as the reader must ask for help in every other case. Nurses there have some agency as they can treat minor illnesses and injuries on the spot, but gas engineers are contacted by the reader, NHS 111 is called and walk-in centres visited. Although the majority of these actions are contributory to maintaining health or *Stay*ing *Well*, no-one will take action to help the citizen unless they act themselves. In this individualist discourse all actions are focused on advice and fixing the problems perceived to be important by the writers, but there is no suggestion of asking for support with other issues which may be important to the reader, for example mental health or loneliness. Citizens must put on extra layers of clothing to keep warm at home, but there is nowhere else they can go to get warm, have a hot meal or some company. Neither is there any mention of doing anything together. Actions are done

for oneself or for other people. Staying well, it seems is a solitary quest, punctuated occasionally by the receiving or giving of advice. The model citizen inhabits a dualistic (Lupton 1995: 120) world in which they are at once capable and helpless, and in need of advice yet giving advice (Brown and Baker 2013: 112). Readers are constructed as 'docile citizens, who accept the truths of public health authorities without question' (Lupton 1995: 106), they obey advice from the NHS whether or not it is needed, and use services sparingly and only when absolutely necessary, obediently playing the traditional role of 'patient', and causing minimum nuisance, but also making a contribution to society through helping others, but asking for nothing in return.

Governments and other public authorities require citizens to behave in certain ways (Bröckling et al 2011: 2), leading to the construction of a model citizen which depends upon those requirements. As discussed in my literature review (2.4.3) high demand for NHS services, resulting in A&E departments exceeding their targets for waiting times, particularly in winter, has led to major problems with capacity in emergency services and this campaign is part of the damage limitation efforts put in place to manage these issues. My analysis of the instructions and advice established that in this case the NHS have a requirement for the public to:

- avoid using emergency services
- reduce reliance on other high-demand and expensive services such as GPs
- increase their use of low demand and cheaper services such as pharmacies and 111
- increase their uptake of vaccinations
- reduce the overall burden on NHS services by increasing reliance on self-care
- increase the tendency for people to provide care for others, and
- increase the reach of NHS official advice.

The *Stay Well this Winter* campaign enlists citizens onto a neoliberal project of wellness in which they are viewed as one of an army of individuals who must change their behaviour in order to effect an impact on NHS services.

There are many presuppositions in the text which are evident in the instructions and advice issued to the model citizen. It is taken for granted, for example, that other services are available and accessible, and that the reader has neighbours or family with whom they interact. It is also taken for granted that the reader is fit and capable of getting to their local pharmacy, or at least making a phone call to them, and that they live at home and have adequate heating, food preparation facilities, internet access and a telephone. The tasks required of the citizen are presented as straightforward, the speed and ease of the actions emphasised through the form of short, snappy sentences: 'just speak to your GP', 'visit a walk-in centre'. The reality though, may be different. It is often difficult to get an appointment with a GP (York 2018), and 40 per cent of walk-in centres closed between 2010 and 2017 (Campbell 2018). Even pharmacists are only easily accessible to those living in built-up areas, as there are few in small villages and rural areas. So while checklists, bullet points, and lists, recontextualise the complexity of life into a series of basic tasks, life is rarely this simple, and health cannot be reduced to ticking a few boxes. Many people will not recognise themselves in the stereotyped depiction of a citizen constructed in this campaign, and what of those who cannot heat their house to 18 Celsius or get any financial help? What of those in rural areas who have no local pharmacy and no transport, or those with long-term conditions which means that they are unable to carry out the tasks in the leaflet?

I have shown that the sphere of operation of the health field is expanded in order to allow the NHS to control and direct the citizen in additional areas of life, whilst maintaining its paternalistic and outdated attitude towards citizens in the target audience. Obedience is produced not only by the assertion of power by the NHS, but also by the acceptance of that authority by the individual. To this end, the sender of these texts exerts paternalistic power, discursively produced using the means available with the expectation that the reader, on the receiving end of the instructions in the campaign, will accept the subject position into which they have been cast (Fairclough 2015: 78). Advice seeking and asking for help place the subject in a submissive role which requires acceptance that one's knowledge is inferior to another's, and fear of sanctions also plays a part in this compliance (Brown and Baker 2013: 125).

4.7 Conclusions

In this chapter, I have shown how in this preventative campaign a number of discursive strategies are enacted through semantic choices in linguistic and non-linguistic modes, to produce a model citizen who is docile, obedient, dependent and helpful. The texts also promote an individualist discourse in which citizens shoulder concerns and caring responsibilities which some might argue should be taken on by the state (Brown and Baker 2013: 26). The tightly-controlled NHS texts encourage the citizen to be disciplined, and prepare in many ways, following numerous instructions in order to stay well, but there are many conflicting messages in the campaign. The biomedical approach to disease prevention (Lupton 2012: 24) is blended with a lay discourse of illness prevention. The citizen is constructed as at once competent and helpless, and is expected to practice neoliberal self-centredness and initiative whilst charitably helping others and limiting their use of the NHS to less expensive services.

The leaflet does not claim to be a comprehensive guide to all health-related winter issues, but the content focuses on certain elements and misses others. There is no mention of the danger of falls and other accidents, for example, even though 'icy pavements and roads can be very slippery'(L55), and despite the high incidence of falls recorded in the target age group. In addition, it would have been helpful to include a list of 'danger signs' for serious conditions such as sepsis or hypothermia, neither of which are mentioned, when emergency care should be summoned immediately. There are, of course, many other facets to staying well, for example eating a nutritious diet (not just a certain number of hot meals) and having a good social life, friends or family, not living in poverty or worry about poverty, not being the victim of crime, addiction etc. The NHS might argue that their campaign is about a narrower definition of wellness, i.e. a lack of illness, yet they dabble in other discourses to some extent, without addressing root causes of people having cold homes, emergency departments being overloaded and old people dying from preventable illnesses.

The NHS not only reasserts its control through branding and paternalistic discourse, and attempts to persuade citizens that they have 'chosen' to go to pharmacies, but also expands its area of expertise through annexing discourses (Conrad 2007) of

temperature regulation, home maintenance, choice of apparel, benefits, energy efficiency, gas appliances, safety, neighbourly conduct and social responsibility. The power over discourse exerted by the NHS is also exemplified by the subject position of the citizen in the advertisement scenarios and in the leaflet. They are positioned as a silent and docile patient, passively taking paternalistic advice from a succession of health professionals. The viewpoint adopted allows for the depiction of the authority figures but not the patient or viewer themselves. This is beneficial to the producers as attempting to represent a typical viewer would be difficult and problematic. But the viewer, discursively represented by a camera angle and a pronoun, has no voice in either text.

Stay Well this Winter is aimed at adult audience with sufficient literacy and cognitive skills to understand and act, yet readers are patronised and told they might not remember. The model citizen must be at once capable yet incapable, they must seek advice and perform frailty, yet must instigate action and look after those who are 'more frail'. The campaign presents a simplified view of wellness and a vastly simplified view of how to avoid illness. In the texts winter is responsible for illness, and people can combat it by staying warm, getting a flu jab and visiting a pharmacist. Multiple instructions are issued to the citizen, but no real help is offered, and the opportunity to create blame arises as the impression is that the reader can avoid illness if only they would follow these simple instructions. The campaign also works to create fear of winter, ignoring many pathological reasons why people get ill as well as the socio-economic links between illness, early mortality and poverty.

Through promoting certain discourses and minimising others the model citizen in the *Stay Well* texts is constructed as a complex creature who must be both vulnerable and responsible (Brown and Baker 2012: 112), at once expected to be public spirited, but passive and dependent upon the NHS. However the producers of the texts exert control over the definition of health and the options available, manipulating the model citizen through a combination of fear, guilt and social conscience to take actions which will ultimately benefit the government. The more covert, economic objective of the campaign is to shift work from busy to less busy services. While the campaign commits professionals to offering help and advice, the behavioural requirements upon the model citizen are more wide ranging and refer not only to

their own health needs. Positioned in a simulated medical environment in which they are required to obey the NHS staff, they are furthermore expected to reproduce and enact ideologies through advice-giving to friends and family. Links to neoliberal values of choice are also invoked, with more insidious links to consumerist and productivity discourses. In last line of the ad, Ranjan Dass says *We're all here to help you stay well this winter*, neatly bringing the name of the campaign brand at the end of his sentence, but elsewhere *Stay well this winter* is stamped on the campaign like another imperative command. Despite repetition of the slogan *here to help you*, the texts pursue a neoliberalist and individualist discourse in which older or chronically ill citizens must seek help and advice from professionals, must practise self-care and must also look after others. In the *Stay Well* campaign NHS policy is transformed, through recontextualisation, into individual actions for the citizen, with few of the true objectives made explicit. However the tactics employed to shift the behaviour of the citizen include discourses of fear-inducement and shaming, and invoke outdated stereotypes which leave older adults and disabled people feeling patronised and infantilised. These individualist discourses isolate the citizen, and as duties are piled onto their shoulders, allow individuals to be blamed for a national problem of insufficient capacity in A&E departments. Government agencies are exonerated of blame, meanwhile, because they appear to have attempted to rectify the problem by printing some posters or making a TV ad.

As stated in previous chapters, the NHS is important and powerful in the UK. NHS discourses can never be politically neutral because they originate in the political sphere, yet the workforce of the NHS are not viewed as politicians, but as caregivers and healers. They are generally respected as being non-party political, although they are increasingly involved in campaigns to change and improve healthcare provision, which are, of course, political acts of protest. The decision that the text of the ad will be spoken by a GP, a nurse and a pharmacist was made in full awareness of the high regard in which the NHS workforce are held, and that citizens value their relationship with medical staff who take part in numerous encounters with patients every day although it is somewhat ironic that in trying to reduce the number of interactions with NHS staff, the NHS use staff interactions to get their message across.

It is in the interests of the NHS for the public to behave predictably, and especially for them to use NHS services sparingly, particularly in the current climate when funding for resources is not keeping up with demand. They have therefore enlisted employees to perpetuate the individualist and neoliberal model of guilt-induced self-care, and drive unwell individuals to contact pharmacists for advice rather than funding the provision of more or better services for those who need them. A study in 2008 found that '84% of adults visit a pharmacy… at least once a year', and 'the term ''pharmacy'' is well understood' (DH 2008: 14) so there is a good chance that the general public already know about the services they provide and do not need to be told to use pharmacies, or what they are for. Pharmacists, of course, are generally based in chemists' shops, but increasingly in supermarkets and a wider variety of locations. So driving citizens away from hospitals and GPs, and towards pharmacists, also represents a subtle shift from a medical setting to a commercial one, and also to locations in which waiting lists are not the subject of legislation.

In McIntosh 2014 I found that advice and information in health promotion texts is intended to be interpreted as if from a medical practitioner. In these texts we do not have to take that leap of faith as they are spoken by real NHS medical staff in uniform and in health-related settings, who are able to 'act the part', to look with an authentic gaze, and to speak in an appropriate tone. The iconic and perfect staff and settings found in the campaign provide a counterpoint to the ideal patient or model citizen. The NHS has at its core the desire to promote and improve health and wellbeing, yet here it also aims to deflect citizens away from A&E and towards pharmacists and other services, with the existence of A&E barely acknowledged. This playing-down of the possibility of genuine emergencies is problematic, because people do have, and will continue to have emergencies, yet it is presumed that the suggestions given will prevent all illnesses. The conditions listed by Ranjan Dass in the ad (S2-3) are quite serious, but the campaign stops short of explaining what to do if all measures fail, and the reader does catch flu or has 'serious complications' (L11), or indeed if the risk of heart attack, stroke or depression is realised, or when it might actually be more appropriate to call 999 and ask for an ambulance. This omission of the option of emergency help is surely deliberate, and must be linked to the objectives of the campaign. Perhaps ambulances and A&E are not mentioned because the assumption

is that UK citizens know all about them and when to use them anyway. However, there is some fairly basic advice in the leaflet; when and how to call an ambulance would not be out of place, and 'hiding' these emergency services is underhand. As the reader is under suspicion of incorrectly interpreting what constitutes an emergency, one of the outcomes of this campaign may be to make people anxious that they are not behaving correctly or are wasting NHS resources, which could lead to serious problems not being treated.

As I shall show in the next chapter, the model citizen is not a constant paradigm, and can be reshaped into different form if this suits the purposes of the text producers. In the second dataset, I move on from this preventative campaign to analyse some texts produced for those who are already in need of treatment, which explicitly reference the extreme busyness of the emergency services and convey this to the reader. The enduring impression of the *Stay Well this Winter* campaign is that it is the model citizen's duty to stay well, and to follow the instructions in order to avoid illness and avoid becoming a burden. Moreover, it is the readers' duty to carry out work to avoid friends and neighbours becoming a burden too. Those who accept this construction of their health citizenship take on the potential to be blamed or to admit blame for not carrying out one of the actions. If illness is something we can prevent, then in the current economic climate citizens have a duty not to be ill, in order to save the NHS.

5. Second Analysis Chapter: The 'Choosing' Texts

5.1 Introduction

In this chapter I analyse a second set of data relating to emergency health services in the English East Midlands. My main focus will be upon a banner from Nottingham University Hospitals NHS Trust (NUH). I will, however, incorporate evidence from related texts from other NHS trusts as unlike the previous dataset, they are produced by several different organisations. After firstly describing and giving an overview of the texts for the chapter, I elucidate the ways that multimodal discursive strategies work cumulatively upon the citizen. Analysis of these data will permit observation of the model citizen construct at a stage of healthcare interaction subsequent to that in the first dataset. Whereas in the previous chapter the campaign was targeted at those who may or may not be ill, these materials are produced in order to influence those who are about to use emergency healthcare services.

The authors again employ a number of multimodal discursive strategies in these public messages. Key amongst these is the strategy of **constructing the model citizen**, through which ideal behaviour is encouraged in relation to emergency services. However this cannot be achieved without the complementary discursive strategies of **re-establishing and maintaining the authority of the NHS** and **establishing the 'correct' use of emergency services.** For this reason, I address the latter two strategies before the former in my commentary below. I have, again, included each of these modes and textual devices under the heading of the strategy upon which it appears to have the most impact. In this dataset, materiality and temporality are of particular importance, as the affordances of each medium of communication impact upon the usefulness of the particular mode to the delivery of the message (Machin 2016: 326). As before, I will analyse and give examples of the discursive resources used to achieve these strategies, starting in each case with linguistic techniques, and continuing with analysis of devices used within the other significant communicative modes. Before beginning my analysis I introduce the texts for this chapter.

5.2 Description of the texts

The examples in this chapter, as detailed in my Methodology, are produced by four different NHS trusts, but each addresses citizens about to make choices in their use of NHS emergency services. Due to its diversity, this is the most complex dataset, as I analyse texts from a range of contemporary channels of communication which have only emerged relatively recently. The communicative resources in the examples interact closely with each other in multimedia complexes of semiosis.

5.2.1 A&E banner

A large sturdy banner is fastened to the wall immediately outside the entrance to the Emergency Department at Nottingham's Queen's Medical Centre (QMC) (see Figure 15 and for context, Figure 22). One image fills the banner, depicting in naturalistic full colour (Kress and van Leeuwen 2006: 160) and at almost life-size, a queue of adults in outdoor clothing. They all face the same direction, which is towards the entrance of the actual Emergency Department of the hospital (see Figure 22). Above their heads

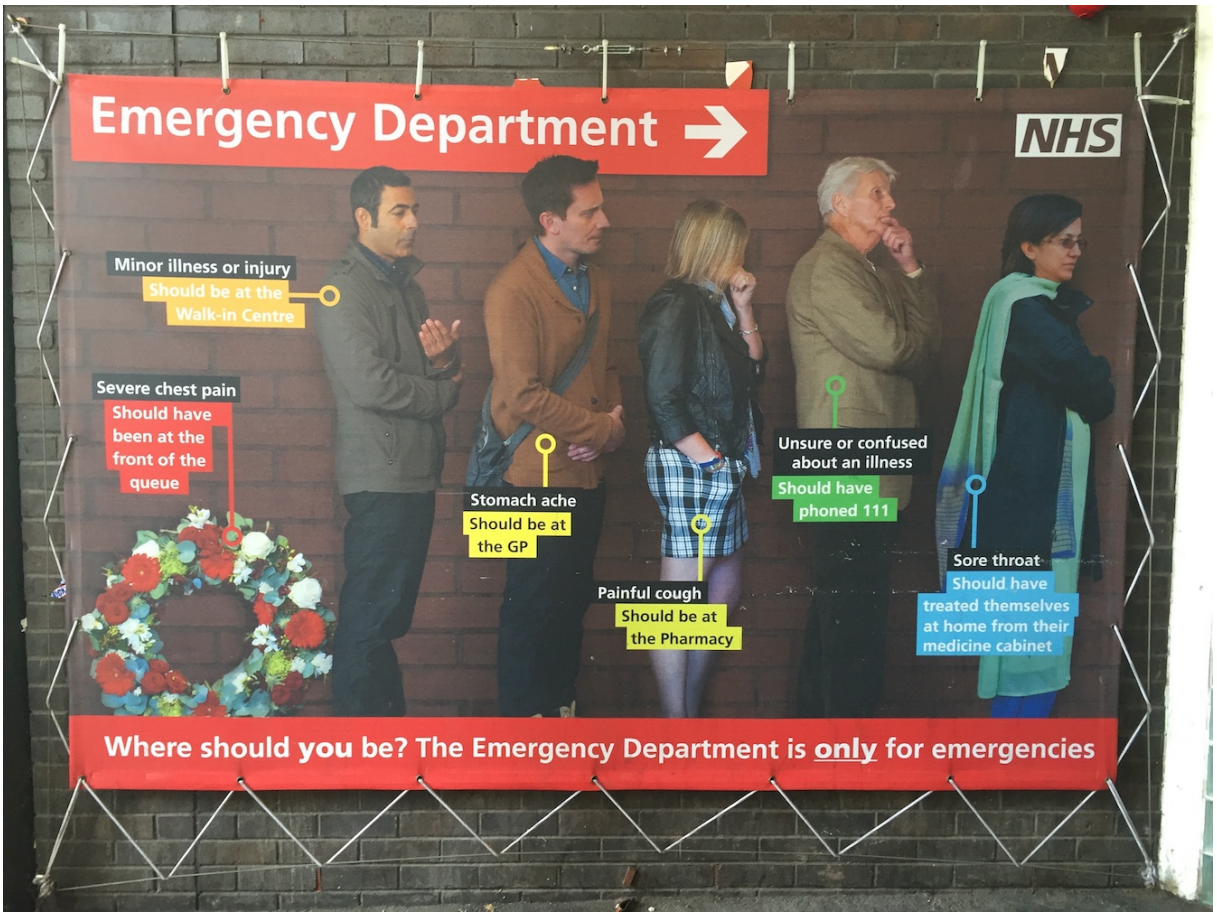


Figure 15: Banner outside A&E department at Queen's Medical Centre



Figure 16: ***You wouldn't call the coastguard...*** **poster on the side of an EMAS ambulance**

is a standard NHS hospital sign which reads 'Emergency Department' in white on red, with an arrow pointing in the same direction as the queue, and there is an NHS logo in the top right corner. At the end of the queue, behind the people, is a large colourful wreath. The language used on the banner is relatively minimal. Along the bottom, in white on a red background, is a strict reminder: *Where should you be? The Emergency Department is only for emergencies*. Each person on the picture has a label which states their complaint, such as *stomach ache*, *sore throat*, and a statement of where they should be or what action they should have taken, rather than coming to Accident and Emergency (A&E). For example, *Should be at the Walk-in Centre*, or *Should have phoned 111*. Last in the queue, the wreath is labelled in a similar manner: *Severe chest pain Should have been at the front of the queue*.

5.2.2 Ambulance posters

East Midlands Ambulance Service NHS Trust (EMAS) displayed posters on the sides of some of their ambulances starting in October 2013 (Ionescu 2013). In the example

shown in Figure 5 (section 3.7.4), there are two posters, either side of the central window. On the left the poster reads *You wouldn't call the coastguard if you fell in a puddle…* accompanied by a picture of water, and on the right, *Ambulances are only for emergencies. Think before you dial! #999wise.* All of the wording appears in white, reversed out of solid colour backgrounds of black and red respectively. Figure 16 shows a closer view of the first poster. The posters have rounded corners and appear to be specifically made to fit the panels of an ambulance. On all sides of the ambulance is the standard emergency vehicle livery, with high-visibility blocks and stripes. The word 'Ambulance' appears several times, along with 'emergency', and the name of the NHS Trust.

5.2.3 Web pages: Derby Teaching Hospitals NHS Trust and Derbyshire Community Health Services NHS Trust

Figures 17 and 18 are screenshots of the **home page of Derby Teaching Hospitals NHS Trust website**. On this page information is categorised and sorted in a number of ways. The page is colourful with many graphics, logos and moving images. Numerous links are provided to redirect the user to other pages and websites where the information they seek can be found. News feeds from social media also appear, as does a 'latest news' box which is updated several times a month. It is a dynamic page, with a 'carousel' feature in which rotating information is displayed in one box, and 'live wait times' for local urgent and emergency services displayed in colour-coded boxes. Two screenshots showing different views of the live wait times feature and the carousel and are provided as examples.

The 'About Live Wait Times' page from the Derby Hospitals website (Figure 19) is reached by clicking on the home page live wait times feature. This page displays the colour-coded live wait times in more detail, and in addition provides some advice about use of A&E services. In contrast to the home page, and despite its title, it is almost entirely taken up with information about A&E, which is included as Extract 1, below. Under this block of text are the live wait times (content shown in Table 3). Details of seven local services comprising two A&E departments, two Minor Injuries Units, two hospitals and an urgent care centre are displayed in rotation, two at a time. The information about each service is framed in a box, which is subdivided into smaller boxes so that the reader can compare the information about facilities,

location and the likely waiting time. The boxes contain text in a standard format, which changes depending upon the busyness of the service, as does the colour of the box (see Table 3).

The live wait times are intended to assist the reader in making the correct choice, particularly regarding whether or not to go to A&E. Below the live wait times is a survey for visitors to the site to complete, which will give feedback to the NHS trust about whether advice on the website was heeded.

The 'Minor Injuries/Out of Hours' page from Derbyshire Community Health Services (DCHS) website (Figure 20) is directly linked via hyperlinks from the Hospitals' website. It also gives the live wait times, and some information about the Minor Injuries Unit. Although published by DCHS, rather than the Derby Hospitals Trust, and with a slightly different 'look and feel'. Shared use of the live wait times feature by these two trusts creates intertextuality and continuity between the two services which serve a geographically similar population. Having described the texts I now move on to my commentary on the discursive strategies they incorporate. I begin, as before, with the strategy of (re-)establishing the authority of the NHS.

5.3 (Re-)establishing the authority of the NHS

In the first of these strategies, the NHS assert its position of authority, as this will allow it to set the citizenship agenda in the domain of Health, and to define the preferred behaviour of citizens using NHS services. In the previous chapter I discussed the NHS logo and its connotations and role in authority building, so will not repeat my observations here. However it is conspicuous throughout all the texts, clearly and unambiguously indicating the presence of the NHS. On the banner (Figure 15) it appears in a white block, reversed out of the picture, so that it is integrated into the image. The NHS logo also appears in several positions on the front, sides and back of the ambulance, in NHS blue and white, and is in the header section of every page of the Hospital and Community Services websites. Many brand logos are viewed in 'decontextualised' settings (Scollon and Scollon 2003: 145) in that they appear in places which are not directly linked to their meaning. The NHS logo, however, is



Figure 17: Derby Teaching Hospitals NHS Trust home page showing carousel rotation 3



Figure 18: Derby Teaching Hospitals NHS Trust home page showing carousel rotation 4

'situated' (ibid.: 146) in these contexts. It asserts the authority of the NHS over the production of the texts, and imbues them with all the values of the NHS including public ownership, impartiality and dependability.

The identity of the NHS is also reinforced by the presence of the typical NHS 'Emergency Department' sign, which appears at the top of the photograph, in Frutiger typeface with an arrow symbol. NHS signage is familiar and ubiquitous in hospitals, so this imitation of the NHS signage style is significant. Indexing the NHS in this way signals to readers that despite the links forged with commercial discourses of advertising by their form (Sarangi and Slembrouk 1996: 26), these texts are important health-related messages, paid for by public money, and that they are beneficial, and in line with the principles and values of the NHS (see NHS 2015b). The divide between communicative modes is crossed as the 'Emergency Department' sign at the top of the banner is part of the photograph, but also functions as a real sign pointing to the doors of A&E. The moralistic 'heading' at the base of the banner matches this very closely, mirroring the colours and Frutiger typeface of the sign above. There is no doubt that this is a message from senior hospital managers, addressed directly to the reader about their behaviour in relation to this Emergency department.

The authority of the NHS to give instructions is demonstrated linguistically in these texts through the frequent use of modal verbs, which are also employed to construct the appropriate behaviour of the model citizen. On the banner, each of the figures in the picture is 'annotated' with a label or caption (Barthes 1977: 39), firstly with the supposed ailment or injury from which they are suffering, and secondly with a *should* statement. For example:

> Stomach ache
>
> Should be at the GP
>
> Unsure or confused about an illness
>
> Should have phoned 111

The *should* phrases as used here are a polysemous (Groefsema 1995: 56) 'device for shaping the relationship between the writer and the reader' (Warchal 2008: 22). The

use of *should* on the banner can be seen both as deontic, in that it has the power to instruct, and as epistemic, in that it conveys alternative versions of actions. These *should* phrases are examples of paternalistic and directive discourse, in which the NHS appropriates the authority to give instructions, and demonstrates this through statements of preferred alternative behaviour. *Should* links the texts to moralistic and value-laden discourses and implies alternative action which would have been taken if the individual had made the correct choice, and hence invalidates certain reasons for attending A&E. Blame is implied, for if those people had not been in the queue, the 'wreath person' with severe chest pains may not have died. This is a serious charge to levy. The people in the queue are ill or injured after all, albeit not severely enough to be 'eligible' for emergency services. The banner does not expressly instruct real life participants not to enter the A&E department, but the illocutionary force of the phrases severely judges them for doing so. The banner stops short of saying 'you' are to blame for a death if you come to A&E with the wrong symptoms, but implies it. It is not made clear whether the error by the queuer is incorrect interpretation of symptoms or wilful misuse of NHS facilities, but a badly made decision is presupposed.

The web pages about emergency care and alternative services published by Derby Teaching Hospitals and DCHS provide further examples, including the following extract from the 'About live wait times' page (Figure 19). Here, *should* is combined with imperatives, another linguistic device used to demonstrate the location of power in a relationship, which I explored in the previous chapter (see 4.5). *Must, t*he modal verb carrying the most deontic force, is also used.

> Stop! Need Emergency or Urgent care? Please remember A&E must only be used for real emergencies, serious accidents and life threatening conditions.
>
> Stop! Think about where you should be going for treatment

The authors of these texts may be making a deliberate play on the polysemy of should as the ambiguity of its meaning is helpful to achieving their aims. Whilst exerting 'oppressive' power (Holmes and Stubbe 2003: 100) through the deontic force of should, they can also appear to be offering a choice and acknowledging a supplier-customer relationship. The normative sense of *should* (Papafragou 1998:14, 26)

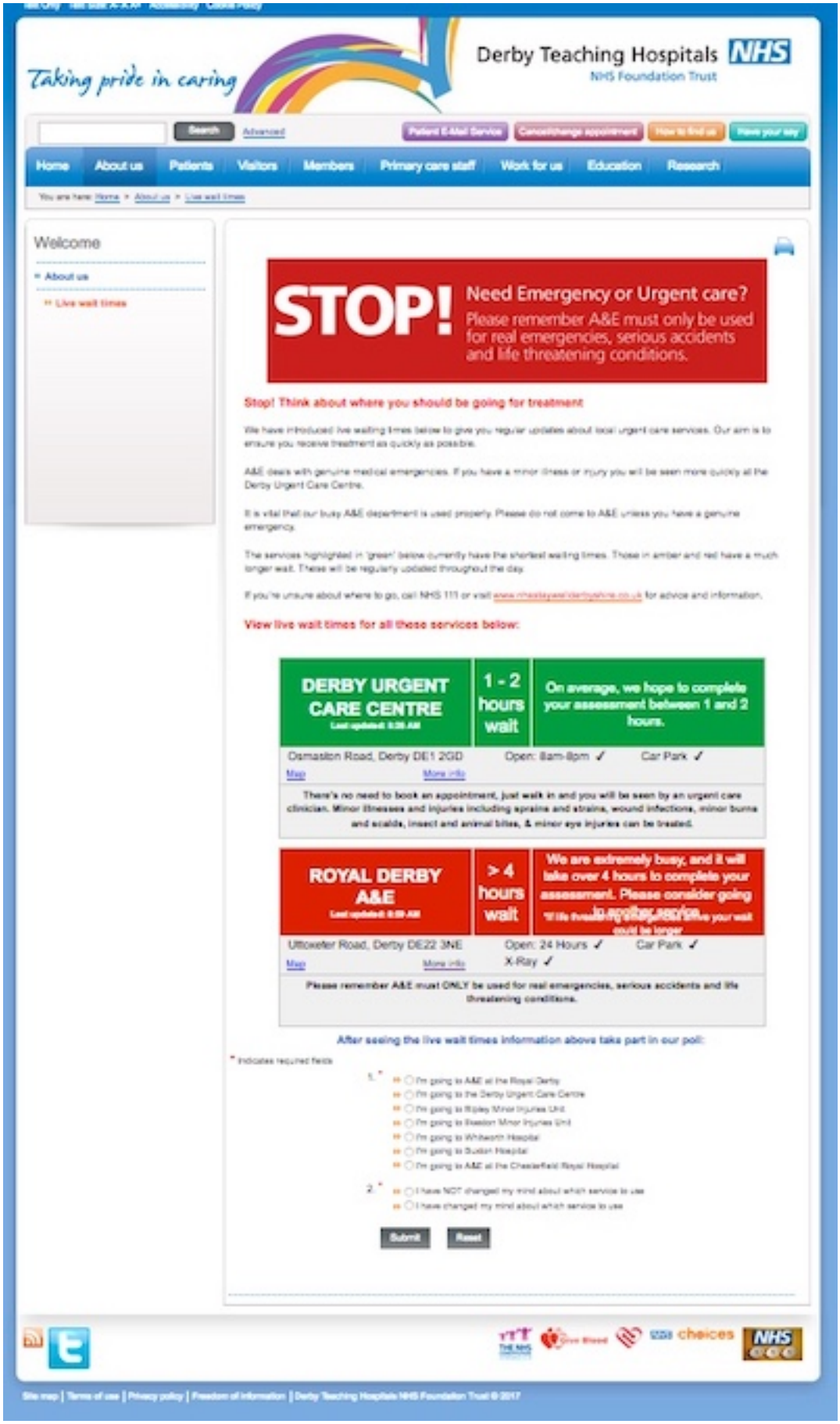


Figure 19: The *About Live Wait Times* page from Derby Hospital website

Extract 1:

STOP! Need Emergency or Urgent Care?

Please remember A&E must only be used for real emergencies, serious accidents and life threatening conditions

Stop! Think about where you should be going for treatment

We have introduced live waiting times below to give you regular updates about local urgent care services. Our aim is to ensure you receive treatment as quickly as possible.

A&E deals with genuine medical emergencies. If you have a minor illness or injury you will be seen more quickly at the Derby Urgent Care Centre.

It is vital that our busy A&E department is used properly. Please do not come to A&E unless you have a genuine emergency.

The services highlighted in 'green' below currently have the shortest waiting times. Those in amber and red have a much longer wait. These will be regularly updated throughout the day.

If you're unsure about where to go, call NHS 111 or visit www.nhsstaywellderbyshire.co.uk for advice and information.

View live wait times for all these services below:

Table 3: Lexical content and colour in the Live Wait Times feature

Text	**Box colour**
On average, we hope to complete your assessment within an hour.	green
On average, we hope to complete your assessment between 1 and 2 hours.	green
We are currently busy, and it will take 2-3 hours to complete your assessment.	amber
We are extremely busy, and it will take over 4 hours to complete your assessment. Please consider going to another service *If life threatening emergencies arrive your wait could be longer	red

is also apparent, as the reader is being trained to adopt new patterns of behaviour which are deemed more appropriate for a model citizen.

> *Should* expresses a necessity relative to existing stereotypes, norms or expectations. The comprehension of *should* relies quite heavily on the sort of structured knowledge humans typically possess about the normal course of events (Papafragou 1998: 26).

Therefore, *should* may indicate an attempt to facilitate the acceptance of the required behaviour as common sense.

To further reinforce their claim to control over the sphere of emergency health services NUH, and EMAS and NUH have chosen locations which Scollon and Scollon referred to as 'non-semiotic spaces' (2003: 111) to publicise their messages. Far from indicating places without meaning, Scollon and Scollon chose this term to signify spaces where emplacement of texts is largely forbidden, or at least regulated. The exteriors of NHS hospitals and ambulances have traditionally carried specific signs only—those which index the purpose of the building or vehicle. These include the names of hospital departments, NHS logos, and instructions to allow them to fulfil their purposes, such as 'entrance' signs, or the bright colours of an ambulance which makes it highly noticeable. Advertising and promotion of products or services has not traditionally appeared on these surfaces, and appears transgressive. Control over whether a sign is transgressive is sociocultural, and is regulated by 'some geosemiotic system which tells members where signs and messages may appropriately appear and where they may not' (ibid.: 148-149). By inscribing these texts upon non-semiotic spaces, NHS trusts are asserting their authority and right to control these spaces, and those who use them. The unfamiliarity of seeing messages or slogans on ambulances or hospitals may well give them additional impact, but it also changes the purpose of the space, politicising and bringing the reader into dialogue with the building or vehicle itself about the validity of their reasons for its use.

Ellipsis and intertextuality also contribute to authority building in this dataset. Both the banner and the posters contain fragments of discourse which contribute to the production of the model citizen, but neither text is sufficient, alone, to invoke the

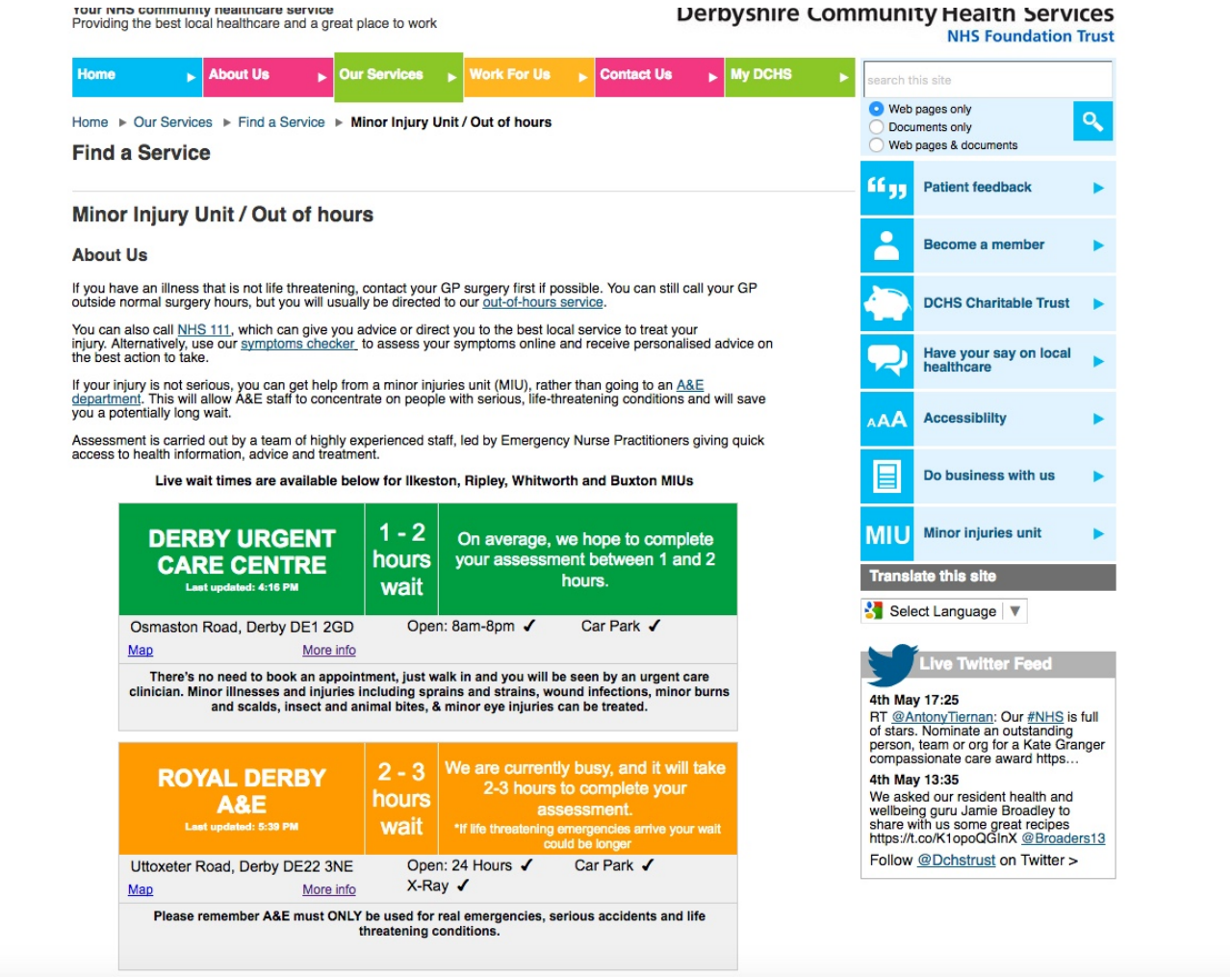


Figure 20: *Minor Injuries Unit / Out of Hours* page from DCHS website.

complete discourse. Although 'discourses may never be fully present in any single text' (Machin 2016: 328), both texts are reliant upon the reader having additional contextual knowledge, and through their use of ellipsis, rather than explaining the context, the writers are taking a risk, and presuming much. On the poster, which reads 'You wouldn't call the coastguard if you fell in a puddle…', the image of water adds little to the meaning and appears purely illustrative, but the language of the poster would make little sense without its physical context (Machin 2007: 172) which 'relies heavily on making implicit connections' (Sarangi and Slembrouck 1996: 27). The writers anticipate that the reader will be familiar with the cultural, social and political references in this statement, despite its brevity, to the extent that the end of the sentence can trail off to be replaced with '…' This ellipsis of a phrase along the lines of 'so don't call an ambulance if it's not an emergency' is an important message, but this instruction is not given, only implied. The writers of each text are evidently presupposing sufficient intertextuality with other texts in the public domain,

including their own websites, but also with news reports about 'misuse' of A&E departments and the ambulance service (see 2.4.3). This again indicates that NHS trusts are assured of their own importance in the lives of the British public. It seems the writers believe that these texts merely have to index the power of the NHS in order to invoke and reproduce it. Although there are a variety of materials and channels, the overarching identity of the NHS comes through clearly. The different NHS trusts speak with one voice which is authoritative, directive, paternalistic, critical and pervasive throughout the various media used to publicise messages about emergency services. Having created a wide range of options for emergency treatment, the NHS has placed the onus upon members of the public to choose the most appropriate service for their emergency. Despite this, the NHS can be observed, in these campaigns, attempting to maintain their status of high-level power in relation to health and the allocation of services.

5.4 Establishing the correct use of emergency services

Having ensured that their authoritative status is secure, the NHS trusts use each of the texts in this dataset to show the correct use of emergency services. This purpose is constructed through the combination of lexical and visual resources, which, as I will show, are clearly intended to be read together. In its simplest form, construction of correct use is achieved lexically through declarative statements, telling the reader that the service is 'only for emergencies'. These clauses index one another through lexical and syntactic repetition, and create a form of parallelism which acts as a cohesive device in a similar way to an advertising slogan (Cook 2001: 149-151):

'Ambulances are only for emergencies' (ambulance poster)

'The emergency department is only for emergencies' (A&E banner)

Online, this phrase is expanded to include the types of emergencies which are eligible for A&E:

'...A&E must only be used for real emergencies, serious accidents and life threatening conditions'

(Minor Injuries Unit page, About Live Wait Times page)

> ‘Royal Derby A&E .... for real emergencies ONLY’
>
> (Derby Hospitals home page)
>
> ‘A&E deals with genuine medical emergencies.’
>
> (About Live Wait Times page)

The introduction of evaluative adjectives such as *real*, *serious* and *genuine* into the copy of the web pages shifts the meaning of the texts from a factual and informative description of the service and how to use it, to one in which judgements can be made about whether attendees are deserving, worthy, and obedient. The circumstances that can be considered to be an emergency are, in many cases, subjective. The inclusion of these adjectives does not, however, assist the reader in deciding which sets of circumstances are legitimate emergencies. No definition is given of the meaning of *real*, *serious* or *genuine,* though each adjective is used several times. The only counterpoint appears to be *minor*, itself a highly subjective term. Objectification of these terms may have enabled the citizen to ‘improve’ their behaviour, but failure to do so leaves the reader unsure and maintains the asymmetrical balance of power in the relationship between NHS and the public through lack of shared knowledge.

Adjectives also contribute to the construction of the user as someone who does not know how to use health services correctly, or who may be a malingerer. The reader is instructed to use the department *properly*, for example, and does not appear to be part of the in-group of patients ‘with serious, life threatening conditions’ upon whom the staff need to concentrate:

> It is vital that our busy A&E department is used properly. Please do not come to A&E unless you have a genuine emergency. (About Live Wait Times page)
>
> If your injury is not serious, you can get help from a minor injuries unit (MIU), rather than going to an A&E department. This will allow A&E staff to concentrate on people with serious, life-threatening conditions and will save you a potentially long wait. (Minor Injuries Unit page)

The majority of these web texts are written in the active voice, which increases the urgency of the message and incorporates ‘action’ verb phrases such as *call your GP*, *use our symptoms checker*, and *just walk in,* signalling to the reader that they have choice and control. The passive voice in the first of the examples above is a hedging

device which avoids the directness of an active statement such as 'use A&E properly' and allows for the ellipsis of subject pronouns, so that no agent is given responsibility for ensuring proper use is made of the service.

We can contrast this with other pages for people coming to hospital on the same website, such as the *Your Appointment* page (Figure 21) aimed at outpatients. Rather than doubting the eligibility of the patient, the information on the page seeks to reassure. The reader is invited to bring someone with them so that they may be 'more relaxed', and is told that 'Throughout your visit, your privacy, dignity, religious and cultural beliefs will be respected'. Rather than being suspicious about the patient's motives for attending, it appears that the writers wish to gain the trust of the reader and convince them that hospital is the appropriate place to be. Rather than inconveniencing other patients and staff by their presence, patients may be on the receiving end of such inconvenience:

> We aim to see you within 30 minutes of your appointment time. However, due to emergencies and unforeseen circumstances, appointments may run behind schedule. If there are delays, we will keep you informed.

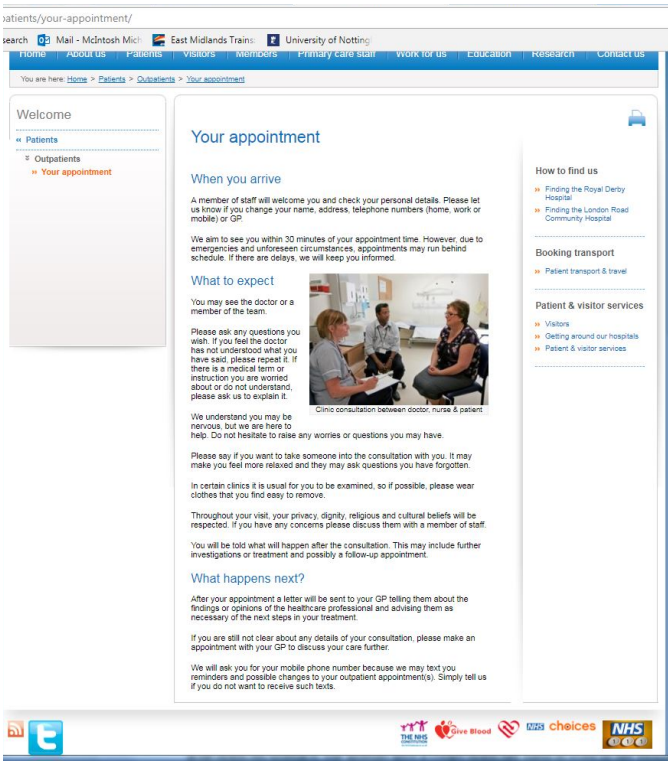


Figure 21: 'Your Appointment' page from Royal Derby Teaching Hospitals NHS Trust website

This web page is a typical example of the pages for patients on the website, so we can see that A&E, and the people who wish to access it, are different. Whereas users of A&E or the ambulance service may self-refer, outpatients are invited and expected visitors to the hospital, having been sanctioned by a professional 'gatekeeper' such as a GP or other health professional. The texts aiming to dissuade the public from using emergency services, then, are aimed at those who have made their own decisions, based upon their own assessment of their circumstances. Referral by a medical practitioner confers eligibility on a citizen in a way that taking individual responsibility cannot. The citizen wishing to receive emergency care must take more actions, and pay more attention to the needs of others than those attending hospital for non-emergency reasons.

Returning to the A&E banner, a strong left to right vector is produced by the arrow in bold type upon the *Emergency Department* sign, the direction of gaze of the participants and the orientation of their bodies which are in a queue from left to right. This vector introduces narrative to the image because it demonstrates what the participants are doing (Kress and van Leeuwen 2006: 59). This information is presented lexically, and these 'ailments' labels are reinforced visually by the stance of the queuers – the man with a stomach ache holds his stomach, the woman with a cough holds her hand in front of her mouth, and the man who is unsure or confused holds his chin, looking perplexed! It is clear that the observer is meant to understand this reductive metaphorical device literally. The language of the banner is fairly impersonal. Each person in the queue is labelled with a few short simple words indicating the reason for their presence: *Minor illness or injury*, *Stomach ache*, *Painful cough* and *Sore throat*. One queuer is annotated *Unsure or confused about an illness*. This metonymy indicates that the physical condition or state of mind of the queuers is more important than the person, as we are given no names or other biographical information. A&E is thus portrayed as a factory or machine which processes injuries rather than people, and this depersonalising of the conditions to the point that the person suffering from them is irrelevant, is also somewhat reminiscent of the discourse of medical records (Fleischman 2001: 477-480).

The banner appears to call for self-diagnosis, as the admonishment involves knowledge that a certain symptom should be treated at a location other than A&E.

Perhaps A&E is for treatment only, and not for diagnosis, if the patient must know what is wrong with them before arriving at A&E. *Minor illness* is a subjective term and would be interpreted in a range of different ways by different citizens. Furthermore, taken to the extreme, each of the symptoms could be an indicator of a serious condition. For example, possible causes of 'stomach ache' listed on the NHS Choices (2016b) website include appendicitis, stomach ulcer and diverticulitis. The same website also states that a sore throat is often a symptom of conditions such as tonsillitis or glandular fever, and that in rare cases it can be 'a sign of a serious problem', in which case the advice is that you *should* go to A&E. Serious conditions are also listed as possibilities indicated by the other symptoms. Likewise if someone is *unsure or confused*, they may be ill. Sudden confusion can be caused by a range of serious conditions including complications of diabetes or thyroid condition, also stroke, brain tumour, sepsis and poisoning by alcohol or carbon monoxide (ibid.). It appears that the messages of the banner are not consistent with information published elsewhere by the NHS. An attempt at self-diagnosis of a sore throat using NHS Choices might lead a reader to attend the service because it may be 'a sign of a serious problem' (NHS Choices 2016b), yet the banner informs them that they have taken the wrong course of action. This is likely to add to the confusion of the patient in deciding where to seek help. It may also increase anxiety, or lead to serious conditions being left untreated.

This text enacts and reinforces the discourse of the 'correct' use of A&E, but it may not be understood without its political and social context. The only information given about A&E is that it is for *severe chest pain* and *emergencies*. We can deduce that it is not for *minor illness or injury,* or the other named conditions, and that it is not a place to attend if *unsure or confused about an illness*. This negative construction of A&E as somewhere *not* to go relies upon the reader's cultural and local knowledge. We are instructed that the queuers should variously be at *the Walk-in Centre*, *the GP*, *the Pharmacy* or *at home*, but these statements again encode numerous presuppositions about the reader. These include being registered with a General Practitioner, having a home, being equipped with a telephone, and being sufficiently well-resourced to have a medicine cabinet which is stocked with a full range of in-date medicines to deal with any minor ailment they might contract. It is also presupposed that they have enough

medical knowledge to have self-diagnosed, and to know the severity of their condition. Although striking in appearance, the banner is only fully accessible to those who understand all of these references, and it is surprising that it does not index an NHS website, where background information could be provided. The recontextualisation of policy on the use of A&E into a snappy, eye-catching image takes place through the deletion of so much detail that the advice may be confusing and contradictory (van Leeuwen and Wodak 1999: 96).

Participating in the practice of advertising, in particular 'on trend' advertising using styles and techniques employed by other organisations, is a contemporary method of demonstrating authenticity. The high production values of the banner also link it to advertising discourses of buying and selling, although in this case what is being 'sold' is the idea that there are alternatives to attending the A&E Department. It is composed in a similar way to an advertisement, on a vertical axis, with the queue image placed at the top and taking up much of the banner, and with the *Where should you be?* caption placed at the bottom. Kress and van Leeuwen regard the top portion of such texts as the 'Ideal' and the bottom as the 'Real' element. Unlike many advertisements, in which a visualisation of 'the promise of the product' appears in the top portion, the image offered up here is a depiction of an undesirable situation. It is, however, as described by Kress and van Leeuwen, strongly contrasted with the meaning of the lower portion, which does explain the 'Real', the 'directions for action' (2006: 194).

Location or emplacement (Scollon and Scollon 2003: 142), including the materiality of the surface upon which texts are placed, appears to be an important communicative mode in this dataset, as it contributes to the discursive strategy of constructing the correct use of NHS services. The semiosis of these locations derives from their immediacy to the subject of the message. Indeed the potential timing of the receipt of the message is also salient. The banner right by the entrance to A&E communicates kind of a 'last chance to be a better person'. Behind the queuing people depicted on the banner is a brick wall (see Figure 15). The banner is physically attached to the brick wall of the hospital with wires which allow the bricks beneath to show through, and the image bleeds off on 3 edges, without a border or frame. The effect of this is a merging between the banner and the wall, so that rather than a

clean, certain, edge to the text, it becomes situated (Scollon and Scollon 2003: 146) as part of the wall and therefore as part of the hospital itself.

On the ambulance pictured in Figure 16 the short messages of the posters, in large clear type, can be read quickly, probably even if the vehicle is moving. The ambulance is pictured parked outside A&E, but as the vehicle is mobile, the setting of the message can be anywhere the ambulance goes in the entire East Midlands. This includes any road, the exteriors of hospitals and other NHS buildings, and events. Ambulances can also access areas where other vehicles are forbidden, such as pedestrian zones. They are brightly coloured and have additional means of drawing attention compared to other vehicles of a similar size, with bright flashing lights and sirens which are switched on when appropriate. When an ambulance is present it is often a focus of attention, particularly for passers-by, and motorists not directly involved in the incident it is attending. The salience of the message on the poster is, therefore, heightened by its context: it is a message about ambulances, posted on the



Figure 22: Photograph illustrating the position and relative size of the banner at the entrance to the A&E Department, QMC, Nottingham.

side of an ambulance. The texts are also surrounded by signs which indicate a) the functioning of the vehicle, such as wheels and mirrors, b) its ownership and place within NHS services (Logo, name of NHS trust), and c) its status as an emergency vehicle (high visibility colours blocks, flashing lights and sirens). These multimodal resources index authenticity through multiple semiotic modes and hence reinforce the high modality of the message. On top of this, the temporality of this message also adds meaning. When we see ambulances they are usually racing through the streets to provide urgent aid, at the scene of a road traffic accident or parked outside a house or other building while the paramedics provide medical assistance inside. Medical procedures are performed in or around the ambulance and it is staffed by health practitioners, so we associate it very strongly with accidents and medical emergencies. The reason we can see the ambulance is that something urgent is happening here and now. The observer of the posters may also be the observer of an accident scenario, or may watch paramedics load a seriously ill person into the ambulance. There may be death happening, or birth, or any number of other critical sites of engagement. It is highly likely that these texts depend upon their situatedness for their coherence (Cook 2001: 152-153), and that they can only be understood because of where they are placed in time and space. The poster text, then, is connected through its emplacement to discourses of emergency health care, despite its brevity and use of ellipsis, thus enabling the reader to link correct use of the coastguard service with that of the ambulance service.

Timing is even more relevant to establishing correct use of services on the web pages in this dataset (see 5.2.3), which all feature the Live Wait Times app. The feature appears in the top right corner of the home page (Figures 17 and 18) which represents the 'new' or 'the realm of the consumer's supposed aspirations and desires' (Kress and van Leeuwen 2006: 186). The heading above it reads '*STOP! Need Emergency or Urgent Care?*' in white text on a block of red. '*STOP*' is the largest word visible, and is designed to catch the eye first on a page full of colour and movement. Underneath are two further blocks of colour containing white text, which change every five seconds, rotating through a series of messages indexing the various facilities which can be accessed by local citizens if they are in need of 'emergency or urgent care'. The meaning in the live wait times, which appear in an extended form on

other pages (Figures 17-20), is derived partly from the framing of lexical and numeric information within a colour coding scheme. It is also partly derived from the link which is created between the reader, and staff based in the A&E team, Minor Injuries Unit or Urgent Care Centre, who enter the wait times into the system.

The frames surrounding the live wait times are set up in advance, including standardised blocks of text to accompany each type of service and each set of waiting times (see table 3). When a member of staff in one of the locations listed on the system inputs the average wait time for that service, the computer program selects and displays the message defined for that number of minutes, and a colour background which also depends on the length of wait. The green boxes of the live wait times do not mention the word *busy*, but amber boxes display the phrase *We are currently busy*, and in red boxes this is intensified to *We are extremely busy*. In this way they contribute to the construction of the correct use of A&E as being temporally dependent as well as dependent upon the health status of the patient. It is only in red boxes that the text *Please consider going to another service* is displayed. The waiting times themselves are a mode through which staff in a busy, or quiet, department can reach the potential patient, indicating their capacity to help, and perhaps their readiness, relative to the other services on the system, to respond.

The 'traffic light colours' of red, amber and green are a familiar colour code, originating in regulatory discourse (Scollon and Scollon 2003: 138, 181), with red generally signifying either 'danger' or 'stop', green to mean 'go', and amber signifying something between the two, depending on the context. In traffic signalling where road use is allocated at different times to different users, a green light means that the reader is authorised to travel upon the section of road ahead. A red light indicates that this is not currently a path the reader can take (albeit usually only for a few minutes). Transgression of this code is serious, and in some legislatures can incur a penalty. The reading of red on the websites may then signify a forbidden or transgressive choice. The message that A&E is busier than the Urgent Care Centre can be effectively and quickly communicated via this multimodal means. The affordance of the colour-coding is that its differences and similarities are more immediately apparent, than text (alone). Colour here fulfils the ideational metafunction, and is more effective than lexis at quickly communicating the status of the service. It

immediately indicates equivalence and non-equivalence, in a way which would take much longer if reading written language. However when A&E is less busy, this framing in colour and text may be less unambiguous. Each time the colours change on the live wait times the status of the service changes, and when all the services are showing as 'green' A&E appears to be equal to the Urgent Care Centre and the other services. This suggests that at times when the A&E department is less busy, they may be more willing to accept lesser injuries for treatment; injuries or conditions which were transgressive may no longer be so. This colour coding system appears to be moralistic because it seems to imply that whether citizens are eligible to use A&E depends upon whether other people have got there first.

Red takes on another meaning in the establishing of correct use at various places in the texts for this dataset, usually as a solid block of background colour for white type, or as a type colour used for headings, where it is notably associated with the term 'emergency' signalling high importance, or 'associated with foregrounding' (Kress and van Leeuwen 2002: 357). Red could also be said to be the colour allocated to 'new' information, although it does not exclusively appear on the right or at the bottom of each text as described by Kress and van Leeuwen (2006: 186). Other colours appearing on the banner appear to have importance in defining the correct use of services, but their meaning is not clear. For example, two of the *should* phrases appear in black and four in white, and the blocks of colour behind them are in different colours, although two are shades of green which suggests that they are not arbitrary colour choices. The impression is that this is some sort of code, perhaps aiming to contribute to the construction of correct use of services, but if so, it is a cryptic one.

5.5 Constructing the model citizen

Having taken steps to ensure the authority of the NHS, and defined the correct use of services, the authors of the texts are, as before, in a position to construct appropriate citizen behaviour for this domain. However, whilst they are certainly in a position of authority in relation to the ordinary citizen as we have seen, unlike police officers when enforcing traffic regulations, the health authorities do not have statutory power

to reinforce their messages concerning use of services. They must find other ways to do so, and in these data they urge NHS users to make the correct choices in order to be good citizens.

In attempting to gain the co-operation of readers, the text producers employ a number of rhetorical techniques to demonstrate that they understand their audience and have an affinity with them. They firstly construct this relationship using synthetic personalisation realised as 'conversationalisation' or the 'appropriation of private domain practices by the public domain' (Fairclough 2010: 98), which may give the impression that there is equity between the provider of information and its recipient. This involves the use of colloquial language and conversational style, such as ellipses (Cook 2001: 173), the contraction 'wouldn't', and personal pronouns. Addressing the reader as *you* in the ambulance posters allows the text producers to construct a citizen whom they claim to know well, as they would need to do so, to be able to say, with certainty, how the reader would behave in given circumstances. The first poster, which reads *You wouldn't call the coastguard if you fell in a puddle …* appears on the left in the 'given' position (Kress and Van Leeuwen 2006: 180) and is here installed as the established position about 'you', the reader. The message on the second is *Ambulances are only for Emergencies. Think before you dial! #999wise*. This is on the right in the 'new' position as it includes the imperative instruction to 'think'. The reader is constructed as a good citizen, who knows how to behave, as parallels are suggested between the two sets of actions (Cook 2001: 151-153). Correct use of ambulances is constructed negatively, as *not* calling an ambulance is again the required (in)action of the model citizen, and the reader is told that they are a rational individual who usually makes good choices thus embodying the neoliberal ideal. Therefore they will *think*, and refrain from calling 999. The inclusion of *#999wise* is an indication that this text interacts with other texts via social media. By including this neologism as a 'hashtag' (Zappavinga and Martin 2018), EMAS not only advertise their Twitter feed and indicate intertextuality with it, but also bring together the two terms '999' and 'wise'. In doing this they create a new adjective to describe someone who uses the 999 phone number correctly. Coining this term allows the trust to link messages across channels into a single campaign and creates a positive discursive association with the observance of the rules.

You is used to address the reader in all these texts, but the absence of other pronouns in the banner text has a rather interesting effect. Ellipsis is defined by Cook (2001: 151) as a linguistic device 'in which an omitted unit is recoverable from a previous sentence'. I propose that, here at least, the 'omitted unit' is also recoverable from an alternative communicative resource. For example, as the receiver of the text reads the words 'should be at the GP' they simultaneously see the male participant in the photo to whom this caption refers. The pronoun 'he' is superfluous, and is omitted. Although the labels appear to refer to the people depicted on the banner, the ellipses also increase doubt about the 'unmarked' subject, allowing for the possibility that the missing pronouns could be *you* (Halliday 2014: 194). So through visual and linguistic cues the meaning of these individuals is brought closer in meaning to 'you' the reader, culminating in the semi-existential question 'where should you be?', which intrudes the mind of the reader and 'attempts to win us over by very direct address' (Cook 2001: 161). The ellipsis in the banner (Figure 15) and poster (Figure 16) is also important because it indicates the ideological position of the authors (Fairclough 2010: 27), and their expectations about the ideological positions held by their readers. As Cook has put it '(t)he absence of reference to shared information has led to the observation that it is what is omitted in discourse, the **gaps** within it, which constitute the shared ideology of the participants' (2001: 179). Through ellipsis in these texts the authors attempt to draw comparisons between correct and incorrect behaviour, but also to demonstrate that model citizen values are shared between the writers and their readers. Other linguistic devices also build affinity between the interactive participants, or possibly between the reader and their duty to the NHS (Evans 2007: 690-691). In the noun phrases 'the GP', 'the Pharmacy' and 'the Walk-in Centre' the pragmatic inference of use of the definite article is not that there is only one GP, but that the GP in question is the particular one that the reader is registered with. The deixis here encodes a familiar way of referring to local facilities, and of asserting that there is an understanding that everyone knows how to use the NHS.

I have already talked about the evaluative adjectives in the web texts, which introduce doubt as to whether a genuine emergency exists, and legitimise a moralistic discourse of good citizenship. This occurs again in the negation of the ambulance posters, with an example held up as incorrect behaviour used to train the reader in

ideal citizenship. However the example chosen is that of calling a coastguard when falling in a puddle, which is clearly a ridiculous course of action. By juxtaposing the action of calling an ambulance for the wrong reason with a ludicrous action such as calling the coastguard for rescue from a puddle, the information producer claims that the individual using the service incorrectly is a figure of fun, the butt of a joke, or stupid and incapable. The rhetoric of advertising is not really appropriate here. It may make for a slick slogan or snappy hashtag, but if choosing well truly is a matter of life or death then perhaps a less frivolous tone should be adopted. In section 5.4 above, I described the use of multimodal cues to indicate that the message of the banner was intended to be understood literally as part of the construction of the purpose of emergency services. In examining the construction of the model citizen however, I will now explore the symbolism of the signs presented in the banner, and will focus in particular on two prominent signs: the queue and the wreath.

Figure 22 shows the emplacement of the A&E banner. It would be hard for any visitor arriving A&E via the main entrance to avoid seeing the banner as they must pass it on their way into the department. As it is so large, for an observer standing nearby, it will fill most of their field of vision. The full-body depiction of the participants in the photograph, at almost life size, is commensurate with Kress and Van Leeuwen's (2006: 125) ideas about the depiction of social distance through field of vision as the viewer can see several people in their entirety. The participants in the photo are engaged in the same activity as the reader: arriving at A&E. The image on the banner has immediate impact and high modality. The photo is in full and realistic colour and the people in the queue represent a demographic made up of 'ordinary' people who could easily be local. The focus is clear, and the subjects are very close to the observer. It is almost as if one could join the queue. The gaze of the subjects is fixed ahead, as they stand in line, motionless, evenly placed, and the observer cannot meet their gaze despite being at or close to their eye level. In contrast with the demand images of the previous dataset, this constitutes an 'offer' image (ibid.: 119) in which the participant(s) are presented to the viewer as 'items of information, objects of contemplation, impersonally as though they were specimens in a display case'. To this extent the viewer is an outsider to the queue, although closely associating with it, and the queue participants are held up as examples of citizens who have chosen

incorrectly. In combination with the *should* phrases, these very clear links between the reader and the text are strong indicators to the reader that they are intended to identify with the participants in the photo but not to behave as they do.

The queue on the banner is symbolic, providing a visual metaphor for hospital services, and specifically the journey through an A&E department. Although patients may not be arranged in a line like the one in the poster, one could consider the whole A&E department as a queue, as there is a waiting system between each stage of the A&E process. On arrival at A&E the patient waits at the reception desk, they are registered, then wait to see a triage nurse, by whom they are sorted and possibly allocated a different place in the queue, depending upon how urgently they need attention. After triage the patient will wait again to see a specialist, then wait to have tests, x-rays and so on. Queueing reminds us that we have to wait our 'proper turn', and share scarce NHS resources, and medical staff are in control of the order in which patients are seen. More significant to the construction of the model citizen, though, is the established association between 'Britishness' and queuing. Forming an orderly queue and waiting patiently for one's turn instantiates British model citizen behaviour in the eyes of British people and in the world at large is an accepted 'trait' of Britishness (Osborne 2015; Woods 2019). The queue as represented in this banner is a symbolic connotation of British behaviour. Although it might appear to be a perfect example of a calm and orderly queue made up of well-behaved British citizens, the depicted participants are all disobedient, and either ill-informed or morally deviant, and the queue itself is illegitimate, with its participants ineligible for A&E. The discourse of blame in the banner, suggests that, if the wreath represents someone who has died because they were at the back of the queue, there is a problem with the British tradition of queuing.

The wreath carries connotations of death. It euphemistically symbolises a hypothetical person who is not present in the picture because they are dead. We know this because it is labelled in the same way as each of the people in the queue. Here, the symbolism can be viewed as a form of visual hedging; the producers of the banner are aware that at this level of realism to depict a dead person would be overly graphic and offensive or upsetting to some, possibly leading to complaints or disengagement with the text. Indeed there is nothing in the picture to suggest the real

nature of life-threatening injury or illness. There is no depiction of blood or other exposed and damaged body parts, nothing disgusting, no indication of extreme pain or fear. Also missing are any of the other participants found in a busy A&E department; there are no NHS staff, nor any children, for example. Although supposedly highly realistic, the image, like those in the first dataset, is sanitised and the reality of emergency care is mediated and recontextualised into a clean and tidy poster which is acceptable for public consumption. There is also no uncertainty, implying that it is easy to decide whether one's condition is eligible. Everyone in the queue should have gone somewhere else, with no in-between stage shown in order to train patients how to decide.

The presence of the wreath, while certainly thought provoking, introduces contradictions and ambiguity. It is a sign which, while indexing a similar referent for many people, may also signify a wide range of meanings. The pathos of the sign attached to the wreath, intentionally or not, introduces irony to the message. It is representative of death, and indicates the absence of a human who was entitled to attend A&E, while the others in the queue were not eligible for A&E services. By implication they are blamed for the death of the person with *severe chest pains*. However, the 'dead' participant represented by the wreath is also picked out for admonishment in the same register as the others, because they are just as much to blame for not asserting their entitlement to a place at the front of the queue. This stark metaphor serves to spur on the citizen to take control of themself, responsibilising and encouraging self-discipline as part of a neoliberal model citizen discourse of self-determination and individualism.

The images in this banner are used for symbolic shaming, as an example of uncitizenly behaviour. The high modality of the text and image, achieved multimodally through several semiotic modes as described above, combined with the salient timing and emplacement of the banner inform the public that their behaviour is wrong and that they should do something different. The symbols of the wreath and the queue are, once more, negative constructions, the wreath a reminder that the consequences of not following the guidance could be ridicule or responsibility for death.

Despite the accusatory tone taken on the banner, the paternalistic, 'corrective' register, and the presence of indicators that the reader is not behaving correctly and may be a malingerer, it is still clear that there is a choice. The epistemic reading of *should* indicates an alternative, and we are told, through the image of the queue, that these individuals have made an incorrect choice to attend A&E. Their other, 'correct' choice, is given on their label: *the GP, the walk-in centre* etc. However it is also evident that citizens must choose well, and that there are consequences of making incorrect choices, as the queuers are indirectly admonished for attending A&E and blamed for the death of a fellow citizen. This responsibilisation is part of an individualist neoliberal discourse of self-control, and the model citizen is constructed as an informed neoliberal individual. The web texts too, reinforce neoliberal discourses. Ledin and Machin (2015) explain how the organising of institutional information using tables and bullet points can shift organisations towards market-based principles as meaning is changed through de-grouping and reassembly of concepts. It is possible to see a similar process in the web texts under consideration, particularly on the Derby Hospitals home page which encompasses so many ideas, each neatly summarised to a few words and framed by being tidied into boxes of matching shape and co-ordinating colours, with NHS services presented as a set of choices, all equally accessible and available at the click of a key. As Ledin and Machin (2015: 466) put it, 'lists have been developed in order to separate items in a paradigm; tables are able to relate logical relations between elements through spatiality'. Choices are made by the writers and those who authorize their work in order to produce this information in such a way that it is aligned with the particular ideology prevalent in the institution at the time (Fairclough 2010: 42), and this recontextualisation (Jones 2013: 29-30) of NHS texts necessarily imposes a certain view of the 'landscape' of services upon the reader.

As has been demonstrated above, construction of the model citizen in these texts is not straightforward. Incorrect behaviour is modelled explicitly, but the reader has to piece together the correct course of action through a process of elimination, and by drawing upon existing cultural knowledge and exophoric reference to other texts. In interpreting the qualities required of the model citizen via such devices as ellipsis, symbolism and combinations of several communicative modes, the reader may

encounter at least two possible versions of the model citizen construct. Intertwined with the neoliberalist discourses of choosing well, and taking responsibility for the self, we again find something quite different. The banner appeals to the reader to put others before themselves, to allow others to go to the front of the queue, or in fact to leave the queue altogether and go elsewhere, so that others who are more needy might be treated. The ambulance posters indirectly ask the reader not to call 999 unless absolutely necessary, and the web pages urge their recipients to measure the calibre of their emergency against a linguistically defined standard, to 'allow A&E staff to concentrate on people with serious, life-threatening conditions' (Figure 20). The political landscape is never made explicit in the texts, but they attempt to appeal to the reader's wider knowledge of the cultural context in which the NHS is buckling under the joint pressures of increased demand and reduced funding.

These texts combine neoliberal discourse with one of sacrifice and co-operation. They construct the citizen as a compassionate partner in the success of the NHS, perhaps as the 'virtuous patient' envisioned by Evans (2007: 689). In this construction, the model citizen is a caring, co-operative and collaborative partner in the effectiveness of the resource-constrained NHS, acting collaboratively with others in the knowledge that other citizens are equally public-spirited and will only uses NHS resources when they are really needed, and allowing others to get to the front of the queue even though they are ill themselves. The eye-level view of the participants in the banner places the viewer as an equal to the queuers. But the 'offer' of the unmet gaze in the image poses the question to the viewer—*where should you be?* The citizen is asked to make a choice between joining the queue, and sharing the blame, or doing something different and becoming an obedient and therefore model, citizen.

These ideologically driven texts appear to be attempting to align the opinions of the public and patients more closely with those of NHS trust managers. Saddled with the responsibilities of reducing costs and adhering to standards on waiting times, they are attempting to establish a discourse of self-restraint in relation to these services. This discourse contradicts others perpetuated by the health services such as discourses of urgent action regarding suspected stroke or heart attack (NHS 2017, British Heart Foundation 2017). It encourages reflection, self-diagnosis and often self-treatment. As in the last chapter, we see dichotomies in the construction of the

model citizen. The text producers do not seem able to resolve the conflict between model behaviour as neoliberal and individualist or collectivist, so they pass on this problem to the reader.

5.6 Conclusions

While health trusts can, and have, prosecuted individuals for misusing their services (East Midlands Ambulance Service 2017) this course of action is expensive and time consuming for the trust. Hospitals could perhaps lock their doors when full, or turn away those not entitled to attend, but the ethical and professional codes upheld by doctors and nursing staff oblige them to provide help to those who present themselves. It is much better then, from the trusts' point of view, for them to be persuaded to go somewhere else in the first place. The exercising of this 'repressive' power (Holmes and Stubbe 2003: 100) is entextualised in the texts of this dataset through the pedagogic explanation of expected, or model, behaviour.

In effect, the construction of citizenly behaviour in relation to A&E services is, rather, a re-defining. The trusts are attempting to alter the paradigm in which the public believe it is appropriate to attend A&E when they have any kind of injury or sudden illness. It appears that they are trying to narrow down the definition of eligible use of A&E, and at the same time educate the public about a range of other services which are now available. They have parcelled up emergency care into several different categories which probably make good sense to the service providers, although not necessarily to the public. Their efforts to change public behaviour are mainly realised through multimodal messages which demonstrate behaviour models which are to be avoided, or in some cases followed. This could be classified as training 'to facilitate "voluntary" decision-making and educate people about the appropriate use of health services' (Lupton 1995: 53). In this dataset the model citizen is generally somebody who *does not do* a prohibited or illegitimate activity. Although 'modern' alternatives to attending A&E are put forward, they are not encouraged through a modernism agenda but through denial of the 'incorrect' behaviour.

In many cases producers of health information do not have control over the time or location in which a message is received. This applies, as in Chapter 4 for example, when a leaflet is widely distributed, or a TV advertisement is shown in several slots over a period of time, or appears online. For most of the data in this chapter though, emplacement and location are semiotic, as the producers have specifically chosen the channel to contribute to the meaning. They have asserted control over the time and place of the message, extended their authority by appropriating the formerly non-semiotic spaces of hospitals and ambulances, and like the *Stay Well* TV advertisement the NHS trust websites again bring discourses of control and model behaviour into the personal realm. Although the texts for this dataset are produced by different NHS trusts, and do not necessarily co-ordinate as one campaign, they work to achieve a common outcome. We are used to seeing health promotion materials from the NHS which are designed to encourage healthy behaviour of one sort or another. However the campaigns in this study, although produced and disseminated by health communications teams, are only indirectly related to health. They are not *about* health, rather they are metadiscourse about following the rules in relation to rationing of health services. They are significant in their own right due to their prominence, the major investment of resources in producing them, and the perceived importance of their messages in relation to the delivery of emergency services.

In this chapter I have investigated the construction of the model citizen, as a discursive strategy within a second range of texts relating to use of emergency services, in combination with other discursive strategies of (re-)establishing the authority of the NHS and establishing the correct use of emergency services. None of these strategies are enacted through one text alone, nor on one level of semiosis. Each text relies on the reader appreciating the intertextual references between these texts and others. They assume a sophisticated understanding of current affairs, and a familiarity with the discourses circulating in the news media in which politicians urge the public to avoid A&E departments because they are struggling to meet demand.

Through control of discourses, including issuing instructions, and 'ownership' of the spaces in which they are recontextualised and dissipated, the authority of the NHS in the domain of health is re-produced. The depiction of the correct behaviour reveals aspects of the underlying ideology which must be followed to become a model citizen.

What emerges is a discourse which is paternalistic in its portrayal of the relationship between the NHS and the people, but conflicted in the ideology which should be adopted. Unlike the docile citizen in the first dataset, the model citizen here, is constructed as having agency. They must take action, and go out of their way to find information about their condition. Rather than staying at home they should be prepared to travel to the most appropriate place for treatment. As in Dataset 1, they must prepare for future accidents and illnesses, by maintaining stocks of medicines in the home, but now they are expected to self-diagnose, and to understand the workings of the various departments of the NHS.

However many presuppositions are made in this dataset about the citizen's resources, knowledge and capacity to choose correctly. These include implications that the reader is a burden on the NHS, wasting public time and money. It is also implied that the reader's injury or condition is not serious, and that they do not know how to use NHS services, and may be a malingerer. It may seem that the risk of 'incorrect' interpretation is slight, as the difficulties affecting the NHS have been widely publicised, but these campaigns do not, as yet, appear to have been effective. Whilst the producers of the texts have gone to considerable effort to be creative and to produce eye-catching texts, placed in meaning-laden spaces, to elicit model citizen behaviour, it is evident that the NHS trusts may not be pursuing this strategy effectively. Ridiculing one's potential audience is rarely an effective move, and referring to humans by the name of their condition is unlikely to engage readers. Through the banner, which tries to shame us for attending the hospital wrongly, the ambulance posters which take this idea even further and suggest we may make poor decisions which are worthy of ridicule, and the web pages with their moralistic register and semiotic colour coding, these texts are attempting to shift behaviour to something more desirable. These campaigns reinforce each other, through their contribution to the reproduction of common discourses, in which the public are to blame for the problems of the NHS, and must take action to remedy them. This is not made explicit, although by directing or presuming to understand the citizen's behaviour, and by shaming those who misbehave, these campaigns and web pages come very close to locating the blame with the unwell citizen. This chapter has shown that the model citizen is again present, although different to the construct in the

previous dataset. In Chapter 6, I will investigate a further set of data found in A&E departments themselves, in which yet another version of the model citizen emerges.

6. Third Analysis Chapter: Friends and Family

6.1 Introduction

My first analysis chapter looked at construction of the model citizen in a media campaign aimed at least in part, at avoiding the necessity for readers to use emergency health services through preventative care. In the second I considered various texts directed towards those about to use emergency services, which urged the reader to make the 'correct' choices in accessing these services. This final analysis chapter completes the journey to emergency healthcare by focusing upon texts found in the waiting areas of Accident and Emergency (A&E) departments, revealing a third version of the model citizen produced by the texts, but also by the environment in which they are found. As explained fully in the Methodology, the texts referred to in this chapter were collected from A&E departments at Lincoln County Hospital, United Lincolnshire Hospitals NHS Trust (ULH) and Queen's Medical Centre, Nottingham University Hospitals NHS Trust (NUH).

Entering the waiting room of a UK A&E department the visitor is bombarded with numerous messages and many genres of information. There are noticeboards and leaflet display racks, but the volume of texts has expanded to such a point that these defined spaces are not sufficient; posters have been attached to walls, windows and doors; leaflets sit not only in the designated racks but also on tables, reception desks and radiators, and there are stickers, official-looking plaques, and notices of many types everywhere. The discursive experience is multimodal and three dimensional, as floors are also used to convey messages (Figure 23), and directional signs with words and symbols hang from the ceilings (Figure 24). Free-standing branded items of equipment, vending machines and pop-up marketing displays (Figure 38) also populate this highly semiotic space, and even waste bins sport images and instructions about what is to be placed into them. The texts in this linguistic landscape (Landry and Bourhis 1997, Heubner 2009, Adami 2017) fall into many categories, covering a wide range of topics. Typical examples include notices about procedures, such as the 'Your Observations' poster at Nottingham (Figure 28) which explains how technology will be used to record patients' vital signs, warning notices many of which state that violence will not be tolerated in the department, and

publications about the role of various charities. Also competing for the attention of the reader are the many signs giving directions to other parts of the hospital, and commercial texts such as the leaflets about a meals delivery service, a sign with a taxi phone number, and various charts and signs about feedback received, showing 'how we are doing'. It would not have been possible to carry out a detailed analysis of the multitude of texts in the waiting rooms, so to make sense of the space, and of the demands upon the model citizen it was necessary first to sort and categorise the texts (see 3.7.4.3). This clarified the picture to some extent, enabling me to develop the criteria explained in the Methodology to select the most suitable texts for analysis. Any text in this space has competition for the attention of the reader, but placing them into categories we find that one of the most prolific types of text are those concerned with obtaining feedback from patients and carers, and the two data collection sites each had several different texts produced with this objective, including a number of texts related to the NHS Friends and Family Test (FFT). The focus of this chapter is upon one such text which was available in both locations. I also refer to some of the other FFT texts found in the Nottingham or Lincoln waiting rooms, and the broader context of the wide variety of texts at both A&E departments.

The Friends and Family Test was introduced to NHS services in 2013, and has since been rolled out to all services (NHS 2018). NHS England require trusts to 'provide an opportunity for people who use NHS services to give feedback through the FFT', in all except the most 'sensitive situations' (NHS England 2015: 29). NHS trusts are also



Figure 23: Floor sign at Lincoln A&E



Figure 24: Example of ceiling sign at Lincoln A&E

expected to provide monthly returns of data to NHS England, and the 'FFT Question' is explicitly specified and tightly controlled, although trusts have freedom to ask additional questions and to use whichever formats they feel are appropriate for their users.

The FFT could be seen as a process of debureaucratisation by which 'bureaucratic strongholds' such as the NHS aim to appear less impenetrable, and to invite the involvement of their users. Whether this actually leads to a better understanding of processes by NHS patients remains to be seen. An extensive corpus study into responses to the FFT question by Baker et al. (2019), reported upon the main areas of concern raised by patients, and investigated such areas as the effect of age and gender upon evaluation. Although they found that patients gave feedback on a wide variety of topics by far the most frequently commented upon topic, for both positive and negative reviews, was quality of service, with comments on actual treatment and competence of staff under-represented. This led them to speculate about 'the rise of consumerist values in healthcare linked to neoliberalism' (2019: 220). In this final analysis chapter I look not at these responses but at the materials which aim to generate them, those texts placed in A&E waiting rooms that entreat patients and carers to provide their feedback.

6.2 Description of the texts

Text A: 'National' FFT leaflet

This is a four-page A5 leaflet (Appendix 3), produced by NHS England in full colour, and available at both ULH and NUH. Approximately half of the front cover (Figure 25) is taken up with a solid 'NHS blue' background, on which the title *The NHS Friends and Family Test - Inpatient and A&E - A Short Guide for Patients,* appears in white. A full colour photo with curved edge and wide white frame occupies the remainder of the cover, with an NHS logo in the top right corner. Inside (Figure 32), each heading is in the form of a question, with the answers given in smaller type underneath. There are also photographs, and at the end, contact details for those who want to find out more. Because of its lengthy title I refer to this as the 'national' FFT leaflet. The analysis in this chapter refers to this text unless otherwise stated.

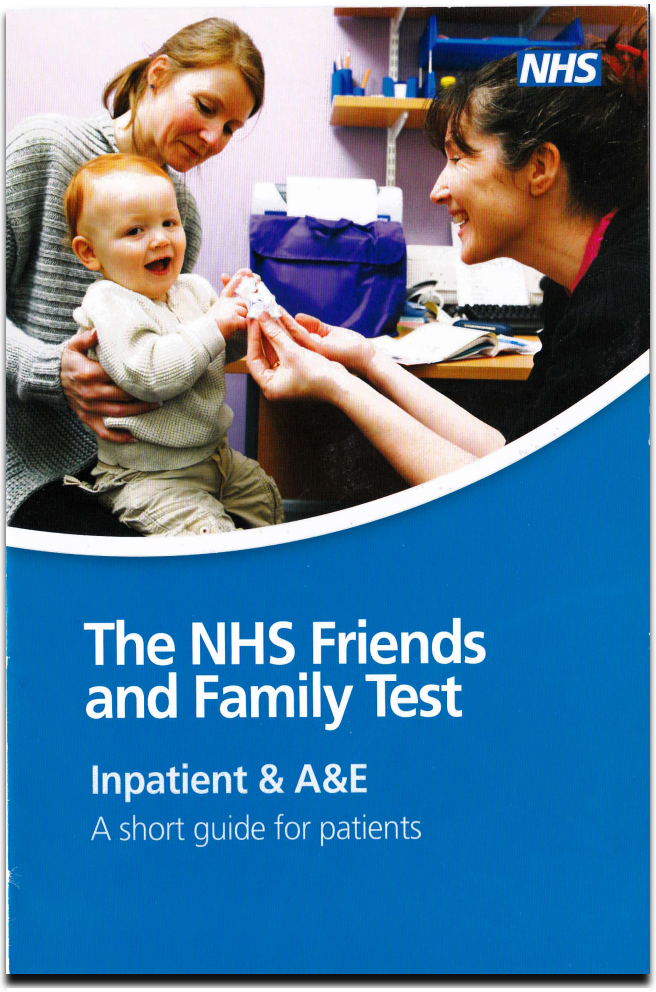


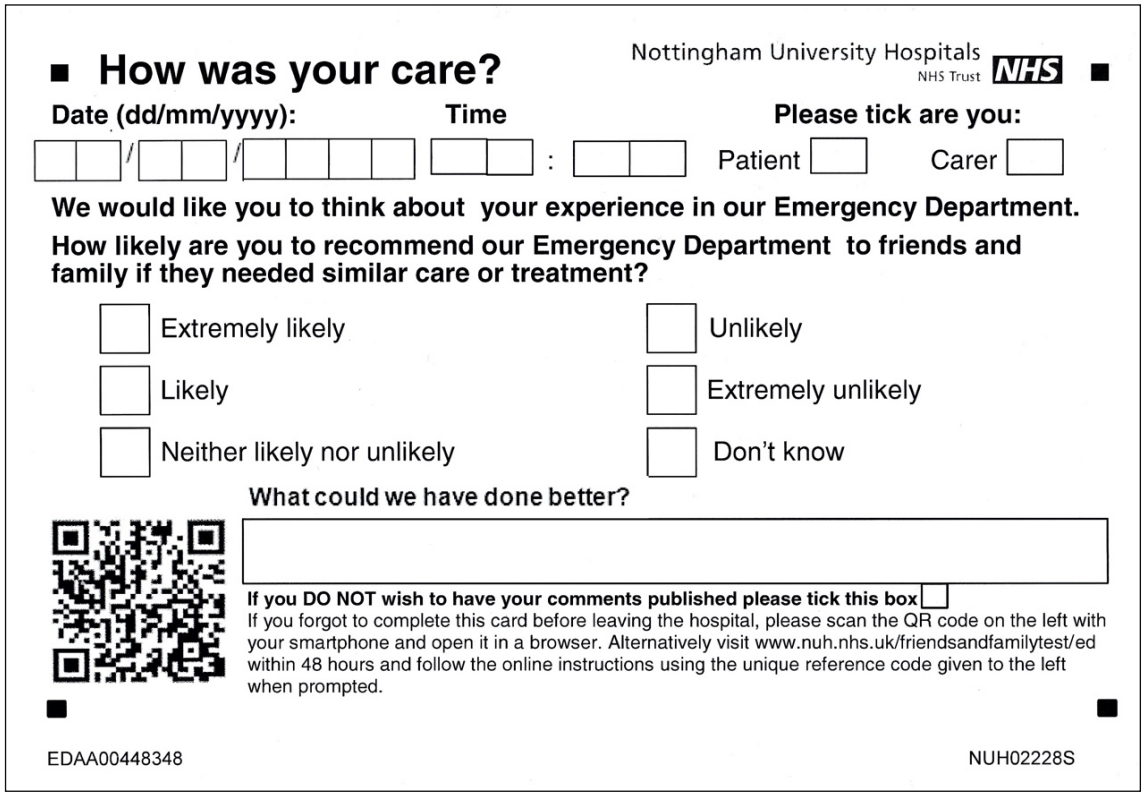
Figure 25: Front cover of the national Friends and Family Test leaflet

Text B: *How was your care?* card

This A5 card (Figure 26 and Appendix 4) was collected from the waiting room at NUH. Published by NUH NHS Trust, it is a simple document printed on both sides in black, on white board, with no pictures, although does carry the NHS logo, the name of the trust and a QR code which can be read by a scanner program on a mobile phone. Otherwise it consists solely of questions and boxes to tick. It is in landscape orientation, and designed to be posted into the survey posting box (Figure 29) Pictures of the cards appear on these boxes.

Text C: *Emergency Care Going Home Survey*

This four-page, A5 form (Figure 27 and Appendix 5) is published by ULH NHS Trust and printed on uncoated paper of a substantial weight, in full colour. A letter from a senior member of staff appears on the front, along with the ULH NHS Trust logo, and two other logos 'Your Experience Counts' and a 'Friends and Family Test' logo. Inside, the format is similar to the *How was your care?* card, with questions and boxes to tick and complete, although the spaces to answer the FFT question are colour coded, and again, contact details for more information are given at the end.


How was your care?

Nottingham University Hospitals NHS Trust NHS

Date (dd/mm/yyyy): / / Time : Please tick are you: Patient Carer

We would like you to think about your experience in our Emergency Department.

How likely are you to recommend our Emergency Department to friends and family if they needed similar care or treatment?

Extremely likely
Likely
Neither likely nor unlikely
Unlikely
Extremely unlikely
Don't know

What could we have done better?

If you DO NOT wish to have your comments published please tick this box

If you forgot to complete this card before leaving the hospital, please scan the QR code on the left with your smartphone and open it in a browser. Alternatively visit www.nuh.nhs.uk/friendsandfamilytest/ed within 48 hours and follow the online instructions using the unique reference code given to the left when prompted.

EDAA00448348 NUH02228S

Figure 26: *How was your care?* card from QMC

L1, L2 etc. in this chapter refer to line numbers in the National FFT leaflet, and a transcript is available (see Appendix 1). I also make reference to the other FFT texts present in the waiting rooms.

The completion of the FFT, is of course only the beginning of a series of actions which will ripple outward through the A&E department, the hospital, and the rest of the NHS. The main objective of the texts in this dataset is to enable and ensure the completion of the FFT by the patient or carer, and to maximise the uptake of the survey the writers again employ several multimodal strategies. Firstly, as has been seen in the previous chapters, they must **i) establish the authority of the NHS** to make demands upon the citizen. In this case, rather than the patient relying upon the NHS, the situation is reversed, and the NHS is making a demand upon the time and intellectual resources of the individual, so must **ii) develop a relationship with the reader** which will render them amenable to carrying out this task**.** It is necessary for visitors to the A&E departments to understand what is required of them and to accept

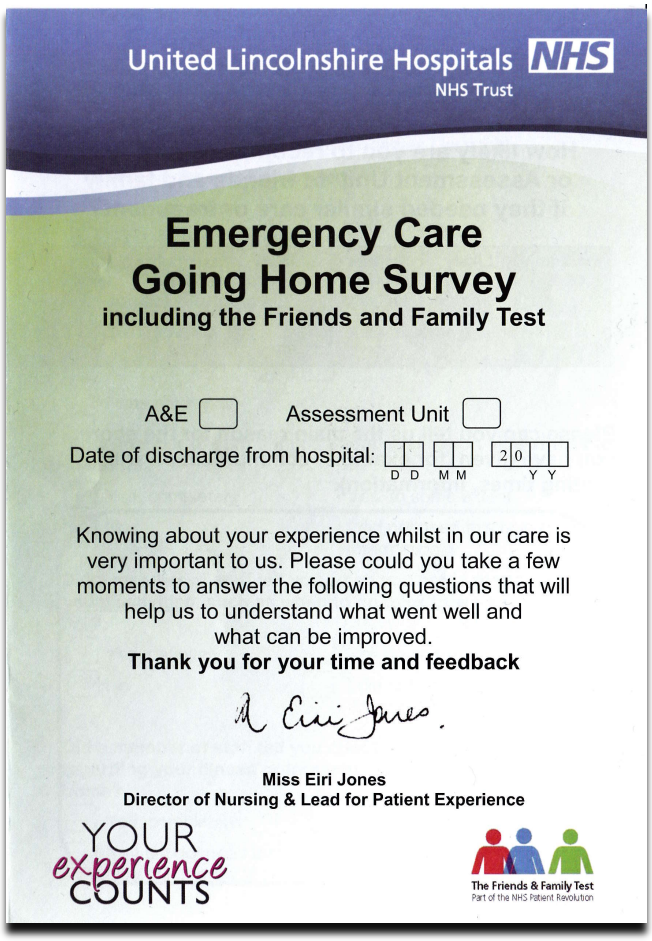


Figure 27: Front page of the *Going Home Survey* from Lincoln Hospital

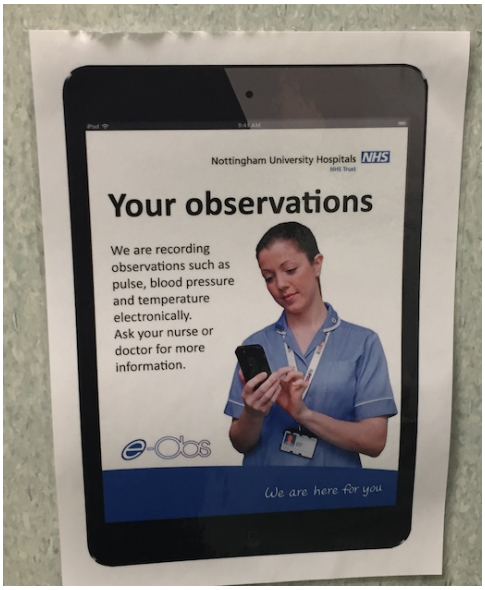


Figure 28: Your observations poster

that reviewing and recommending is part of the healthcare experience, so this is achieved through the strategy of **iii) normalising of feedback discourse,** and when these three strategies are in place the **iv) construction of a model citizen** who is keen to help the NHS by giving freely of their opinions can take place. Again there is overlap between these strategies, and the language and other communicative modes used to achieve them, and as before, points are addressed below under the most pertinent heading.

6.3 (Re-)establishing the authority of the NHS

As in the preceding datasets, we can see in these texts the use of pronouns to establish the synthetic personalisation found in many public sector texts. In the FFT national leaflet there are 26 *you* tokens, but only two of *us,* and no instances of *we.* The only occurrence of *I* is in the sentence 'Where can I get more information?' (L25) which also refers to the reader. Instead of first person pronouns the writers have preferred labels such as 'the NHS' (L5, L7), 'the information' (L7),' hospitals' (L22, L24), 'the hospital' (L23). More frequently qualified with the possessive determiner *your* in 'your NHS service' (L26) and 'your hospital' (L16, L17, L19, L24), as I shall discuss later in this chapter, this occasionally leads to odd constructions, for example:

L17 Your hospital will be very keen to hear from you so it knows what you think of the care or treatment you have received

However, odd choice of wording does not seem to have concerned the creators of the FFT, as the FFT question itself, stipulated by NHS England, is phrased in a curious way, with a mismatch of tenses between the verbs *are* and *needed*, so that careful reading is required for its comprehension:

L10 "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

In the simple present 'how likely are you to recommend our ward/A&E department to friends and family...' is more naturally concluded with '...if they need similar care or treatment'. Alternatively, substituting 'how likely are you...' with the conditional 'how likely would you be...' would also be satisfactory. The inclusion of the '/' further complicates the syntax.

Also common in public information and contributing to synthetic personalisation and conversationalisation is the question and answer format used in the national leaflet. This mimics the turn-taking structure of an interview, with the reader cast in the question-asking role, although, of course, the questions here are generated by the writer rather than the reader. This conversational pattern sets up what Sarangi and Slembrouck (1996: 38) have termed 'seeking' and 'giving' frames, which draw

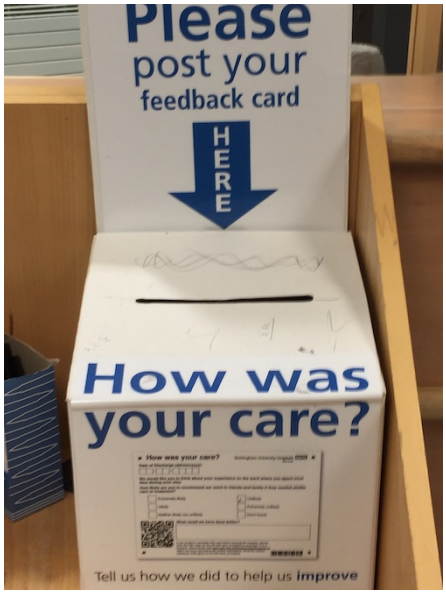


Figure 29: Survey posting box on the reception desk at Nottingham A&E

divisions between clients and institutions. The NHS as a public authority thereby lay claim to their entitlement to ask questions or set the agenda. The information in leaflets from the NHS and other public bodies is intended to take the place of a real conversation with a professional or representative of the organisation (McIntosh 2014: 35) and bureaucratic interactions, although often fashioned as conversations between reader and writer, are 'complex, multi-level types of socio-economic interest relationships' (Sarangi and Slembrouck 1996: 59). However, the answers in this dialogue are framed in generic terms, recontextualising the meaning of the process. Possibly because this leaflet is produced nationally and must appear relevant to every A&E or inpatient service in England, it gives very little detail.

Even though in this case it the NHS who need the help of the public, they maintain control of the process through clearly specifying the information required and ways in which it may be provided. This can be further explored by looking at Text B, the *How was your care?* card (Appendix 4) which is designed to collect the patient's feedback. The FFT question appears on the front of the card, with five scaled responses from 'very likely' through to 'very unlikely' plus 'Don't know'. There are also spaces for the date and time; here the boxes also indicate the format in which the information should be supplied—the time should be entered into a space with two boxes, a colon, then a further two boxes, without an option of 'am or pm', indicating that the respondent should use the 24hr clock. Some of the questions include specific guidance on completing the section—for example, 'date (dd/mm/yyyy)' and 'please tick'. On the reverse of the card are additional tick boxes for the collection of demographic information, and the respondent is also asked to indicate whether their day-to-day activities are limited by a long-term health problem. A list of options is given for each question, so that the citizen is required to choose one of the permitted answers. On the front of the card is a box for a 'free text' response to the question *what could we have done better?*, but it is very small at only 12 x 161mm, indicating that the response given should be short. There is no space beneath the box, so in order to write more than a sentence or so, the patient would have to continue in an unofficial space on a different part of the card. So the NHS control the possibilities for feedback, limiting them to those which fit to the defined specification, and organising them into space-limited boxes which 'constrains the client's activity in that it does not

allow clients to tell a whole story' (Sarangi and Slembrouck 1996: 128). Rather than an 'opportunity' for the patient, who might like to give feedback in a different way, or to explain at greater length, the questions are designed to collect measurable data in the required format. This allows counting and categorisation, and will aid the NHS in interpretation and recontextualization of the data into other formats and discourses.

Subtly and in diverse ways, the NHS keeps control, through both lexical and non-lexical modes. The national FFT leaflet, like many other texts in the waiting rooms uses 'NHS blue' and white, which as I have previously pointed out, contribute to the construction of identity of the NHS in its publications. The NHS typeface Frutiger, or the authorised second choice typeface Arial (NHS England 2018b) are also used throughout even the simple FFT items. Clearly the message has got through from national to local NHS communications teams about the importance of a corporate approach to style. As with the previous datasets, the NHS logo features strongly as a signifier (Ledin and Machin 2018: 34) in the production of NHS identity. Every text concerning the FFT carries this simple logo, sending a clear message that these publications belong to the NHS, with all the additional values and cultural associations which accompany that ownership.

The NHS logo is also reproduced many times on other texts in the waiting room, most commonly in combination with the credentials of the trust responsible for the A&E department, namely ULH or NUH. Other publications on display carry the logos of NHS departments and geographical regions such as NHS Blood and Transplant and NHS Nottingham City. Indeed these logos may be the main way by which NHS texts are distinguished from the other texts there, as although the waiting rooms are within NHS hospitals, and therefore entirely under their control, between the two sites for the study there are over sixty non-NHS logos visible on the photos I took during my visits. These signify public bodies such as local councils and government departments, charity and voluntary sector organisations and private companies. The presence of these organisations is communicated by their logos on the many posters and leaflets, but also, for example, on, drinks machines, hand-cleanser dispensers and supposedly 'non-semiotic' items such as medical equipment. These logos also sometimes appear alongside the NHS logo, as on some of the texts in the Lincoln waiting room, which sport an FFT logo or a strapline 'your experience counts' (see

Figure 31). The effect of this is to fragment the NHS identity, so that even though all carry the NHS logo, there is something different, or additional, that applies to certain items. Whether or not they understand, or are interested in what these differences are, this may allow people to group and categorise the many communication items. The visibility of many other logos may disrupt the strategy of authority production and certainly contributes to the confusing assemblage of messages in the waiting room, which is quite different to the clarity and unanimity depicted in Chapter 4.

The FFT texts are therefore competing for the attention of the reader with texts conveying diverse discourses. For example there are overtly commercial texts promoting products and services, which belong to sales discourses of prices and buying. These include the notice with the number of a taxi firm, leaflets for a commercial home meals service, and the bright and brash cold drinks machine. The posters and leaflets bearing the logos of charities and voluntary organisations carry a variety of messages, often combining discourses in a single text, including supportive advice-giving discourse and fundraising rhetoric. Also visible at both sites, are texts which are not addressed to the public at all, but rather to staff; notices about confidentiality, instructions on where to park moveable equipment, instructions on rubbish removal and handwashing, are clearly visible to patients along with those specifically addressed to them (Figure 30). These belong to workplace discourses of organisation, cleanliness, efficiency and more. There are not sufficient visual clues for the reader to know, without reading, whether the posters are intended for them, so as

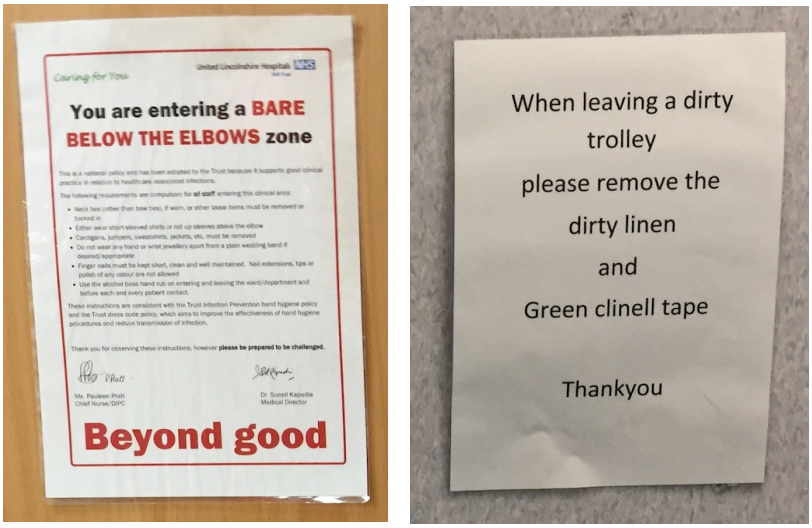


Figure 30: Signs in public areas but addressed to staff, from Lincoln (left) and Nottingham (right)

they have an 'official' appearance it may be necessary for patients to read them to ascertain that they are not relevant. All these texts co-exist in the semiotic space of the waiting room, but although there are many non-NHS texts, it is not a free-for all. There are few commercial texts, for example, certainly in comparison with those from public bodies and charities, and these too are limited to a select few. Choices have been made about what to allow and what is not appropriate within the linguistic landscape of the A&E waiting room. Although there are a melee of messages vying for the attention of the reader, they all fall within certain boundaries, perhaps reflecting an organisational policy about topics relevant to the occupants of the waiting room. The space is owned and controlled by the NHS so (presumably) they aim to serve their own interests (Shohamy and Waksman 2009: 321) and the interests of the people waiting. But not all NHS discourses are sanctioned here either. Though this is the A&E department there are no traces, in this large volume of texts, of the NHS discourses of crisis, cuts or closures found in newspaper stories, neither are there messages about the inefficiencies of which successive governments have criticised the NHS. Texts displayed will not be anti-NHS or discourage people from providing feedback. Despite the apparent disorder in this 'arena through which various agendas are being battled, negotiated and dictated' (ibid.) the discourses deemed suitable for the waiting rooms are controlled and sanitised.

6.4 Developing a relationship with the reader

I have shown in the previous chapter how the NHS has attempted to engage readers through use of humour, or shame them into acting differently from the way in which they intended. Rather than escalating the calls for patients to avoid A&E perhaps by using threats or stronger sarcasm, the producers of the various FFT texts adopt a tactic of heightened politeness, attending to the face (Brown and Levinson 1987: 61) of their readers order to influence them to complete the FFT. Several of the FFT texts include the overt politeness markers *please* and *thank you*, and other indicators that threats to face are being addressed. For example, even though it is in effect a form, the ULH 'Emergency Care Going Home Survey' (Appendix 5), includes six instances of *please*, a *thank you*, and a personal address from the Director of Nursing. Official

forms are often worded very curtly, with simple labels like 'Name' 'Address' as shorthand for the instruction 'write your name here' etc. This form differs from the convention, explaining fully what is required, and indexing politeness norms through use of mitigating terms such as *could you*, *we would like you to*, *can you*, *feel free to*, and *if you would prefer.* The 'How was your care?' card from NUH too, despite being limited to two sides of A6, makes space for polite form by beginning 'we would like you to think about….' and uses 5 *please* tokens. Other FFT texts including the basic 'Have you been discharged?' poster (Figure 31) follow a similar pattern. Compared to the NHS texts in previous chapters, there is detectable respect and even deference afforded to the reader here.

The national FFT leaflet also provides contrast to texts in the other datasets by avoiding direct requests to complete the FFT. Unlike the texts in dataset two the writers do not appear to have made any attempts at irony or humour in the FFT texts, and there are no threats associated with not complying. Rather, as I discuss later in this chapter, the text describes the FFT and lists the benefits it will bring, giving reasons to complete the form rather than directives to do so (see section 6.6), and thus attending to the negative face (Brown and Levinson 1987: 62) of readers. There is a prevalence of passive verb constructions:

L6 You will be given the opportunity

L9 you will be asked to answer

L11 You will be invited to respond

L13 You may be asked

L13 or you may be invited

These verb phrases give the impression that the citizen must wait for permission before they can carry out the action of completing the questionnaire. They also remind the reader that here in the hospital they perform the role of patient, and do not necessarily have control over what happens to them. This positioning of the reader in the traditional, passive patient role is quite a contrast from the active role they were expected to take in the previous dataset. Even in active constructions the reader is often reminded that their subject position is that of recipient:

L6 When you receive care

L9 When you are discharged

Posters on the walls (Figure 31), and the prominently positioned feedback posting box (Figure 29) at Nottingham, reiterate the 'important question' to citizens in the waiting room. The reader is constantly reminded that they are receiving care, whilst being asked to complete the FFT and being told how helpful it would be for them to provide information. These texts attend to the positive face (Brown and Levinson 1987: 62) of the reader by repetition of this point, implying that the status of the reader is elevated because of the important task they need to complete.

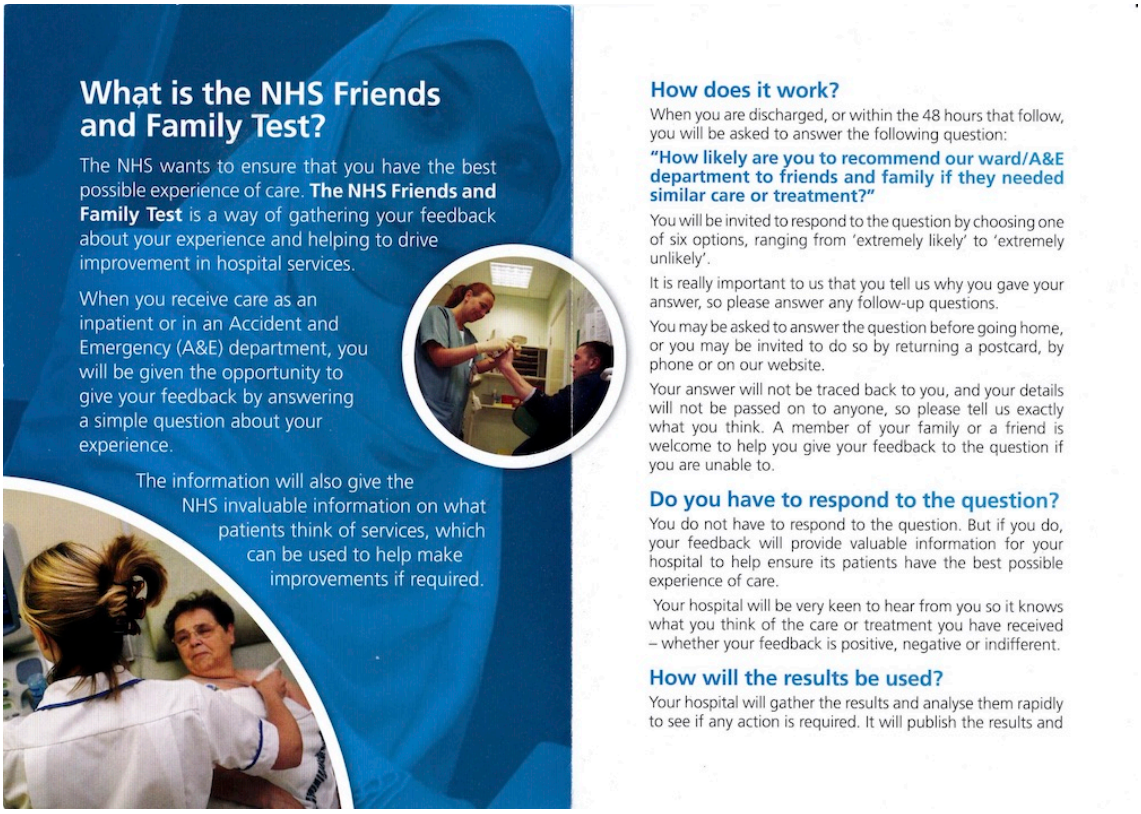
It is useful to remind ourselves that politeness is 'based upon recognition of differences of power, degrees of social distance and so forth and oriented to reproducing them without change' (Fairclough 2015: 92). Any change in the degree of



Figure 31: Posters about completing the FFT

politeness is likely to be a manoeuvre engineered to obtain co-operation whilst maintaining power relations. It may be that completing questionnaires is perceived to be a step over and above the 'patient role' (Evans 2007), and in those terms may be seen as face threatening (Brown and Levinson 1987: 67ff.) so excessive politeness is required to ensure that the patient takes part. Alternatively they may also be an attempt to induce gratitude, or to generate guilt in those who have not yet completed the questionnaire. However, when considering online responses to the FFT Baker et al. (2019: 75) found that 81% of ratings were for either 'extremely likely' and 'extremely unlikely' to recommend, with a total of only 12% giving either 'likely', 'unlikely 'or 'neither likely or unlikely' ratings. They conclude that an extreme experience is more likely to motivate a patient to respond than a mediocre one, which may imply that experience is a more effective motivator than any of the texts, however persuasive or polite they may be.

Photographs in the leaflet also contribute to the strategy of relationship building, by establishing the writers' perceptions of the relationship between the reader and the NHS. The photos are interspersed with the printed text, although they do not illustrate it or help the reader to understand it, so must have been included for another purpose. Of the five photographs in the leaflet, four are alike in that they each depict a different member of staff and a patient, plus in one case a parent or carer of a patient. These four photos are reproduced in realistic full colour, each showing health professionals in health settings but in contrast to the depictions of staff in the first dataset they are all 'offer' images) with no-one, apart from a baby, looking directly at the viewer. Rather than speaking to the camera the staff in these texts are doing their job, working with patients and providing care, as the reader looks on. The patients in the pictures are depicted interacting with the professionals, through eye contact or physical contact. The gaze of the medical professional is on their patient, and each case the medical person is in physical contact with the patient, although insufficient detail is shown to completely understand what kind of care is taking place. Neither is it clear what type of health workers they are. The staff member in the photo on page one, for example, wears a dark top which does not look like a uniform. She could be a GP or a social worker, therapist or some other professional. In another picture on page 4, a nurse stands next to a woman who is lying or sitting. The nurse appears to



What is the NHS Friends and Family Test?

The NHS wants to ensure that you have the best possible experience of care. **The NHS Friends and Family Test** is a way of gathering your feedback about your experience and helping to drive improvement in hospital services.

When you receive care as an inpatient or in an Accident and Emergency (A&E) department, you will be given the opportunity to give your feedback by answering a simple question about your experience.

The information will also give the NHS invaluable information on what patients think of services, which can be used to help make improvements if required.

How does it work?

When you are discharged, or within the 48 hours that follow, you will be asked to answer the following question:

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

You will be invited to respond to the question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely'.

It is really important to us that you tell us why you gave your answer, so please answer any follow-up questions.

You may be asked to answer the question before going home, or you may be invited to do so by returning a postcard, by phone or on our website.

Your answer will not be traced back to you, and your details will not be passed on to anyone, so please tell us exactly what you think. A member of your family or a friend is welcome to help you give your feedback to the question if you are unable to.

Do you have to respond to the question?

You do not have to respond to the question. But if you do, your feedback will provide valuable information for your hospital to help ensure its patients have the best possible experience of care.

Your hospital will be very keen to hear from you so it knows what you think of the care or treatment you have received – whether your feedback is positive, negative or indifferent.

How will the results be used?

Your hospital will gather the results and analyse them rapidly to see if any action is required. It will publish the results and

Figure 32: Centre pages of the national leaflet

be asking the patient a question, and looks over the top of her glasses to make eye contact with the patient who looks up at her. It is clear that a health interaction is taking place, but the nature of the transaction is not so clear. As the scope of the leaflet — inpatient and A&E —is very broad, these photos illustrate health encounters, but not specific ones, so that the information is not perceived as applying only to certain interactions. We can say that these photographs rely on 'iconic signs' to communicate generic representations of experiences 'in a way that could not be directly depicted by language' (Ledin and Machin 2016a: 6) but nevertheless explains, reproduces and develops the relationship between the NHS and its users. In this text we are not told the names of the professionals, and there is no caption to clarify their role, yet their authenticity is not in doubt. In contrast with the first dataset the lighting of the scenes is not so bright, appearing less like professional studio lighting, and more like a real hospital setting. The settings therefore seem authentic, and are likely to be real NHS settings, unlike the staged and idealised ones shown in the first dataset. Bodily stances and facial expressions also appear appropriate and natural. The pictures depict an 'imaginary relation' (Kress and van

Leeuwen 2006: 118) modelling actual interactions and the relationship with the professional which takes place in health encounters. The depicted staff are intended to represent all, or any, staff that the patient encounters in the health setting; the depicted patients stand for the patient and represent their role in those settings, attempting to remind the reader of health interactions they have experienced.

However these photos only contribute to relationship building with some sections of the community. I have talked (in section 4.3) about the ways that depictions of people can operate as a non-linguistic mode, to communicate to the audience that the information in the text applies to them, and in the previous analysis chapters I have mentioned the demographic mix of depicted participants. On first inspection there is little or no indexing of diversity in this text; all participants are white-skinned, all staff are female, and only one of the adult patients is male. However there is a fifth photo which sits behind the text on the inside pages. This appears to show a woman wearing a hijab or other Muslim headgear. Although this is the largest photo in the leaflet, it is reproduced as a black and blue duotone, meaning that it is printed in only these two colours, rather than full colour. Showing no surrounding context, the duotone is presumably dark so the white text is readable, but this renders the image of the woman somewhat ghostly as it is difficult to discern any detail. Because of this, it is not possible to distinguish whether the woman in the picture is an NHS staff member, a patient, or as is likely, the subject of a stock image from a photo bank which depicts someone doing something completely unrelated. It is plainly a photo, but has lower 'naturalistic modality' than the others due to its limited colour differentiation (Kress and van Leeuwen 2006: 160). It is therefore not clear why she is there, what meaning she is meant to add to the text, or why she is blue!

Furthermore, the other four photos are framed with a wide white frame, and a shadow added to give an impression of three dimensions, with the effect that they appear to be in the foreground. This fifth photo is treated differently: it is in the background, with text on top of it. Somehow it is meant to indicate the presence of non-white participants, or the relevance of the FFT to them, but this is not demonstrated clearly. Despite this, Non-white and non-English speaking users of the NHS are still expected to participate. Texts B and C, intended for completion by patients, ask for various demographic information including gender, ethnicity,

sexuality, religion, disability and age details. Indeed the *How was your care?* card asks only two questions about service standards, but seven about the status and demographics of the respondent, showing that they are keen to categorise and sort those who complete the forms. When viewed in relation to the previous NHS texts about emergency healthcare it is clear that a different relationship between writer and reader is being constructed. This reflects the altered relationship with patients when the NHS, rather than providing a service, requires a service from the citizen.

6.5 Normalising the discourse of feedback

Having demonstrated that a new kind of relationship with the citizen is required, the strategy of normalising feedback is necessary to maximise the proportion of patients and carers completing the FFT. The objective of this strategy is to ensure that feedback becomes a natural part of the healthcare experience, rather than some additional or unusual step, or an action which is only carried out in special circumstances. The strategy is enacted in the national FFT leaflet and also through the cumulation of texts about feedback. The volume of texts, and their materiality, play a part here, as does the nature of their content, with posters displaying charts, percentages and statistics, along with semiotic deployment of colours contributing to the normalisation of this discourse. Much of the normalisation of feedback discourse has already taken place away from the hospital, and before the A&E visit. When buying goods and services customers are commonly asked to provide ratings and feedback about the quality of products and about their experience of customer care. This applies in particular to online shopping and booking of hotels and entertainment where the trend has accelerated to the point that '(s)uch is the prominence of online reviewing that it has become a taken-for-granted, "naturalised" genre of communication' (Baker et al. 2019: 16). The real and virtual worlds have also become interlinked to the extent that visitors to real shops, restaurants, hotels and many other consumer services see online ratings displayed in store, and are asked to leave feedback on a review site such as TripAdvisor after their visit. Businesses uses a variety of tools and methods to request feedback, so citizens are becoming accustomed to being asked to give comments, ratings and recommendations.

Surveys and feedback collection have been conducted in the NHS for several decades (Coulter 2013: 10ff), although never on the huge scale of the FFT. Although it is a relatively recent innovation, in the texts the FFT is not introduced as a novel process, and there is no hint that this is new or out of the ordinary. The leaflet makes it clear that the FFT is not the only way to tell the NHS about experiences, making reference to *existing ways of gathering feedback* and *other forms of feedback used by the hospital* (L24). It states that readers can *still pass your compliments or complaints to your hospital in the normal way*, suggesting that this is a pre-existing procedure which the reader has done before and with which they are familiar. It is presented to the citizen as an everyday activity which is normal in healthcare, and with the presupposition that healthcare is similar to hospitality because similar questions can be asked about



Figure 33: Detail from *Going Home Survey* form

both sectors. Patients, of course, have assumptions of their own about how A&E and the NHS are supposed to function, what tasks should be carried out by doctors, nurses and administrative staff and in what manner these tasks should be done. The FFT frames the A&E experience in terms of likelihood of recommendation, which aligns it with other experiences which can be recommended or not recommended and raises the question, to which I shall return later in this chapter, of whether citizens do view hospitals and health services in the same way as they view hotels and shops. Apart from a simplistic explanation that *(y)our hospital will gather the results and analyse them rapidly to see if any action is required* (L19), nowhere in the texts do the writers explain the complex process by which selecting a 'likelihood' rating and posting a card into to a box can be converted into *improvement in hospital*

services (L5). There is an assumption that people understand how the responses convert into to change, with no real attempt at explanation of how this complex process might take place. The NHS appear to assume there is intertextuality with other texts about feedback, or that the public are so familiar with the process that it would be superfluous to include this information. To present this mechanism as a simple step is misleading as there are many factors and processes involved, and although the public at large may be familiar with feedback in a general sense, it is important to pay attention to the ways in which this largely commercial discourse is newly associated with health services. Another notable feature of the leaflet is that although published by the NHS, because of its focus upon process, there is limited use of actual health-related terms. Instead there is a preference for commercial stock phrases, or 'empty business language' (Machin and Mayr 2015: 135) such as *the best possible experience of care* and *drive improvement* (L5). With a few substitutions the leaflet could be about almost any product or service, and this may be a deliberate move to align it more closely with other texts about feedback.

Colour comes into play as a communicative mode in the strategy of normalising feedback, but it is deployed in a completely different manner to the use of the blue

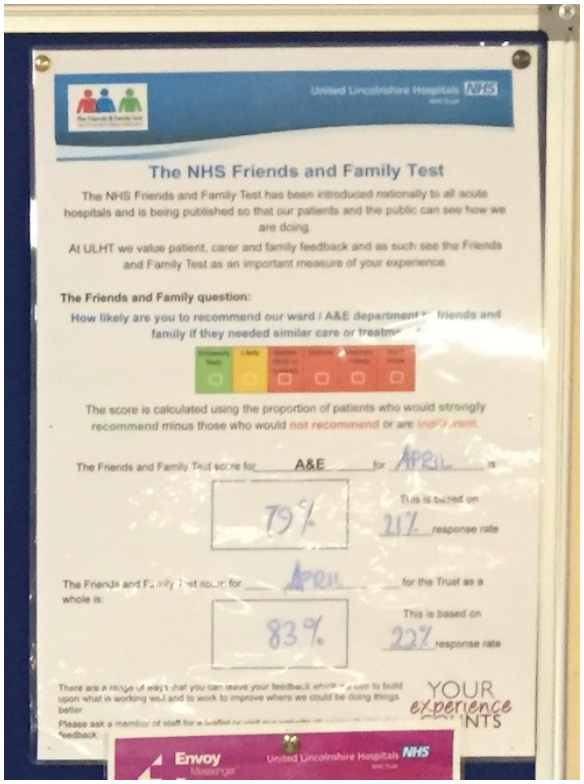


Figure 34: FFT Results poster at Lincoln, showing additional logos and latest local results

and white of the NHS identity referred to above and in other chapters. There are several different systems or 'grammars' of colour (Kress and van Leeuwen 2002) working alongside each other, with ranges of colours used semiotically in the waiting room, to represent values, and in particular a specific point on a measured scale. In the 'Going Home Survey' leaflet, the patient is invited to tick one of seven colour coded boxes to indicate how likely they are to recommend the service to their friends and family (Figure 34). In this 'Likert scale' which 'combines(s) both typological and topological meaning-making' (Jones 2013: 55), colour is a signifier of certainty, with green indicating the highest likelihood of recommendations being given, and orange, the least, although somewhat confusingly, 'don't know' is also coded orange. At Lincoln Hospital an A3 poster entitled 'The NHS Friends and Family Test' has been printed, laminated and posted on a noticeboard (Figure 34). It explains the test in similar terms to those in the leaflet and other texts, showing the different scores which can be given, from 'extremely likely' (to recommend) through to 'extremely

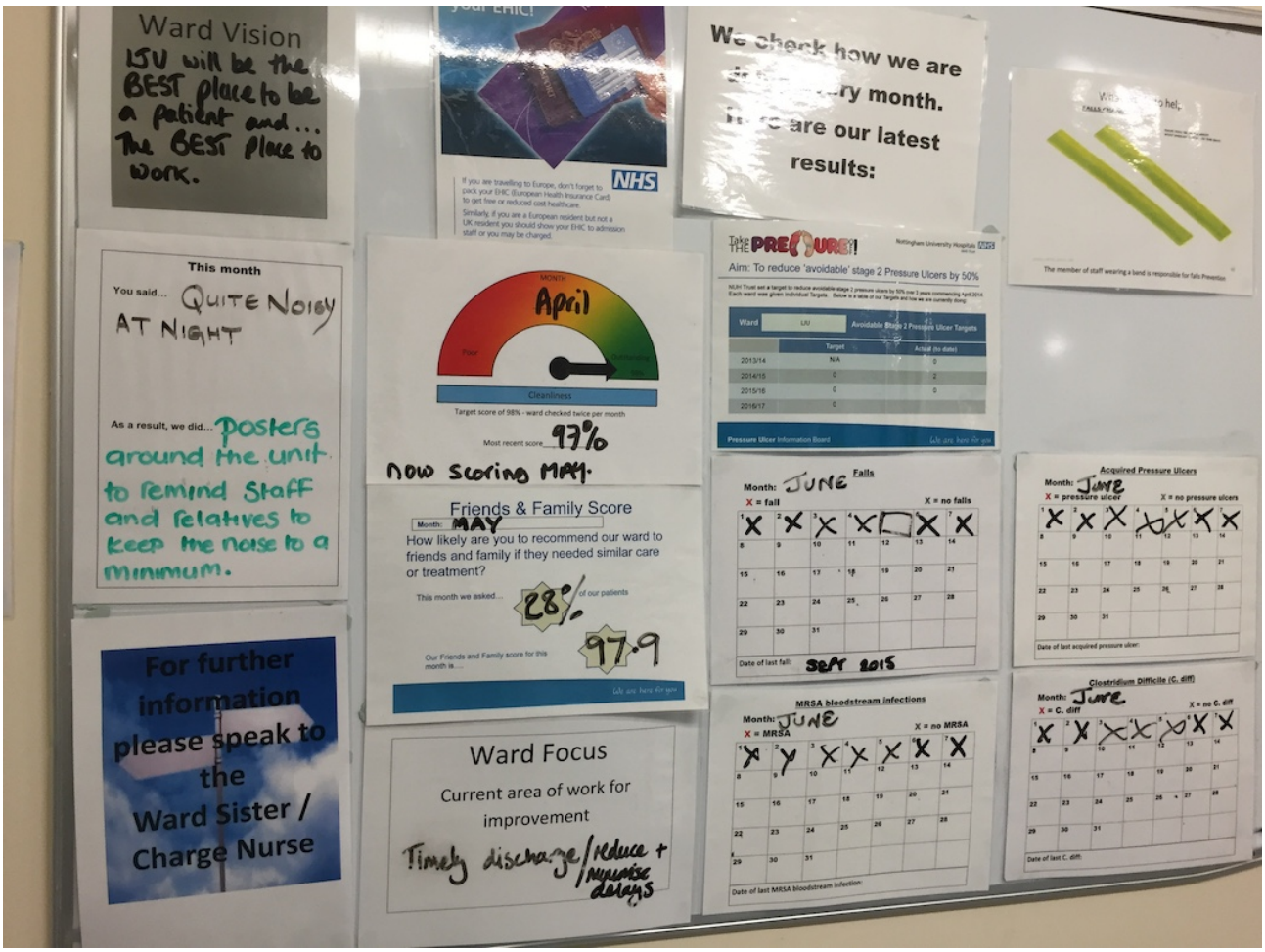


Figure 35: Noticeboard at Nottingham with notices relating to feedback and performance.

unlikely'. The orange boxes on the form have been replaced with red ones, so that 'neither likely or unlikely', 'unlikely', 'extremely unlikely' and 'don't know' all have a red background. The printed poster has deliberate blank spaces which have been filled in by hand, to give percentage scores for the FFT and the number of patients who have participated locally.

In a similar vein, at NUH there is an entire colourful and busy noticeboard full of 'performance' metrics, charts and Figures, many of which are produced in a similar fashion to the one at Lincoln — preprinted sheets which are laminated to create a wipeable surface, with up to date information written in by hand using a black marker pen (see Figure 35). Colour is again employed semiotically to code responses and scores. The NUH FFT ratings, for example, are shown on a semi-circular scale, like an election swingometer, moving from red, through yellow, to green. The score for the current month is indicated with a moveable arrow, as a position on the 'swingometer'. The colour here indicates a Net Promoter Score (Reichheld 2003, Graham and Maccormick 2012: 11), which is the aggregated score of the number of 'customers' most likely to recommend, minus the numbers of those least likely to recommend, thus showing a very rough and ready mean score. However Baker et al. (2019: 97) caution on this use of a numerical scale. They note that, 'the linguistic analysis of what the grades actually mean indicates that this is not an interval or ratio scale where ratios between the grades are consistent', because respondents assign different criteria and values to each rating. They also comment that while allowing for large amounts of data to be processed at speed, it may not be sufficiently nuanced to capture opinions because it over-simplifies attitudes. Foregrounding the numbers and percentages of patients completing the FFT may imply that 'the information contained in the utterance itself is subservient to the procedures' (Sarangi and Slembrouck 1996: 45). Displaying the 'results' in this way which combines 'top down' signs from senior management and those which are 'bottom up', or originating locally (Heubner 2009: 74) indicates to readers not just that the information is current and regularly updated, but also that their ratings have been noted, even if only for the purposes of updating a chart. They may not be as clear or uniform as, for example, the PALS texts (see below), but as in Dataset 1, where 'real' doctor and nurses were more believable because of their unpolished acting skills, the handwritten additions to the

posters increase their authenticity and currency modality markers (Kress and van Leeuven 2006: 158) as they bring the content closer to reality.

Both waiting rooms also display other posters showing colour-coded performance ratings from the Care Quality Commission (CQC), which is the government organisation tasked with inspecting hospitals, among other services. On their posters red means 'inadequate', while yellow means 'requires improvement' and green means 'good' (Figure 36). At Lincoln, the energy rating certificate for the building is also placed nearby. This too uses colours graded from dark green, through lighter greens to yellow orange and red (Figure 37). This time green means 'more energy efficient' and red means less so. All of these posters also include graphical representations of data, and rely on the colour literacy of the reader, and although in these examples green always indicates the positive end of the scale, and red the negative end, in each case the same colours have quite different meanings. There are even more 'colour grammars' present in both waiting rooms, with semiotic use of



Figure 36: CQC Posters at Lincoln showing colour-coded quality ratings

individual colours. Red in particular is fairly prominent, and in these settings generally means 'stop' (Kress and van Leeuwen 2002) as it is used around doors with controlled access, but it also has a special meaning related to the emergency department, and many signs around the hospital pick out the name of this department in red. For the staff who see the charts every day they may represent a whole range of discourses emanating from the management of the organisation, for example change, increased control, competition and more. For patients, perhaps the charts, numbers, statistics, figures, and colour-coding represent scientific discourses of investigation and measurement, or business discourses of control and progress, but however they are interpreted it is clear that colour is deployed semiotically with an expectation that its multiple meanings in this space will be accurately interpreted by readers.

The normalisation of feedback and feedback mechanisms is achieved partly by individual texts, but partly by the context in which they are found. I have already mentioned that there are several different texts on the subject of the FFT in both waiting rooms, but the FFT posters, leaflets and boxes are not the only publications in the waiting room aimed at trying to elicit feedback. There are also many texts over the two sites which actively seek some kind of interaction from the reader over and above simply reading and absorbing the information. The reader is urged, variously, to call helplines, report abuse of different kinds, and to become a volunteer or an

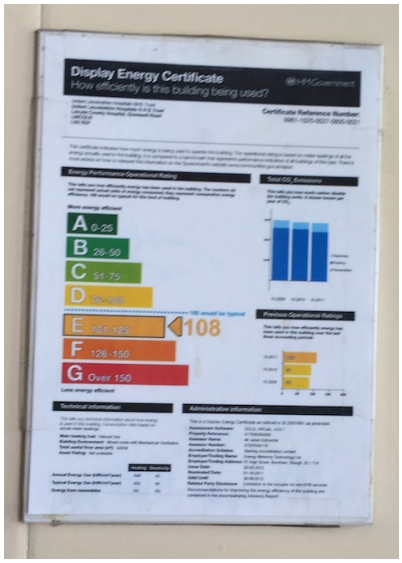


Figure 37: Energy efficiency poster at Lincoln, showing colour-coded ratings



Figure 38: PALS pop-up display and framed poster at Lincoln

organ donor. Competing strongly for the attention of the readers are the communications of the NHS Patient Liaison and Advice Service (PALS). PALS is a team based in each NHS trust which aims to assist patients to navigate the bureaucracy of the NHS and to understand it better. Their publications encourage the reader to get in touch for support, or to provide feedback in the form of a complaint or compliment about an NHS service. The PALS texts have arguably the highest modality of any publications in the waiting room, with several copies of their posters displayed in prominent positions, and at Lincoln, two free-standing pop-up display stands (Figure 38). Their posters are placed in picture frames, which both draws attention to them and keeps them in good condition. At Nottingham PALS have several different leaflets in the waiting room, including one which has been translated into several languages, and one in Makaton. Their titles include 'What do you think about our services?', 'See it my way' and 'Your views are important to us' (Figure 39), and the pop-up stands mention complaints and compliments. Whilst they contribute to the strategy of normalising feedback, there is a good chance that some readers may not distinguish between the FFT texts and the PALS texts.

As in the second dataset, the materiality of the texts again becomes a communicative mode in the strategy to normalise feedback. In the same way as Kress and van Leeuwen (2006: 160ff) describe a sliding scale of modality in relation to pictures, it is possible to talk about materiality, which 'comprises the interrelated semiotic

resources of surface, substance and tools of production' (ibid.: 225). The reader takes their cues about the relevance of each text from the quality of the text 'product' but also from its authenticity. The FFT publications range from the glossy full colour national leaflet to the simple 'Have you been discharged?' sheet printed out and taped to a door. The forms—one very basic and one unusually highly specified, and the posting boxes, each have something to contribute to the meaning of their content and the reader's understanding of their physical modality may contribute to their likelihood to complete the survey. Text B, for example, is demonstrably a short form because it fits onto a single A5 sheet, and the white FFT posting box not only affords the citizen a convenient place to post the form, but can also contributes to the FFT process by displaying a prominently placed appeal to take part. The quantity of texts, and their materiality and production standards, together with their prominence in the waiting rooms, reproduce the importance of this feedback discourse.

6.6 Constructing the model citizen

Whether or not a patient participates in the FFT is subject to several factors, but through the discursive strategies I have already mentioned the NHS attempt to

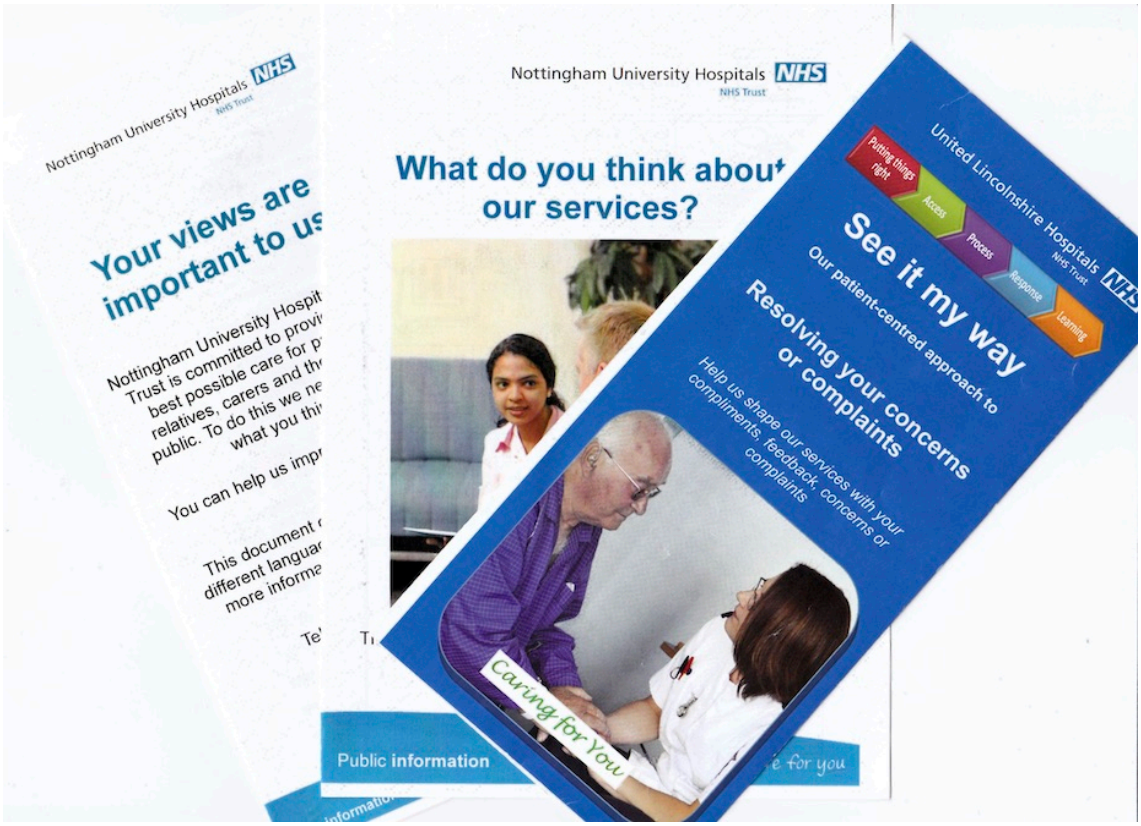


Figure 39: PALS leaflets

ensure that as many people as possible do so. They assert their authority, derived from the privileged position of the NHS as both the oracle on Health in the UK, and as a branch of government. Through framing the patient as a respected participant in healthcare transactions, and by normalisation of the process of feedback as part of the healthcare experience, the text producers have again laid the foundations for the production of a compliant model citizen. As with the previous analysis chapters, it is important for all pieces of the jigsaw to be in place, so that the correct version of the model citizen can be produced.

In this dataset, in addition to the obedience expected in relation to use of health services, the NHS want the citizen to provide a service by giving feedback, an obligation which may extend into the period after the treatment has finished. Having established the normality of feedback discourse by giving prominence to this naturalised form of communication, we can now see how lexical choices by the writers manipulate the patient into a position of obligation in an attempt to influence them to complete the FFT. For citizens wishing to carry out their duties in relation to the NHS the basic requirement of the FFT is to answer one question, although they are also encouraged to respond to any others posed at the same time. The *Would you recommend ...?* phrase is problematic, and not well understood by patients even when not couched in unusual syntax. 'Likelihood of recommending' belongs to a marketing discourse in which personal recommendations are a powerful selling tool. Whether 'recommending' is a concept which should be associated with healthcare is questionable, and in user testing it has caused confusion and even anger, as patients felt the term to be inappropriate or were not sure what they were recommending (Kmietowicz 2012: 1). Indeed the Picker Institute Report to the CQC (Graham and MacCormick 2012) advised against use of the Net Promoter Score in healthcare questionnaires, and singled out the term *recommend* in particular because of the difficulty respondents had with it. The Net Promoter Score is a device widely used by companies wishing to measure or predict the loyalty of their customers, but has been criticised as ineffective even in commercial settings, as the claims made about its accuracy in predicting consumer behaviour have been refuted (ibid.: 11). Use of the FFT question as specified raises many questions in itself. Is loyalty, as in repeat business, what the NHS actually wants from patients? Will it not lengthen waiting lists

and increase inequalities if patients recommend services? 'Recommending' links this health discourse yet again to neoliberal discourses of choice. It implies that both the recommender and the recommendee have options over whether to use a service, and as I have said, this is not always the case in healthcare provision. It is particularly inappropriate when considering the 'real' purpose of A&E as described in the texts in previous chapters. If a citizen is bleeding to death, or having a heart attack the choice to use any given A&E department is whether to live or die, and if any choice is made it is likely to be on the basis of distance to the hospital rather than any other preference. In their investigation, Baker et al. discuss the history and use of the FFT but do not take issue with the question or the use of 'recommending'. They find that some FFT participants use the word *recommend* in their responses to the online version of the FFT, but do not comment on whether this term may have been used because it was included in the question. However the findings of the Picker Institute (Graham and MacCormick 2012: 12-13), suggest that some patients may not engage with the FFT process at all, or may not give relevant answers.

The language of the national leaflet is oriented towards justifying the collection of the data by the NHS and to motivating patients and carers to participate in the FFT. It includes the assertion that 'you do not have to respond to the question', but the reader of the text is given a number of reasons why they should indeed take part. These are paraphrased in Table 4. There is significant overlap between these proffered reasons, with all points mentioned at least twice albeit with slightly different phrasing. These reasons are echoed in other FFT texts, for example the phrase 'we value your feedback' appearing on both the 'Your Experience Counts' poster and the 'important question' poster (Figure 31). This repetition contributes to the normalisation strategy, additionally serving to reinforce the idea that completion of the FFT is the correct course of action for a potential model citizen. The question about whether the question is compulsory (L15) is answered with an additional justification for participation, and there is otherwise an assumption that readers will comply. The answers are repetitive and make assumptions about the information requirements of the reader. The writers presume that the patient has certain concerns: that they desire anonymity, that they will want to compare hospitals, and that speedy publication of the aggregated results is important to them. A clear

omission is the lack of any question about the outcome or effectiveness of the treatment, which, from the patient's viewpoint is likely to be the most pressing aspect of their visit. It seems then, that the purpose of the FFT may not be to find out whether A&E users are happy with medical outcomes, nor as we have seen above, to necessarily 'drive improvement', but to transform patients into customers, because providing feedback is part of the customer experience. However, in another dichotomy, the equating of emergency healthcare (and other hospital services) with commercial establishments permits the dilution of the ideals of civic common ownership and encourages the public to value them not as an indispensable public resource but as just another business in the market economy.

Table 4: Reasons to take part in the FFT given in the national leaflet

1	to 'ensure that you have the best possible experience of care'	L5
2	to gather feedback about your experience	L5
3	to help to drive improvements in hospital services	L5
4	to give you the opportunity to provide feedback	L6
5	to give the NHS 'invaluable information on what patients think of services'	L7
6	to collect information which can be used to 'help make improvements if required'	L7
7	because it is really important for the NHS to know why you gave a particular score.	L12
8	to 'provide valuable information'	L16
9	to provide information which will help ensure patients have the best experience of care	L16
10	so that the hospital knows what you think (whether positive, negative or indifferent).	L17

The writers claim that participating in the FFT is beneficial to the patient. For example, at L6 they state the following:

> When you receive care as an inpatient or in an Accident and Emergency (A&E) department, you will be given the opportunity to give your feedback by answering a simple question about your experience.

In the UK, hospital services including A&E are provided for the public and are provided by the NHS. The choice of wording draws attention only to the former, and positions the act of giving feedback as an 'opportunity' for the patient, also drawing attention to the personal nature of this opportunity through two instances of *you* and two of *your.* There are various other ways this point could have been framed. For example, the sentence could have read along the lines of *when we provide care we will ask you to give us feedback about how well we did.* The benefits to the individual providing the feedback are overstated, but the writers clearly feel that it is necessary to provide some justification, rather than simply instructing patients to complete the questionnaire. This can be seen as an acknowledgement that roles have been reversed and it is the patient providing something that the NHS needs, rather than the converse. Also foregrounded is the importance and value of the patient's contribution, although not, in this case by using services wisely or practising self-care, but by providing data. As mentioned above, there is repetition of the value of the information provided by the patient, and there is a focus on the brevity and easiness of the task, although readers are also urged to answer any additional questions asked by trusts, which in the case of text C extends to four A5 pages of questions!

The NHS are attempting to dissuade the public from attending A&E, so the reader may never visit again or benefit from any potential improvements, although others may. Commercial organisations often provide incentives for respondents to give feedback, including discounts, prize draw entries and free products. Online review site TripAdvisor assigns progressive levels of 'expert status' to those who provide ratings and reviews, and regular contributors to their site can earn virtual badges and receive commendations, or 'helpful' votes from readers. Others, such as Marks and Spencer, pay reviewers with loyalty points, and mystery shopping companies reimburse the cost of meals and goods in exchange for feedback and ratings. The NHS offers no such incentive and it is clear that despite their appropriation of commercial feedback discourse, that it is anticipated that patients and carers will give freely of their time and opinions. The FFT texts therefore construct the model citizen as one who is altruistic, who although short on time and concerned about anonymity, requires little incentive to participate, save a simplistic explanation of reasons and process, and a certain degree of flattery. In a kind of obsequious attempt to paint the

reader as a model citizen in order to secure their co-operation, this construct attaches positive moral values to the NHS user, but also through doing so reiterates that certain values are expected of NHS patients. As in the previous datasets this mindset could again be linked to notions that citizens have the power to save the NHS if they will only follow instructions and advice. However here the model citizen who heeds the call to participate in the FFT will help the NHS not by practicing self-care or smart choices, but by assisting it to develop its commercial aspirations.

In the first analysis chapter I commented upon the low modality of actions by readers when compared to NHS experts such as pharmacists. Here the position is reversed, as in contrast with the decisive action of the patient in rating the service, their competence at completing the survey and their creativity in writing their response and the positive action of submitting a card or online survey, the actions by the NHS appear to have lower modality. No commitment is made to making any changes or improvements. The survey results do not seem to have any major impact but can merely 'help' (see Table 5).

Table 5: Instances of *help* and *helping* in the national leaflet

L5	The NHS Friends and Family Test is a way of gathering your feedback about your experience and helping to drive improvement in hospital services.
L7	The information will also give the NHS invaluable information on what patients think of services, which can be used to help make improvements if required
L16	You do not have to respond to the question. But if you do, your feedback will provide valuable information for your hospital to help ensure its patients have the best possible experience of care.

The meaning of *help* as used here is ambiguous. It is not clear whether it is meant in the sense of assisting in the success of a process, or in actually making a difference. Whichever is the case, the NHS do not even oblige themselves to carry out such improvements, stating that the results will be analysed 'to see if any action is required' (Line 19). They also make no promise of a reply or response of any kind. Indeed the focus is upon the anonymity of the questionnaires, although the NUH staff have implemented changes, and illustrated this by providing an example of feedback to which they have responded. Close to the 'performance' noticeboard there is an

example of a customer comment about noise at night caused by a photocopier, which has been remedied (Figure 40). Baker et al. also found that NHS services sometimes post responses to online feedback.

As mentioned above a number of clauses in the national leaflet are written in the passive voice. An effect of using the passive constructions, which are less direct and assertive, is that they allow for the omission of the actors carrying out the actions (Machin and Mayr 2012: 105). When it does feature, the agent is often quite a vague entity such as 'your hospital'; it is difficult to pin down who is placing an imposition upon the reader.

L5 The NHS Friends and Family Test is a way of gathering your feedback about your experience and helping to drive improvement in hospital services.

The repeated use of *you* and *your* here, with the omission of any agent, diminishes the role of the NHS in requesting or demanding action from the patient, without diminishing the obligation on the reader. Perhaps it also draws attention to the public ownership of the NHS, thus pointing to the responsibility of the reader to support 'your' NHS by carrying out the requested actions.

Texts B and C each have spaces, as I have already mentioned, for the responses of the person completing the form. The categories of input requested from the citizen

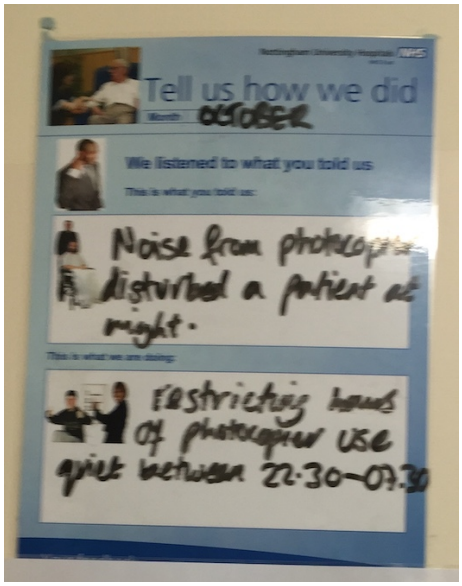


Figure 40: Poster from Nottingham explaining action taken in response to feedback.

creates links to scientific discourse, but it may also have intertextual links for the citizen. The demographic questions are similar to those used in applications for jobs or benefits. They entreat the respondent to categorise themselves by age, gender and ethnic group, and ask for information about religion and language. This breaking down of data into 'institutional sub-categories' is a frequent feature of bureaucratic discourse, even when it is not clear why these pieces of information are being collected (Sarangi and Slembrouck 1996: 41). Contrary to being a single simple question about NHS services, these forms delve into details about the individual, aimed at 'processing people' (Sarangi and Slembrouck 1996: 128) so that they can be measured, counted and transformed into statistics. By contributing their biographical data, citizens add value to the scores given in the FFT question. The data provided by the patient is referred to as *your feedback* or *your answer,* conferring ownership of the ratings and other answers upon the patient, but when it has been transferred into the hands of the NHS it is depersonalised and referred to as *information* or *the information*. This reflects the actual process, because the individual entries will lose their importance and personal significance as they are amalgamated into a database and used to generate reports. The data provided by the patients is commodified, analysed and may ultimately be used to defend or justify changes to policy, funding and more. The gloss put onto the 'back end' of the data collection process is that *Your hospital will gather the results and analyse them rapidly to see if any action is required* (L19) a process that, combined with the massively generic nature of the subject matter renders the content almost meaningless. Whether it will actually be used to *make improvements* (L7) is sidestepped. A little akin to 'advice' in the first analysis chapter, the leaflet sees the generation of a new commodity: *the information* from *your feedback*. A value for the 'product' of information is brought into being through its description as both valuable and invaluable, and indeed it is liable to be bought and sold (Kollewe 2019). Healthcare statistics contribute to the 'bioeconomy' (Rose 2007: 34) as 'statisticalisation', or converting intangible ideas such as opinions into numbers and statistics allows them to be known, evaluated and managed (Rose 2007: 33).

The NHS do not ask for a sophisticated contribution, but for the feedback to be useful the patient or their representative must be able to articulate the issues of importance

to them. Many of the texts in the waiting room seek to elicit some kind of action, and providing feedback is just one of these actions but it is a specific, intellectual kind of action, which consists of several parts. It is necessary to first experience a service, so that one is qualified to report upon it, then the recipient of the service must reflect upon the expectations they had beforehand, and whether those expectations were met. They must then translate this expectation versus reality scenario, first into a numeric rating, and then explicitly into words. The FFT respondents are also asked for some further information, which they may or may not feel is relevant to their rating. Finally they must submit the feedback in the approved way, by filling in a card or form, and posting it in a box, handing it to a member of staff, or finding the web page and submitting their response online. If they do not complete this process their response may not be counted, and the time spent upon it will be wasted. We can see then that this model citizen must be sufficiently intelligent and articulate to provide the NHS with the correct type of 'valuable information'.

Feedback of this type in the NHS used to be 'largely the terrain of face-to-face conversation' (Sarangi and Slembrouck 1996: 24). Naturally many NHS patients will thank the staff providing care to them, or maybe complain to the receptionist about the facilities, or will give some other direct and immediate feedback. They may feel that they have completed their health 'transaction', but this no longer seems to be sufficient. The model hospital patient should now provide anonymous comments not to the frontline NHS workers caring for them, but to generate data, with scores aggregated for analysis, measured, compared and regurgitated, not only as scores on a swingometer, but in reports to government, and statistics so that opinions can be recontextualised as knowledge. As in Sarangi and Slembrouck's comments about universities (ibid.), 'bureaucratisation at the level of personal relationships' with staff is likely to lead to a change in actual relationships.

So it can be seen that NHS users are learning to make links between commercial and health discourses, and to frame their healthcare experience using terms originating in commercial discourse. The FFT invites the patient to evaluate the health service in terms of their own personal feelings towards the service, and by association with commercial discourses they may evaluate it in terms of their experience of hotels, shops and other businesses. The texts in the present study are used to prompt the

FFT responses analysed by Baker et al. (2019: 70), who found that the most frequent driver of feedback is a focus on interpersonal skills rather than 'technical aspects of care'. They comment that that this 'provides evidence that patients are applying such consumerist values when evaluating their experiences of healthcare' due to the influence of consumerist philosophy of customer. They speculate that the patient might not feel sufficiently confident of their own medical knowledge to comment upon the skills of the physician, nurse or radiographer, but they are likely to have experience of customer service, if not in hospital then at least in shops and other businesses.

Literacy in multimodal grammars is also a requisite for the citizen using A&E services, as in addition to the semiotics of colour I have already discussed, a good understanding of the 'grammar' of symbols is required to interact with texts in the waiting room. These range from the directional arrows on the department names hanging from the ceiling (Figure 24), to the large graphics of hands in red circles deployed on the floor to draw attention to a hand cleansing station (Figure 23, also Figure 8, Methodology), and the line drawings or 'icons' (Scollon and Scollon 2003: vii) on bins indicating what should be put into them (Figure 38). Arrows, which are used extensively in signage, road signs such as the symbols for 'stop' and 'no entry', and specific symbols for hospital functions also appear on posters and other publications, and of course there are the well-understood 'male' and 'female' icons on toilet doors. Inside the entrance of the Lincoln waiting room is a large notice, which instantiates the power of symbols as a communicative mode. The notice, entitled 'Department Guide', is an index to the symbols used to represent the different services available at the hospital, some of which are, in themselves, complex concepts. Under each symbol the name of the service is given in eight languages, so that the code can be understood by readers of each of these languages. A row of flags, which stand for languages, is given at the bottom as a key. The expectation is, in addition to being able to read the many written texts that patients and carers, patients and carers will have an understanding of these semiotic systems of colour, symbols and logos, in order to evaluate which texts to heed and which to ignore, and to navigate their way around the department and the wider hospital.

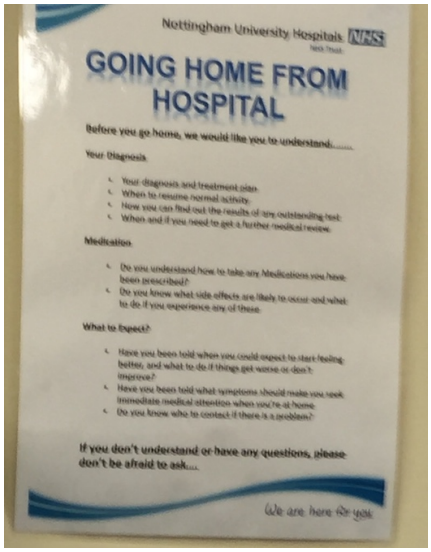


Figure 41: Going Home from Hospital poster at Nottingham

As referred to above, there are links to other discourses found in the A&E waiting room, including those of advertising, charity, violence and caring, and the model citizen here would also do well to be an avid consumer of information! Much of the material is optional reading, but this is interspersed with important messages instructing patients not to eat before being seen by a nurse, and what they need to know before going home (Figure 41). The types of information present, and absent, reveal the views of those who have curated the space in the waiting rooms about those who may be waiting there. Domestic violence is a recurring theme, for example, as is violence against staff. The citizen must navigate their way through the myriad of messages and select those which are relevant and important, those which must be acted upon and those which can be ignored.

The rhetoric of this dataset may not have the same level of deontic force (Halliday 1985: 86ff) as the texts in in Dataset 2, but instead uses repetition and 'product placement' of the texts in prominent positions and multiple locations, plus a sycophantic level of politeness to achieve its aims. The model citizen here is not the halfwitted older person or the wilfully ignorant queue-member of previous datasets, but a sophisticated and valued contributor to official statistics! He or she is literate in multimodal grammars, and has the ability to filter out what is relevant from a melee of messages, even if ill or injured.

6.7 Conclusions

Completion of the FFT is by no means compulsory, but the ubiquity and volume of the texts is geared towards securing maximum participation and the repeated highlighting of its importance positions the FFT as an integral step in the healthcare encounter. Although a duty to complete the FFT is imposed upon the citizen who is imbued, via the texts, with altruistic qualities, the agent making the imposition is in many cases erased, and the seriousness of the imposition minimised. Whether or not the drive to enrol patients as FFT participants is successful depends upon its true meaning and purpose. If the NHS is more interested in receiving feedback on its interpersonal skills and 'customer service' than the clinical skills and proficiency of medical practitioners, then, as Baker et al. (2019) have found, they are gathering a wealth of knowledge, as the respondents to the FFT are providing this 'data' in large quantities. However if they really want to know about quality of treatment they may need to take the advice of the Picker Institute (Graham and MacCormick 2012) and ask a different question. More specific questions, such as 'did we make you better?', 'does this NHS service provide good value for the public', or perhaps 'how could we improve this service?', would focus the minds of the respondents upon practical changes. Although the quantitative ratings are published, publication of the comments and suggestions is not objectively done, and as Baker et al. point out, 'likelihood of recommending' scores do not directly correlate with the gravity of issues raised in the 'free text'. The anonymity of the questionnaires protects not only the patient, but also the NHS, because there is no way for patients to know whether major failings have been raised by others. The problem of a photocopier keeping patients awake is easily fixed. Lengthy wait times, dilapidated facilities, insufficient staffing and other systemic problems, of course, are not.

Although there are discourses of health in the waiting room, they are only scantily evident in the NHS texts sampled. The question and answer format of the national leaflet, whilst claiming to answer the questions that patients might have about the test and related processes, simplifies and generalises to the point that it fails to provide any useful information, save that there is a Friends and Family test and the NHS want you to complete it. It is also noteworthy that synthetic personalisation takes contrasting and sometimes contradictory forms in the different datasets. For

example take the careful deployment of pronouns in Datasets 1 and 3, but their ellipsis in the A&E banner, likewise the gaze and demeanour of the NHS staff, both in the demand images of the *Stay Well* campaign and the offer images of the FFT leaflet. Each of these engage with the reader in seemingly inconsistent ways to achieve similar goals. In Datasets 1 and 3, the use of genuine staff and realistic settings contributes to the believability of the message, even though they appear to be instantiated quite differently. In another apparent contradiction not only do the high production values of the Stay Well texts impart their authenticity, but so also do the hand-written additions to the feedback posters in this final dataset.

Unlike those in previous chapters these texts are arguably simpler in that they do not seek to entertain, or provide wit or irony. This third dataset sees various texts clustered around a common purpose: the completion of the FFT, in which, although it does not improve their own physical health, nonetheless works to shape the patient, or their carer, yet again, into a model citizen. The model citizen is produced here as someone who can assist the NHS in its own project of self-improvement. It may be useful to consider whether hospital waiting rooms provide information which is critical, not available elsewhere, and must be absorbed and adhered to, or whether the information is optional, and provided as something to pass the time during a long wait for treatment. In other words, does the information provide an opportunity, or a duty for the citizen?

This set of texts does not make specific reference to saving NHS services, but it does talk about improving them. Although the patient completing the FFT form has the power to give a positive or negative review, and may feel responsibility or a sense of control in that something may be done because of their feedback, in reality the 'invaluable information' referred to in the leaflet will be the data from thousands of respondents, reduced to the 'category-type' (Sarangi and Slembrouck 1996: 129) revealed by their demographic data, combined and processed into a score which can be compared with other NHS teams or measured over time. Although ostensibly to improve services, the feedback could equally be used to praise or reprimand staff, or incorporated into management reports and plans which will affect funding (Baker et al. 2019: 12). 'Wide scale continual monitoring' of healthcare processes is seen as 'essential to quality control', but 'is also a cost-effective manner of looking for ways to

re-distribute falling financial and other resources' (Sarangi and Slembrouck 1996: 26). Likewise, there is no guarantee that the 'improvements' mentioned are the only outcome. Actions justified as service improvements in the NHS, have included bringing in expensive consultancy firms to write reports, subcontracting healthcare work to private companies, and funding hospitals through PFI, but these 'improvements' have not always been beneficial to patients (Pollock 2005). Alongside other government measures designed to propel parts of the NHS into the hands of commercial organisations the introduction of the FFT might legitimately be interpreted as an advance gambit in a push for the privatisation of services. Given that much more feedback is about 'service' than 'treatment' (Baker et al. 2019: 45), and that the NHS are not doing anything to dissuade respondents from this, it could also be seen as a distraction technique, to detract from the real issues affecting the NHS. What could be considered deceitful is that the NHS is trying to present the FFT as a benefit to the citizen, but it is fairly clear that the benefits are almost entirely to the NHS. Whilst appearing to cede power they maintain control through choices made in lexis and form.

The differences between the FFT and other feedback mechanisms, although obvious to those familiar with the management structure of the hospital, may not be so clear to the reader, who could be visiting the A&E department for the first time in their life. Although visually distinct, there are linguistic similarities in the texts which may confuse. What is missing is any indication of when it may be more appropriate to fill in a complaint form or use another method of feedback, and it would be easy for a patient to think that they had filed a complaint by completing the FFT, as the national leaflet implies that something will be done, and improvements can be made. The conscientious patient must also therefore be aware of the different schemata for providing feedback.

The discourse of feedback also raises various questions, for example whether or not patients see themselves in a 'consumer' role in relation to NHS emergency healthcare, and whether, 'recommending' is an action they consider in relation to services for which one is supposed to be seriously ill or injured in order to qualify. Although citizens are urged to complete the FFT, it is likely that there are many occasions when friends or family would recommend visiting A&E, but that doing so would be against

the advice on the posters and web pages in Dataset 2. It is worth remembering that 'real emergencies', which 'genuinely' qualify the citizen for emergency healthcare, include chest pain, difficulty in breathing, unconsciousness, severe loss of blood, severe burns or scalds, choking and severe allergic reactions (University Hospitals of Derby and Burton NHS Trust 2019). People in these states are unlikely to complete a questionnaire, may not actually be aware of the care they are receiving, or may die or become so debilitated that they cannot give feedback afterwards. Those receiving the most urgent care, perhaps arriving by ambulance, will bypass the waiting room and be taken straight into a treatment area, so it is conceivable that they will not see any of the texts. It is also unlikely in the case of these 'genuine' emergencies, that a patient will even be in a position to exercise choice of A&E department. More responses are likely to come from those who have conditions seen as less urgent, who have to wait, so have time to read all the notices, find the appropriate forms and complete them. Perhaps they are less badly injured, or may be a friend or relative attending with a patient. Might they also be defensive about why they are there, and try to justify it? The text producers do not try to elicit whether the reader is attending A&E for a 'legitimate' reason, as there is no question about whether or not you used A&E 'correctly'.

Encouraging the use of the FFT questionnaire as the norm for feedback may diminish the contract of trust between healthcare professional and patient, distancing them from each other and instigating a mediator to pass on comments. Opening up a line of communication from the patient through to the management of the organisation brings benefits, in that poor practice can be reported, for example. However it also subtly removes power from frontline staff who are taken out of the loop by the need for anonymity. By placing distance between patients and frontline staff they also diminish the power of these staff in relation to management. They are no longer a conduit for the feedback, and they therefore lose control of information about themselves and their work, and become dependent upon the analysis team or managers for an understanding of how well they are doing, rather than direct receipt of the feedback themselves.

The relationship between health staff and patients may be further damaged by this evaluation process which casts the medics and administrative staff in a supplier role

and ‘turn(s) a citizen into a client’ (Sarangi and Slembrouck 1996: 55). Staff may welcome the feedback, but the data may not be used only by managers, or other sections of the NHS, to request additional funding or justify maintaining or increasing staffing. It could equally be used for the opposite purpose of reducing resources, or censuring staff. In some cases then, patients may unwittingly be playing a part in damage to the service. The ubiquity of these texts focuses the minds of both patients and staff on the compunction to get the FFT done, and staff are aware that the percentage of patients completing the questionnaire is being counted, so reminding and cajoling patients into filling in a form and answering the questions becomes a new task for them.

In terms of the ‘journey’ of this thesis and of the model citizen, this dataset is important in that it demonstrates that FFT participants have ‘arrived’: they have become model citizens by fully participating in neoliberal practices and generating their own contributions to neoliberal discourse. It seems that the model citizen construct in this dataset is, yet again, complex. The reader of the texts is required to act as a consumer in relation to ratings and reviews, when giving feedback about their experience when in a patient role. This applies even to those citizens who have found themselves sufficiently ill or injured to be waiting in an A&E department. The model citizen is expected to bridge the gap between real, bodily healthcare and data collection out of obligation to the NHS or to fellow citizens, meanwhile their data may not contribute to improvements, but could be monetised.

Critically for the construction of the model citizen, this dataset points to evidence that citizens are learning how to reproduce capitalist ideologies for themselves, in response to the stimulus of a question belonging to neoliberal discourse. The model citizen in this dataset is valuable not as a patient or a human, nor in terms of their own health, or survival of a serious illness or accident, but in terms of the value they can add to the work of the team through praise or suggestions for improvements. As I have shown in this chapter, the requirements upon the model user of NHS services are by no means limited to their correct use of the facilities but now also include the internalisation of neoliberal concepts and their practiced reiteration through the obligation to rate and review public services in similar ways to commercial businesses. The model citizen is one who helps the NHS not only through correct use

of services, but also by providing insight, opinion and biographical data. I now move on to explore in more detail the increasing demands upon the citizen which I have uncovered in this study.

7. Discussion

7.1 Introduction

This study, the first of its kind to apply Multimodal Critical Discourse Analysis (MCDA) to a themed approach across diverse datasets, provides ample evidence that power relations are being discursively enacted in public health information texts of many kinds. Also one of the first studies to investigate the production of power in such texts, my investigation has revealed important insights into the positioning and treatment of the citizen in these information materials, through the device of the model citizen. I have demonstrated that far from being impartial and benign, this data is ideologically motivated and aims to influence the citizen in much wider aspects of life than those traditionally thought of as 'Health'. The model citizen has proved to be a complex and multi-faceted construct, and in this chapter I consolidate the main findings of the thesis and consider the significant contribution of the model citizen construct to power production in health and further afield, both as a counterpoint to the authority of the National Health Service (NHS), and as an exemplar in political manoeuvrings.

The frequent production of the model citizen construct in these texts is in itself worthy of investigation, and in section 7.2 I discuss the significance of this phenomenon in public information about Health. Engaging with these texts on a large scale allows us to observe a wider picture in which the characteristics of the model citizen are adjusted depending upon the requirements of the producers. I explore, in section 7.3, the types of citizen produced, commenting upon the potential impact upon real NHS users and their relationship with medical staff. The ideologies behind the texts are so prevalent that they cannot be accidental, and in 7.4 I consider in detail how the various manifestations of the model citizen point to motives ulterior to the stated aims of the materials. There are also anomalies in this construct, which I discuss in section 7.5, and although an overall ideology of neoliberalism prevails in the texts, the model citizen is a conflicted being. The unresolved contradictions between ideologies in the texts suggest that the producers are expecting a sophisticated intellectual engagement from subjects whom they often treat as less than competent health service users. In particular, the citizen must navigate a course

between neoliberal values and forgoing personal needs, as instantiated in the dichotomy between individualist versus collectivist discourses. In section 7.6 I consider the true nature of the texts.

Finally in this chapter (section 7.8) I discuss the contribution of current technologies of public information to governmentality, and consider their meaning in relation to power, the NHS and the present-day citizen using health services. I examine the effect upon the citizen of the conflation of medical and governmental power, and consider whether discourses in widely disseminated texts sanctioned by the NHS are tantamount to unethical manipulation. These texts appear to go further to influence the real citizen than those described by Fairclough (2015: 206), and Kress and van Leeuwen (2006: 117ff) so I ask whether this constitutes a new and more advanced kind of governmentality. In response to the major problems with capacity in emergency services the NHS has experienced over recent years, particularly during the winter months, high demand for services has been claimed to justify Accident and Emergency (A&E) departments exceeding their targets for waiting times (DHSC 2019). As the texts make many demands upon the citizen, I also consider the impact of such duties, in the context of an under-resourced NHS whose principles of universal healthcare are compromised in a largely capitalist society.

7.2 Constructing the model citizen in health communication

Discursive strategies to construct the model citizen have been identified in all three of the datasets (see Table 6), and I have shown how semiotic resources are deployed to communicate ideas, values and identities and how they enable and constrain different kinds of interactions. By encompassing a variety of genres in my study, and selecting texts from various stages of the 'journey' to A&E, I have been able to show that the model citizen is a frequently-used device in public information about emergency healthcare, and appears, due to its prevalence, to be a preferred strategy of the NHS. Although I recognise that there may be other discursive strategies at work in the texts, the evidence points to the presence of the strategies listed in the following table, in each respective analysis chapter.

Table 6: Discursive strategies identified in the three datasets

Dataset 1: Stay Well texts
1. (Re-)establishing the authority of the NHS
2. Developing the authenticity of the Stay Well brand
3. Establishing the 'correct' use of NHS services
4. Constructing the model citizen

Dataset 2: 'choosing' texts
1. (Re-)establishing the authority of the NHS
2. Establishing the 'correct' use of NHS emergency healthcare services
3. Constructing the model citizen

Dataset 3: Friends and Family Test texts
1. (Re-)establishing the authority of the NHS
2. Developing a relationship with the reader
3. Normalising the discourse of feedback
4. Constructing the model citizen

Whilst my focus in this chapter is upon the strategy of Model Citizen Construction, I also acknowledge that its counterpart in power production, the (re-)establishment of the authority of the NHS, is also present in every dataset, and is an important strand in the positioning and the framing of the citizen. Although often produced using different communicative modes, these two strategies are dependent upon each other, and between them reproduce the relationship between governed and governing, or the citizen and the elite. Several other strategies were identified and investigated but occurred in only one dataset, or varied from one dataset to another. These less frequently occurring strategies are somewhat secondary to the two main and inextricably linked ones. The development of authenticity in the first dataset, for example, sets up a precondition of authenticity, which is then built upon as part of the production of power of the NHS. Likewise, in datasets one and two, the strategy of establishing the correct use of services is a precondition to the strategy to construct the model citizen. Indeed all the discursive strategies identified in these health promotion materials from the NHS and PHE work, at least in some part, to maintain the status quo of power relations and develop the citizen as a subject.

The presence and prevalence of the model citizen strategy is important for several reasons. Previous critical discourse studies have researched the discursive production of medical power, but have focused mainly upon face-to-face encounters between doctors and patients or between medical personnel. With few exceptions CDA has ignored the role of health promotion materials in the production of these power relations. This is despite their omnipresence, diverse manifestations and increasingly sophisticated production, and their convergence with advertising and other genres. In illuminating the presence of the model citizen in texts from the NHS, and its interaction with the authority-producing strategies, my research has evinced the same asymmetrical power dynamic in published health promotion materials. This in itself is sufficient reason to merit further investigation, but in addition, the data also reveal an ideological leaning which is evident upon close reading of the various semiotic modes. Because often the most important conversations we have about health are not with doctors or in hospital settings, but in the home or community (Jones 2013: 3), these materials, distributed as 'factual', cannot be viewed uncritically as simply by-products of health encounters, and their importance in the construction of ideological formations (Fairclough 2010: 30ff) cannot be underestimated. In many cases the time and attention of medical practitioners is rationed, often to only a few minutes per patient (Royal College of General Practitioners 2019: 8) but the texts are available to peruse at will, are broadcast repeatedly into homes, or placed in front of large numbers of people at emotive times. Each interaction between a citizen and a health promotion text is a site of engagement with potential to impact health outcomes. As 'hegemony ... subtly works through the management of the mind of ... citizens, for example by persuasively constructing a consensus about the social order' (van Dijk 1998: 3), the potential of the discourses present in these materials to impact on ideologies in society cannot be ignored. While further study would be required to prove a specific impact on subjects, as ideologically oriented texts, imbued with institutional and medical power and 'indexing social structures and processes' (Mautner 2014: 391) they deserve thorough investigation by the CDA and MCDA community.

The frequent appearance of the model citizen construct is also significant in that it is a demonstrable technique, or rather set of techniques, that the NHS is employing. The

citizen is recreated each time using a combination of semiotic communicative modes, and although discursive strategies per se may not be in the minds of the text producers this prevalence cannot be an accident, and its use is evidently of value to the NHS. Time and again the model citizen is brought into service to explicate desired behaviour, or to make an example of undesirable behaviour, so its presence proves that these materials are carrying out not only ideational communication but also interpersonal communication work on the reader. The authority of the NHS is unchallenged in any of the texts; indeed we barely see any trace of the voice of the receiver, except in the limited and acquiescing questions in the Friends and Family Test (FFT) leaflet. There is no middle ground in which, perhaps, the citizen might use a service which is closer to home, or might attend A&E with lesser symptoms if they are extremely worried. So certain actions (or inactions) are required of citizens, and their attitude is also modelled, as one which accepts the voice of authority. The discursive construction of the citizen therefore reflects the expected behaviour of the reader, but also the desired relationship between the elite and the citizen.

There have been moves to simplify, and to use plain language, in public information for many years, so it is not surprising that all three datasets rely in some form on the frequently-used device of synthetic personalisation which often accompanies this (Fairclough 2015: 216). This 'major strand in the systematic restructuring of the societal order of discourse' alongside the conversationalisation we have seen in this study, could be seen as a shift in social relationships which gives more power to the 'consumer', but instead, as viewed by Fairclough is a significant contributor to the stealthy maintenance of power relations in public discourse. Whilst enabling the participation of readers through easy-read formats, these 'egalitarian discourse forms' (Sarangi and Slembrouck 1996: 33) are employed strategically to simulate power sharing and create the illusion of choice. Indeed in these data the relation between the model citizen and the NHS, often achieved through techniques of synthetic personalisation or conversationalisation, illustrates the expected power dynamic, and thus reproduces asymmetrical power. I have demonstrated that synthetic personalisation is not purely a lexical technique, and that diverse communicative modes are combined to achieve an enhanced effect of personalisation. While clarity is important, in all three datasets the recontextualisation of lengthy

policies into easy-read formats has resulted in the reduction of complex processes to a few trite lines, simplified and made generic to the point of saying virtually nothing new or useful. This level of simplification neither engages well with citizens nor imbues them with increased power.

Contributing to defining the subject position of the citizen is the presumption, by the trusts, that their discourses of choosing correctly and avoiding misuse of emergency services are 'mainstreamed' or generally understood and accepted by the public. Many of these texts are dependent upon contextual knowledge (Machin 2007: 172) which rely 'heavily on making implicit connections between "loose" bits of message' (Sarangi and Slembrouck 1996: 27), without which they would be difficult to understand. Importantly, NHS trusts have policies about producing information using plain language, which should be 'clear, concise, straightforward, honest, open, professional, respectful and accessible' (NHS England 2019). The text producers evidently believe that they are providing clear information, so the omission of these details — for example the ellipses in the texts such as the ambulance poster, and its intertextuality with social media via a hashtag—are of sociocultural knowledge which they presuppose the audience *already have.* We can be sure this intertextuality is presumed, because the texts rely upon the effectiveness of fragments of this discourse in their communication about using services. They presuppose that potential users of services have a sophisticated overview of discourses of control currently circulating in the media and health fields. Patients are assumed to have assimilated, and to have identified themselves with, discourses in which patient behaviour is the cause of a crisis in the NHS.

This is particularly evident in the first two datasets, but the FFT texts in Dataset 3 are no less reliant on intertextuality. They presuppose an understanding of references to commercial feedback discourses, with an expectation that readers realise that they are participating in a system of recommendation. Alongside following official advice regarding NHS services, this requirement to appreciate intertextual references could be seen as another duty upon the model citizen. Whilst presupposing this intertextuality, the text producers also project stereotypes onto their audience and expect certain gaps in their readers' knowledge, targeting their communications accordingly. For example in several of the texts the reader is presumed to have

formed certain opinions about emergency services and to think 'incorrectly' about the purpose of A&E departments. This positioning of citizens is part of a sequence of reciprocal cause and effect in the construction and treatment of imagined audiences (Butsch and Livingstone 2014: 9). However the model citizen in these texts is not simply imagined 'positively or negatively', it is a much more nuanced and complex construct, as I shall explain in the next section.

7.3 Adapting and controlling the model citizen

The finding that the model citizen construct is not a constant, but can be varied depending upon the requirements of text producers, is also significant. As we have seen, in each of the datasets, the NHS enlist a model citizen with different characteristics. The TV ad, leaflet and other texts of the *Stay Well* campaign bombard the citizen with worrying 'facts' and instructions, and urges them to exercise caution and manage risks, going to great lengths to avoid many and diverse risks, such as 'winter illness' and boiler problems! The citizen is encouraged to stay close to home, and practice the neoliberal principles of risk management and preparedness. The texts in the second dataset urge wise and timely decisions about emergency healthcare at the point of need and harness the neoliberal tenet of choice but manipulate the citizen into a position where the 'best' choice is not to use emergency services. The texts show examples of incorrect behaviour which is criticised and shamed, and the citizen is constructed as knowledgeable but liable to misuse vital services. The model citizen in this dataset is encouraged to take on the duties of self-education, self-diagnosis, and understanding the increasingly complex range of 'urgent care' facilities, choosing different services which best match the specific health problem, rather than any other personal exigencies. Unlike the passive construct in the first dataset this model citizen is active and mobile, able to get online, interact in real time with information about services, and travel around to different facilities in different locations depending upon their level of busyness.

In the third and final dataset of the FFT texts found in A&E waiting rooms we observe the emergence of yet another version of the model citizen who offers comments, compliments and complaints to the data-hungry NHS. They are able to navigate the

linguistic landscape of the A&E waiting room, interpreting complex combinations of multimodal signs, with messages communicated not only lexically but also through discrepant grammars of colour, and the semiosis of symbols and pictures. In the FFT the behaviour in question is that of the staff. The duty on the patient to provide ratings and reviews on their 'experience of care', like an eBay parcel, or hotel stay, dialectically both imagines and shapes the citizen into a new identity as a consumer of a service whose qualities can be reduced to recommendability. Model citizens in this dataset are capable of self-categorising in various ways and altruistically submit their personal details and opinions for the good of the NHS. It is clear from the presence of these three distinct versions of the model citizen that the construct is moulded to suit the interests of the NHS at a particular stage of the 'journey' to emergency services.

7.4 The model citizen as a neoliberal subject

Although the journey metaphor is not a perfect fit, as many users of emergency healthcare will not see texts from all three stages, it is possible to observe a progression through these datasets from preventative campaign to decision making texts, to completing the FFT after a visit to A&E. It is also possible to trace a strand of neoliberal ideology throughout all three constructions of the model citizen, because each of the model citizens in these texts is generated as a neoliberal thinker of a particular type. In Chapter 2, I drew links between neoliberalism and health, and have highlighted examples of these elements of neoliberalism in the analysis chapters, showing how discourses of health are combined with notions of risk management and planning, commercialism and choice. Here I explore further the discourses of neoliberalism and the ways in which they act to influence the citizen. Most prominent of these is the discourse of choice which is present in all three datasets.

The idea of choice in healthcare often relates to 'rights' to choose a GP or opt for a different location for an operation to take place, but in these data we often see choices curtailed and citizens' options limited. The model citizen in the first dataset is given a list of NHS services, yet no real choice is offered as the repetition and lauding of pharmacists and advice-seeking, and the relegation of more expensive services to the

end of a list, are strong indications to the reader about the correct way to behave. In the second dataset, the citizen is shown many choices, but through combinations of shaming discourse, pictures and colour coding is trained not to make the choices that are undesirable to the text producers. The many competing discourses in the waiting room become a case of too much choice, or perhaps an inappropriate choice, for the reader who must attempt to ascertain what is important and what is not. The construction of the citizen as a buyer of soft drinks, an organ donor and a taxi traveller are also taking place alongside the construction of the user of A&E, and the reader is drawn in different directions by the varying texts in this space. Despite the optionality of the FFT there is a 'strong, implicit disciplinary dimension to bureaucratic procedures' (Sarangi and Slembrouck 1996: 59) so citizens engaging with the texts may feel that in order to become model citizens they ought to take part. The FFT and follow up questions also impose institutional frames upon the citizen, to whom the recommending of services may be unimportant, but who may have other relevant comments. Perhaps ticking boxes and giving personal details does give a feeling of empowerment to some citizens. If they can recommend or not recommend an A&E department, it may appear that the patient does indeed have choice. Nevertheless, it is an additional duty placed upon citizens which, intertwined with the discursive strategy of establishing NHS authority, may appear to be a condition of NHS use, and a further burden upon those wishing to be model citizens. Dualistic positions have been observed many times in these data, and this issue of choice is an excellent example. It seems that choices are at the heart of model behaviour for the citizen using health services, but also that there are numerous ways in which the producers attempt to influence and constrain them. Despite neoliberal discourses of consumer power and freedom of choice, these texts also constitute a reminder that in health there are 'rules' about use of services and true choice is absent or limited, with citizens forced either to conform, or to be placed in an out group or deviant state.

Texts such as the *Stay Well* campaign and the A&E banner occupy a place in a contemporary discourse of wellness which encourages an individualistic approach by readers who 'to become model citizens ... must internalise and follow the many pieces of advice provided' (McIntosh 2014: 30), and must 'make themselves up' (Rose 2007:140ff). This turn to individualism can be observed, not only in the third dataset

which explicitly requests consumerist feedback, but also in the more subtle manoeuvres taking place in the other datasets, such as the absence of community or family help in the *Stay Well* campaign. It could be argued that an individualistic approach may be relevant for the everyday actions in Dataset 1, but it is also applied to sometimes urgent or critical decisions about whether the type and severity of illness or accident merit a 999 call, and such individualistic discourses may impact negatively upon the wellbeing of the reader. While doubtless there are people who use one service when another would perhaps do, the texts rely on self-made lay decisions about the type and severity of symptoms, allowing responsibility for errors to be transferred to the patient or their loved ones. Few members of the public are expert at diagnosing serious conditions or recognising when a superficial injury becomes more critical, and in some cases will not have the experience or knowledge to make correct decisions. Delegating this responsibility to members of the public allows blame for any adverse outcome to be deflected onto the patient, who becomes more involved in diagnosis and decision making about treatment than in a traditional sick role (Parsons 1951). The citizen is even blamed for making a wrong choice if they do not access emergency services when they should have done, so that responsibility and guilt are piled upon the reader of the texts, no matter whether they may be extremely ill or vulnerable. This could well add to the worry for a reader already in a difficult or dangerous situation, also possibly contributing to social isolation, and the NHS must ensure that the drive to be a model citizen does not inhibit readers from seeking help when they really need it. The increasing number of sources that patients should check before attending A&E, and the moralistic and guilt-inducing discourses, work to filter and reduce the number of attendees, but could harm those who need emergency services if they delay treatment because of uncertainty.

For Clarke et al. (2007: 16), this individualising approach goes hand in hand with the production of 'citizen-consumers', in which

> the transformation of citizens into consumers is understood as diminishing the collective ethos and practices of the public domain (embodied in the figure of the citizen) and both privatises and individualises them (in the figure of the consumer).

By individualising then, the NHS transfers some authority away from themselves towards the citizen, but it is consumer power rather than collective power of citizens to own and control their communal public resources. In these data public services are often closely aligned with private ones through use of advertising media so that patients are 'increasingly encouraged to look at the NHS not as a valuable shared legacy...but as a collection of businesses offering things to consume' (Pollock 2005: 50). Advice is framed as a readily available commodity, and the reader's own information is commodified. The patient is also positioned, particularly in the FFT texts, as a customer who has rights similar to those buying holidays and consumer goods.

There are various flaws in linking health discourse to the discourses of commerce and capitalism, the most obvious being that for commercial organisations the objective of receiving feedback is usually linked to increasing sales or footfall. The aspiration to improve standards of care is positive, but NHS trusts are actively dissuading citizens from attending A&E. Therefore the technology of requesting and receiving feedback might be seen as somewhat of a dichotomy, which 'could be said to create a set of expectations and put patients in a customer role, thus potentially contributing towards a market discourse of the NHS' (Baker et al 2019: 14). The contentious term *recommend* forms part of a neoliberal commercial discourse in which the user is a consumer with spending power who can 'vote with their feet' if displeased in any way. Presumably the aim is to achieve as many 'highly likely to recommend' ratings as possible, but it is unclear how 'recommending' an NHS service can improve its quality. Rating hospital services in this manner assumes that they have the capacity and capability to improve in a similar way to commercial businesses. This is untrue as publicly funded services typically have a more complicated model for changes to funding, and complex decision making structures compared to private businesses (Nutt 2002). If more people use A&E, without a corresponding increase in capacity this will not improve the service, but may make it worse. 'Very likely' ratings will not necessarily lead to increased funding from government so that services can be improved. Rather, they are likely to be used as an example, goal or a basis for criticism for other services, which will be required to improve their scores or explain why they cannot achieve such high ratings. Furthermore, even if improvements are

made in response to feedback this may lead to worsening ratings because of increased expectations (Baker et al 2019: 217), although Duffy (2018) disputes this viewpoint as surveys from Ipsos MORI and others point to a UK public which applies different values and standards to public and private sector organisations.

In the FFT texts the NHS are putting aside health discourses and engaging with commercial discourses of customer care and 'market economy logic' (Sarangi and Slembrouck 1996: 26) which links 'good performance' with positive outcomes, although in the commercial sector this is because it leads to more profit. Indeed, speed of throughput in A&E appears to be valued more highly by the government than other indicators such as survival or recovery rates! Marketing discourse as used here, has been merged with, and tends to subordinate, many kinds of public discourses, with a result that is it 'becoming increasingly difficult to differentiate "informative" discourse from "persuasive" discourse' (Fairclough 1994: 257). The development of this rhetoric may prove problematic for the NHS as it impacts upon the organisation, and imposes new obligations upon both user and provider in terms of the practices of 'customer care' required. These are 'quite separate and independent from the primary product or service on offer, including ensuring that consumers encounter happy and friendly staff who will treat them like an honoured guest or close friend' (Baker et al 2019: 70). Their findings, that more comments concern customer service skills than health expertise, provide evidence that citizens are indeed reproducing neoliberal ideologies in response to a question which closely associates health services with commercial ones. Through being asked in particular ways, and having to respond in particular ways, the citizen learns and internalises connections between public services and commercial discourses and rehearses neoliberal notions of choice, markets and the superior rights of the customer (van Dijk 1998: 6). They not only reproduce consumerist discourse but also ultimately generate their own contribution to the canon by participating in and producing comments and reviews, understanding the NHS as a commercial organisation which is part of the market economy. Furthermore, these reviews are proliferated through such channels as social media, quotes on noticeboards and websites reproducing and normalising the discourse of feedback in health services. Staff are also drawn into the production of commercial-like texts when providing replies to reviews online, as they

enter into a public relations role (Baker et al. 2019: 190) which manages the reputation of the organisation whilst answering points raised by respondents. This again is an expansion by the NHS into discourses which were not previously part of 'Health', and its use by NHS staff reproduces and strengthens the ideology which claims that public and private services are alike. The existence of such discourses, generally accepted to form part of an overarching ideology of neoliberalism, in the NHS and other public institutions have been observed before (for example Brookes and Harvey 2016; Clarke 2004), but this analysis reveals the many moments when such discourses also spill out into the publications of the NHS, annexing non-health discourses into their dialogue with the reader and subtly linking the domain of Health with neoliberal dogma. The texts do not simply represent politically neutral 'Health' information as claimed in the Information Standard, but also reflect and promote ideologies which are present within the NHS.

7.5 Conflicted discourses of health citizenship

Despite the presence of these commercial and individualist discourses, to become a model citizen the NHS patient does not simply have to buy into neoliberal ideology. The readers' standards of behaviour are also held to account through a discourse of selflessness which entreats readers to put the needs of others, and the requirements of the NHS, ahead of their wishes regarding their own health. For example in the first dataset, the imperative upon already *frail* citizens is to take responsibility for oneself and other *more frail* neighbours. In the second dataset the web pages encourage the citizen to consider the needs of others above themselves, with evaluative adjectives positioning the reader as possibly undeserving of emergency healthcare. The reader of the ambulance poster and A&E banner are invited to evaluate their own moral stance, with suggestions that choosing incorrectly may cause problems in accessing services for other citizens. Readers of the FFT texts who have benefitted from NHS treatment are expected to reciprocate by providing their own personal data and feedback. What is evident from these texts is that model citizens have certain moral or ethical expectations placed upon them by the NHS. It appears that there are values attached to being an NHS user, but in another of the many contradictions within the

texts, this caring and selfless attitude is quite at odds with the individualistic and commercial discourses of neoliberalism. Indeed, both overt and tacit obligations are more closely aligned to moral duties. However this is not articulated in collectivist terms or as part of the social responsibility of common ownership, but in terms of one's moral duty to sacrifice one's place in the queue, care for the needy, place less financial burden on the NHS or provide data, so is still arguably an individualist discourse.

The NHS communications teams which produce the texts have a difficult task, as their potential audience is anyone in the UK, but their framing of the citizen is often contradictory, particularly when relating to the mental processes of citizens, including their intellect and ability to make appropriate decisions. The seemingly inconsistent position in which 'the individual is posited as being the site of a kind of dialectic between responsibility on one side and vulnerability on the other' (Brown and Baker 2013: 112) is possibly a symptom of addressing texts to massive, undifferentiated audiences. It seems that the writers are unsure of how to frame their readers, who of course, in such large numbers, will encompass a spectrum of abilities, as well as a wide range of attitudes to the texts, some compliant, some less so. The very existence of the texts implies that some citizens are by default at least transgressive or hapless, and at worst deliberately sabotaging systems and processes. There is also anomaly in the instructions to the citizen to act with urgency even if it's just a cough or a cold, but to check with NHS 111 whether they have the correct definition of life-threatening emergency. And while *Stay Well this Winter* plays on the trusting relationship that members of the public hope to have with health professionals, it seems that they are not trusted with information about the reason for the campaign. The model citizen is produced, but the authority-producing strategies are also required to keep the citizen in their place. The alternative versions of the ideal NHS patient that I have identified may cause confusion, making it difficult for the citizen to judge for themselves what mindset is expected when using NHS services. The conflation of contradictory discourses may leave the citizen less sure of themselves and what they are expected to do than they did before they accessed the 'information'! It is hard to imagine that anyone could ever achieve the status of model citizen so conceived, as not only are the duties and responsibilities many and diverse,

but they are also subject to change, and appear to increase every time the NHS produces a new campaign.

7.6 Saving the NHS

As I have shown, the subject matter of the texts is not necessarily what is expected. The minimal information about health in Dataset 1 is almost all basic and repetitive. Mainly about getting inoculated and preparing for winter, it directs people away from emergency healthcare and towards other services, particularly the heroic pharmacist. The texts in Dataset 2 are not about health, but about access to health. They barely give any healthcare information except for a few instances when emergency healthcare should not be used. They also actively and multimodally work to discourage, delay and deflect potential attendees. There are few lexical references to any aspects of healthcare in the FFT materials, with the main focus of all the texts on securing the co-operation of patients and ensuring that their data is captured in the correct format. Without the context provided by the photographs and logo there would be little to distinguish the national leaflet from customer feedback texts from commercial organisations. Looking across all the datasets, although these texts profess to belong to the genre of health information, the advice they include about health conditions and how to treat or remedy them is sparse to non-existent. Health discourses are present only through implicature and intertextuality, and clues that the subject matter is Health come mainly from non-lexical modes. Instead, we see a proliferation of other discourses, mainly concerned with behaviour management, often working to expand the remit of health. Regulation of behaviour seems to be more important than advice on actual health issues.

Nowhere in any of these texts is there any mention of the underlying reasons for the difficulties emergency healthcare is experiencing. These include lack of sufficient funding, struggles to recruit doctors and nurses, and lack of capacity in hospitals to absorb emergency admissions (see 2.4.3). This is against the backdrop of the 'controversial and politically-fraught reality of an increasingly commercialised model of UK health care provision' (Brookes and Harvey 2016: 299). It has now become established, however, that rather than being caused by unwell people the main cause

of pressure in A&E is mostly a systemic one linked to lack of capacity elsewhere in the hospital system. This creates backlogs and delays for emergency admissions, and throughout the whole system of emergency healthcare (Pollock 2005). A Kings Fund report 'What's going on with NHS waiting times' (2020) states that 'the rising number of attendances at A&E is not the main factor affecting performance'. So this cynical attempt to blame the sick for using services incorrectly and hence deflect attention from the root causes is carried out in the knowledge that the true origins of the problem lie elsewhere.

The texts this study represent an attempt, in effect, to shift the paradigm regarding use of A&E away from its former meaning as service for all who need help urgently. Then, through adjustment and normalisation of a new discourse of citizen behaviour, to realign users of health services with a new ideological formation in which model citizens practice self-care whenever possible, internalise a set of rules about use of the various NHS urgent care services, and avoid using emergency healthcare except in extremis. I have speculated in previous chapters that the ulterior objective of these texts may be to 'save the NHS'. Much of their content is not so much about staying well, but more about protecting the NHS, not just from being overcrowded, but also from being criticised for not doing something about the difficulties in which it finds itself. Citizens are being diverted away from emergency services, not because staff object to treating minor injuries but *because they are so busy*. The likely reason for the production of these texts is as a reaction not only to this pressure, but also in response to reports in the media about the dilemma faced by A&E and the ambulance service, and because of pressure and sanctions from government on hospital trusts which do not meet government waiting time targets. As Sheila Mitchell, Marketing Director of Public Health England (PHE), said in Marketing Week, 'everything we do in marketing is based on that higher NHS order and what we can do to help the NHS' (Gee 2016). In a health system dominated by statistics and balancing the budget, these texts can be seen as the mediated versions of the directives to comply, issued to NHS trusts by Government ministers, in which trusts have been penalised and humiliated for missing externally-imposed targets. Indeed, Sanders et al. (2011: 88) raised concerns that the shaming, by the Government, of hospital trusts for missing four-hour treatment targets would lead to shaming being passed down through the

hierarchy of hospitals and ultimately onto patients. As these texts do little to educate the reader about healthcare, it may be deduced that they are instead aimed at enrolling the model citizen onto a project to save the NHS.

The 'crisis' in A&E, as described and elaborated upon in the press (see 2.4.3), is one story in the narrative which presents the NHS as a failing institution, unable to cope with the healthcare demands of twenty-first century Britain. Examples of the 'failing NHS' discourse are common in the media and this narrative, on occasion, verges upon a discourse of chaos and anarchy, which the ruling party would wish to avoid at all costs. The esteemed place of the National Health Service in British culture is such that an impression that the government had lost control of the NHS would lead to repercussions, possibly as serious as removal from power by a public which is in many quarters suspicious about the safe stewardship of the NHS by the Conservative party. Yet it is certainly projected as an organisation in need of help. The producers of the texts, particularly in Chapter 5, but also to some extent in the other datasets, rely upon the media to provide context about the state of NHS emergency services. They use these texts, masquerading as Health Promotion, to counter this discourse of failure and potential chaos. Through the texts in this study they propose a solution to the 'crisis': patients can bring an end to the chaos by changing their behaviour, and order will be restored. This discourse is not found in any of the texts or in the waiting rooms, and patients attending A&E or using the ambulance service are not explicitly blamed. It is merely implied. Through this recontextualisation by deletion (Machin 2013: 352), there is a 'factual gap' (Cook 2001: 152) which depends upon shared knowledge for the communication to take place, but also avoids mentioning any other aspects to which the producer does not wish to draw attention (Cook 2001: 171). Because no other cause is discussed or reason given, and in conjunction with the omission of the NHS as an agent in many of these texts, readers will fill the factual gap with information they have acquired from other sources, such as news media, and make the link between A&E chaos and patient behaviour. They may then begin to blame themselves or others for 'failings' in the NHS. Another possible conclusion, perhaps for the reader who is less engaged with the news, might be that the 'crisis' is nobody's fault and the situation is hopeless and insurmountable.

Successive governments appear to be able to shrug off blame for the state of emergency healthcare, and this may well be due to the dissemination of patient-blaming texts. PHE claim that with the *Stay Well* campaign they 'have begun to shift the cultural norm' around patient behaviour in relation to A&E departments (PHE 2018a). As with many other public health campaigns it is extremely difficult to know whether any particular text is responsible for a change in behaviour. The main benefit to the government of such campaigns, however, is that if it is seen to be taking action (Beattie 1991) it may be able to play down its own role in creating the problem, and pass the blame onto citizens.

7.7 Situated semiotics

Context is always important in critical discourse studies (Woods 2006: ix) and throughout this thesis I have tried not to lose sight of the places in which the texts are located, because the settings of these particular texts forms a significant part of their semiosis. Firstly through the emplacement (Scollon and Scollon 2003: 210) of texts in locations where the emotional load of the message will be increased, such as the hospital entrance, ambulance and A&E waiting room, and secondly through their encroachment beyond 'health spaces', extending the reach of Health into the home and other locations via TV advertising and websites.

I have also found that temporality is a relevant aspect of situated semiotics in some of these texts. Kress and van Leeuwen discuss temporality in terms of timelines in conceptual representations (2006: 94), but its importance in these datasets is not about their history but in terms of their immediacy to the situation of the reader. All of these data address a reader who must act now in order to fulfil their obligations as a model citizen. This applies to the actions needed *this* winter in the *Stay Well* campaign, the timeliness of the survey responses in Dataset 3, and even more pertinently to the reader of the texts in Dataset 2 who stands at the entrance to A&E next to the banner and is faced with the choice of whether or not to adopt the version of model citizenship demonstrated there. The Derby Hospital web pages reflect a situation changing by the minute, with a link created between the A&E staff inputting data in real time, and the viewer of the live content, which adds to the pressure on the

citizen to choose the correct action and not to be a burden on the NHS. It is possible that the ubiquity of the texts, their materiality, temporality and their multimodal nature assist with comprehension and enable the assimilation of ideas, discourses and ideologies (Paivio 1991; Weinstein et al. 2019: 169). Furthermore, many of the texts work to change the actions people take, not only in health locations, but also in their daily lives, and before and after healthcare encounters. They are not just about not using services, but also about defining where and how healthcare services should fit into one's life.

It may be that by choosing locations such as ambulances and hospital entrances the NHS can reach their target audience more cheaply and efficiently because they 'own' these spaces. However the fastening of these fragments of discourses onto the walls of hospitals and ambulances, using methods of inscription (Scollon and Scollon 2003: 129ff) which integrate the message with the semiosis invested in the spaces cements the discourse into the NHS building or vehicle, so that it becomes part of that hospital or ambulance. The authority of the NHS to flout norms regarding non-semiotic spaces is a marker of their control over each space and what happens within it. In attaching these texts in such a way the NHS trust demonstrates that the discourses they entextualise are the world views which are appropriate to adopt in these places. Likewise by the absence of any alternative discourses such as underfunding of the NHS, the trusts demonstrate that this is the version of the truth which applies, and other viewpoints are not valid.

In the emotionally charged setting of A&E it is clear that the discursive landscape, made up of the many signs in the A&E waiting room, impacts upon the meaning of the texts. The FFT texts are in competition with many other discourses in the waiting room, but although there may be a jumble of signs in this semiotic space, it is also a regulated space. The presence of items on the walls and in the leaflet racks implies a level of endorsement, so access to the patients in the waiting room by these organisations has been obtained through a process of legitimisation and control, whether this is a lengthy policy document or the whim of the receptionist. These other signs compete with the NHS messages, and many of them also entreat the citizen to act, whether it be making a phone call to report abuse, signing up to be an organ donor or buying chocolate from a machine. The complexity for the citizen is

increased because of this mass of information which indexes many discourses, but also because of the variety in the deontic force of the messages. In the third analysis chapter I asked whether the information in the waiting room provided an opportunity, or a duty for the citizen. There is an attempt to sell completion of the FFT as beneficial to the patient, but the FFT texts are clearly aiming to get something from the reader, rather than providing them with a medical service. If we extend this argument to the other texts, we can consider whether any of them provide more benefit to the readers or to the producers.

Why, though, would citizens take instructions from a piece of paper, web page or TV advertisement? The advice in health promotion texts is intended to stand in place of face-to-face advice from a medical professional (McIntosh 2014: 35), but even with the strong symbolism of NHS staff, the reader is surely aware that they are watching an advertisement, or holding a leaflet, or standing next to a banner. Yet these texts are inanimate artefacts which appear to have their own power. Entextualisation, whether into the form of a written document, or perhaps a TV ad or official poster, also causes a change in the material of the text. Instead of being simply an object, the 'top down' text is also imbued, through discursive strategies of power production, with some of the authority of the producer. The text which lays down the law, or the 'rules' of conduct, *becomes* the law (Coulmas 2009: 16). As this 'discourse become flesh', addressed to large populations but working on individuals, is now part of the material world, it begins to be used and to become part of social process and interactions, and can therefore be instrumental in transforming discourse into actions by people. The texts themselves become part of that practice if users engage with them in ways such as checking the live wait times or completing the *Going Home Survey*. So to some extent comprehension of the message by the reader is not critical, but what is more important is that the authority of the NHS is recognised and understood. By publishing these texts, the NHS participate in communication acts which start, stop or change sociocultural practices. Citizens who wish to be model citizens will follow the guidance, whether it is beneficial or detrimental to them. We can now see why the parallel strategy of authority production is so important in the NHS texts. It is clear that the power dynamic between the NHS and its subjects is of high importance.

7.8 Power and Manipulation in public information

Modality is of particular importance in power production in these data, and the NHS uses deontic or 'relational' modality (Fairclough 2015: 142) to demonstrate in its appropriation of language, its powerful position in relation to the reader. As well as its content, the form of the message contributes to our belief in its reliability (Kress and van Leeuwen 2006: 155), and as I have shown, modality can be demonstrated through non-lexical modes, such as the presence of the NHS logo, the materiality of the TV ad and the quality of the photographs. It appears to be important to the NHS to demonstrate authenticity, for example through the demographic mix of actors, the materiality of the texts and the extensive use of non-lexical modes to achieve high level of certainty in their legitimacy as the authoritative voice in health. This is a non-lexical equivalent of 'expressive' modality (Fairclough 2015: 142). As it leads and controls health-related matters in the UK, the NHS also seems to subscribe to an additional kind of 'organisational modality' which is generated through demonstrating contemporaneity, relevance, authenticity, and presence. Whilst adding to the types of modality described above, this organisational modality also confers status upon the NHS as a worthy leader on health matters because it is able to operate in the modern world. By embracing innovative, responsive and relevant communication channels, and through the expertise with which the text producers position their communications alongside others using commercial-like and commercial quality advertising techniques, the NHS is constantly renewing its right to govern the realm of health, and to instruct and train citizens.

The use of mainstream marketing techniques marks NHS as an important and relevant player in the public domain of health discourses, but also allies the institution with commercial communication methods, linking it to economic discourses of profitability and productivity which are far from its core values. It is important not to lose sight of the evidence that whilst providing information for NHS users these texts are also perpetuating ideologies by 'strategically directing behaviour to fulfil a vested interest related to a specific political project' (Sarangi and Slembrouck 1996: 33). Employees of organisations may be so invested in naturalised institutional discourses (Fairclough 2010: 42-44) that they may not, in many cases be aware that they are reproducing them. They may believe that they are politically

neutral and operating in the public interest, however 'there is no means of producing an unbiased sign' (Kress 1993: 179) and from a position of power the signs that are issued will always be in the interest of the sign producer, and text producers must choose an identity or 'position' (Gee 2014: 21ff) from which to address their audiences. The way in which these objectives are achieved may be taken for granted, meaning that it is part of the dominant ideology (Fairclough 2010: 30) of the organisation and does not need to be stated. This may mean that much of the communications and their socio-linguistic consequences are not thought through during production, as they are part of a naturalised discourse.

Using van Dijk's (2006) definition (see 2.5.2), this construction and re-construction of citizens could certainly be described as manipulation. What is expected of citizens is made very clear through the discursive strategies in the campaign, yet much, as I have said, is hidden from them. However the tactics employed to shift the behaviour of the citizen include discourses of fear inducement, ridicule, shaming, or infantilising, and allow individuals to be blamed for not solving a national problem if they do not act, or sometimes even if they do. In the meantime, the government appears to have made some attempt to fix the problem. After all, they have printed some posters or produced a TV advertisement providing 'information'. My analysis has shown how citizens are constructed in this way, and how they can become neoliberal subjects by assimilating ideology via multimodal stimuli. By aspiring to be model citizens, by obeying instruction, being more careful, taking on more self-care, but also by reproducing government ideologies in their own words, and in particular by reducing their use of services, citizens are manipulated into assisting the government in their plans for the diminishing or privatisation of the NHS. The emergence of three distinct model citizens in a selection of NHS material about emergency services suggests that there may be many more versions of the model citizen employed in texts produced by other NHS services. Indeed in McIntosh (2014) I found another such construct which demonstrated ideal behaviour in relation to drinking alcohol. The significant variation in these constructs confirms that public information about health is a technology of governmentality, the texts in this thesis are artefacts in this social practice (van Dijk 1998: 6), designed with the specific purpose of manipulating the behaviour of the public.

Although it seems in many cases that the reader has agency, and indeed must exercise this agency to achieve model citizenship, on close inspection the texts reveal that citizens have very minimal power to effect change. They are entreated to help themselves and others, but can only do so within proscribed ways, by going to the chemist, for example instead of calling an ambulance, and by staying home and keeping warm, rather than expecting to be looked after in retirement. As I have demonstrated, it may be implied through synthetic personalisation in the texts, yet there is no intention from the NHS to devolve power to citizens, which might involve offering genuine choices. The level vector in the gaze between the depicted participants in the *Stay Well* texts and the reader, indicates equality, but only inasmuch as they attempt to gain our cooperation through their authenticity as NHS staff. The choices made within the meaning potential of semiotic modes during recontextualisation of discourses not only construct the model citizen but also manipulate the subject position of the NHS staff in relation to the model citizen. In Dataset 1, they are heroic and iconic, uttering authoritative words of wisdom and comfort. In Dataset 2, staff are referenced as being 'busy' and readers are urged to free up their time to deal with 'genuine emergencies' by taking themselves elsewhere. In the FFT texts they are the object of scrutiny, depicted in photographs but bypassed in the feedback loop. It can be seen then that the NHS view their staff as a resource to be deployed as necessary for the purposes of emotionally manipulating the public. Power is exerted remotely through these texts by taking advantage of the citizen's expectations that medical staff will provide objective and beneficial advice, which should be followed. The identity of NHS staff is being manipulated for the purposes of controlling their patients, and although the staff are used, the root of this power exerted upon the citizen is, as my data analysis exposes, NHS management, underwritten by the government and supported by the ingenuity of communications teams. The citizen's acceptance of this subject position signals their acquiescence, but there is some evidence that citizens are resisting these 'self-restraint' discourses of model citizenship. Despite the claims of PHE mentioned earlier in this chapter, A&E departments continue to be overwhelmed by numbers of attendees 'legitimate' or not, and ambulance services periodically publish lists of illegitimate reasons for which errant citizens have attempted to call ambulances.

Indeed it may take something much more momentous to change the actions of such large numbers of people. Congruently with the claims I make in this thesis, as part of their initial message to the nation about controlling the Covid-19 outbreak, the UK government told citizens that it was critical to 'protect the NHS' by staying at home (HM Government 2020). The BBC, which only in February 2020 carried stories about the worst winter to date for A&E departments, reported on 7th April 2020, during the Worldwide Covid-19 outbreak, that A&E numbers had fallen by 29% in March, with 1.5 million visits in England, compared to 2.2 million during the same period in 2019 (Roxby 2020a).

Individuals may think they are exercising free will, and indeed may have bought into the neoliberalist rhetoric that they are exercising choice, because 'people are not conscious of being socially positioned as subjects, and standardly see their own subjective identities as somehow standing outside and prior to society' (Fairclough 2015: 124), but they are increasingly dependent upon instructions from government telling them how to behave. Indeed NHS directives to behave in particular ways may not be perceived as emanating from an elite if they can be presented in such ways that they are received as common sense (Fairclough 2015: 13). Through deployment of the model citizen such public discourse from public bodies is presented not just as the voice of the organisation, but also the voice of the reasoned and reasonable citizen. It delivers not official advice but common sense. This is another reason why it is powerful and cannot be challenged, because it appears 'objective and disinterested—and hence as an impartial, public voice that purportedly represents all citizen-subjects' (Park and Bucholtz 2009: 487).

In none of the texts is there any challenge or alternative given to the entextualised assumptions about power dynamics, individualism and consumerism, nor even to the anomalous discourses of self-sacrifice. Instead, they indicate that, in the minds of the writers at least, these discourses belong to a naturalised ideology. What appears not to be naturalised is the expected behaviour of NHS users! It might be expected that a neoliberal approach to health would encourage citizens to use the NHS to fulfil their individual 'health needs', to mix and match healthcare services as part of one's 'package of care', and to 'go private' if necessary to ensure a speedy and efficient service. These texts presuppose that citizens have to be taught how to use the NHS in

a ‘non-neoliberal’ way despite operating in a neoliberal domain. We have already seen evidence of the loyalty of the British people towards the NHS, but are these texts being used to manipulate the public into acting to save the NHS by giving up their right to treatment? Health promotion has always been about behaviour change (Lupton 2012: 32), but these texts take the idea to the next stage. They are not just aimed at changing health-related actions but at changing the attitudes, mindset and ideology of individuals, put simply, not just changing behaviour but also converting the reader into a model citizen. Perhaps we are witnessing an example of what Rose (2007: 6) has termed ‘subjectification’ — a recoding of ‘the duties, rights and expectations of human beings in relation to their sickness, and also to their life itself’. But given that ‘constituting subjects is what ideology is all about —*all* ideology is in one way or another to do with positioning subjects’ (Althusser 1971, as cited in Fairclough 2015: 124) we should not be surprised that such a powerful entity as the NHS attempts to shape citizens to meet its own interests, even though it is meant to be a public resource which ‘belongs to the people’ (DH 2015: 2).

So it is possible to observe the production of an ideological formation (Fairclough 2010: 30ff) in which the public are responsible for the deterioration of a part of the NHS. This is not a new phenomenon. In addition to ringing 999 for ambulances too often and for the wrong reasons, and attending A&E incorrectly, patients have been previously blamed for overusing GP services (Robinson 2012), and ‘bed blocking’ among other misdemeanours. It would be easy to expand this argument to all NHS services, and for the government to claim that when the NHS model of health care fails it is the because of action by the public, overusing and abusing the service as a whole. As with other dominant ideologies if continuously perpetrated and reproduced it becomes invisible as an ideology and accepted as a common sense truth. A&E is clearly of high value to people judging by the ‘save our A&E’ campaigns that spring up when an A&E department is threatened. But is blaming the citizen for the failings in the system the right way to either improve or rescue services? By selecting this ideological stance the NHS trusts, which are supposedly non-partisan, are entering into political theatres in which they align with the ruling party and its discourses of control, and against the public, and they deny discourses of underfunding, downgrading and privatisation. Health promotion texts are presented

as simple, unbiased truth from a politically neutral organisation, but the underlying and unchallenged neoliberal ideologies render them highly political. However, NHS trusts and their communications teams would do well to tread carefully around neoliberalism which 'has consistently been hostile to the public realm' (Clarke 2004: 30). Governmentality is not necessarily 'bad' if it is for the greater good, indeed power can be exerted for positive ends (Fairclough 2015: 26) but the covert shifting of responsibility for the 'failure' of the NHS whilst stripping it of resources and its power to provide services to those who need them, brings under suspicion the construct of the model citizen, and these genres of public information in general.

7.9 Conclusions

Citizenship, as discussed in the literature review (section 2.3) is made up of a combination of rights and responsibilities. The citizen owes duties to their country or other region, and in return receives rights and protections. The texts in this study downplay rights and entitlements, which are barely mentioned, yet each adds new duties to the role of the citizen: making a winter plan, consulting pharmacists, checking the wait times for services and refraining from using them, and completing surveys and ratings. All these additional duties are reshaping citizenship in relation to health. I have stated that the model citizen is the one who conforms with whatever instructions are being given at the time, and, obedient and responsive to changing instructions, absorbs the information provided, and follows any guidance given. The citizen in these texts must also buy in to a discourse in which patient behaviour is both the cause of and the solution to a crisis in the NHS. The versions of health citizenship I have uncovered in these texts have little to do with health status. Although they relate to illness and injury these duties also extend to times when the citizen is well. They must learn and prepare for illness and other winter hazards, and after recovery must evaluate the treatment they received.

The generation and distribution of so many texts which seek to control and shape the citizen into an ideal form implies that there are alternative ways of using the NHS which citizens sometimes employ, and that this is behaviour which does not comply with the preferred (or permitted) conduct of NHS users in the view of the information

producers. There are also new ways of using the NHS, such as the array of urgent care services, and the 'choice' to ring 111 and speak to an 'advisor' rather than seeing a GP. There are rules about when and how to use them, but these are not consistent, and it appears that potential patients have to be re-educated into how to use each service, or how to be better consumers by giving feedback. These materials serve as instruction materials for those who have never used emergency services, and training materials for those who are using services 'incorrectly'. An overarching duty of users of health services appears to be the obligation to stay abreast of information materials and new requirements upon the citizen!

Conveniently for the current political administration, this model citizen is a neoliberal subject who performs their function as an individual in an increasingly commercialised health service reflecting many of the values of the government of the day. Yet in all of these datasets the NHS relies upon the desire of the citizen to do the right thing, to be helpful, unselfish and public spirited, no matter whether they are ill or injured, and whether they are at home or hospital. These texts, like neoliberalism in general (Monbiot 2019), offer much but arguably deliver very little for the ordinary citizen. They suggest that there are many services and choices on offer to the public, and that the citizen's duty in return is a moral one to take responsibility for staying well and looking after others (Cederström and Spicer 2015: 30). But my research has shown that all that is on offer in these texts is advice. The modern citizen must be constantly alert to news, and able to combine NHS discourses with other knowledge, to deduce the appropriate way to proceed, navigating citizenship with consumership, understanding wry humour and irony as well as having an appreciation of multimodal communicative grammars such as an understanding of hidden meanings including those in voice quality and colour. We are perhaps witnessing a 'next generation' technology of governmentality employing 'advanced' synthetic personalisation techniques which now borrows from multimodal advertising techniques and taps into advances in the psychology of non-verbal communication to carry out its insidious work. Neither is governmentality a static process. Government agencies have recourse to significant resources and one component of their power is realised through the continuation and increasing sophistication of governmentality. New communication channels, novel ways of using existing ones and insights into

human behaviour gleaned from research not only add to the authority of the NHS through increased institutional modality, but also allow access to wider demographics of citizens. Health, an area where governments can legitimately engage with citizens, is being used to develop neoliberal subjects. These citizens may well apply such ideologies in other domains (van Dijk 1998), and at the ballot box.

These aims of asserting control over the behaviour of citizens are of course contradictory to the tenets of neoliberal capitalism 'in which freedom to choose is paramount and health is publicised in similar ways to consumer products' (McIntosh 2014). Free market proponents, and other critical audiences, might question whether this is an endeavour in which it is appropriate for the NHS to engage, or whether it constitutes an overstepping of the remit of a national health service. I am not arguing that the NHS is not beneficial. Its very purpose is to promote the health and wellbeing of citizens, and the fact that its employees were prepared to be depicted in some of these texts is just one among numerous examples of the commitment and care contributed by its workforce. Those employees recruited to take part are surely doing so because they believe they are directing their readers to stay well. Yet through these texts, and with the complicity of the featured staff, the political and organisational decisions which have resulted in lengthy waiting times in emergency departments and GP surgeries are recontextualised into specific actions for individuals. It may be that the public want a strongly authoritative NHS which issues direct and infallible edicts. But should the NHS also reproduce stereotypes such as the hapless older citizen, in its public-funded communications, and is it also the place of the NHS to construct capitalist ideologies in its users, covertly imbuing them with neoliberal characteristics? Could it be that the tension in the NHS between health provider and power base is out of balance and that the NHS are more concerned with governing than with healing? All of these texts about the metadiscourse of emergency healthcare influence the NHS user in overt and subtle ways to behave as required in order to become a model citizen. We should question why this is happening, and whether these are examples of the government exercising their power to control citizens through the emotive politics of the NHS.

8. Reflections and Conclusions

8.1 Introduction

I have investigated and discussed the ways in which the construction of the model citizen takes place in seemingly innocuous texts from the NHS. Here governmentality is brought to bear on citizens via the guise of 'health information', and is achieved incrementally by numerous component parts combining in texts to form strategies which work on the individual. This thesis makes a positive contribution to the field of Multimodal Critical Discourse Analysis (MCDA), representing as it does a large study into the hitherto uninvestigated phenomenon of the model citizen. In it I have demonstrated that established CDA and MCDA tools can be combined in novel ways to uncover ideologies in diverse data. Furthermore, I look at multimedia datasets of public health materials, which have been under-represented in critical discourse studies. This application of MCDA has exposed the attempts of PHE and the NHS to influence citizens, using multimodal discursive strategies to combine health discourse with discourses of control. Through these hidden mechanisms they look to expand the domain of health and influence NHS users to behave and think like model citizens.

I begin this final chapter by revisiting the aims of the thesis, and addressing the extent to which they have been met. I also discuss the methodology and framework used for the study, and its usefulness for the task in hand, together with its limitations. I reflect upon my findings, firstly in general terms, then more specifically in relation to their significance for emergency medicine, for communications teams in the public sector and for the field of MCDA. I also consider future directions for this line of study.

8.2 Aims, findings and contribution of the study

In this study I set out to investigate the role of the model citizen construct in educating or persuading Accident and Emergency users about correct ways to use NHS services. I have responded to my research questions by conducting an innovative and thorough study which has exposed the role of multimodal discursive strategies in NHS texts, and the precise semiotic means by which such strategies construct,

reproduce and evolve the correct use and purpose of the NHS. In answering my research questions I have found that NHS public information texts construct the model citizen in many forms. They also re-establish and maintain the authority of the NHS in a surprising variety of ways, which would not have been evident in a study looking purely at spoken or written language. Combining analysis of language and other modes, I have demonstrated the major contribution that MCDA can make to the study of health discourse.

This study is one of the first to consider how ideologies function in British public health communication texts, and how they are realised not only through language but several strains of semiosis. It instantiates a novel and useful application of MCDA, illustrating a framework which reveals and critiques discursive strategies, while combining established CDA and MCDA tools to demonstrate their effectiveness in a large study covering a complex range of texts. This is also the first study of its type to investigate evidence of a specific construct, and to consider the model citizen as a subject of the NHS in this way. The main findings of the study are discussed in detail in the previous chapter. They are the revelation that the discursive construction of the model citizen is not only frequently relied upon in health communications with the public, but that it is a multi-layered construct, produced through many communicative modes, to suit the needs of those responsible for the texts, and imbued with contradictory but largely neoliberal ideology.

'Language is so structured to mirror power relations that often we can see no other ways of being, and it structures ideology so that it is difficult to speak both in and against it' (de Parker, 2001: xi). Through control of discourses, and 'ownership' of the spaces in which they are recontextualised and dissipated, the position of the NHS as the authority in this domain is re-produced, but the way in which this is achieved is a complex picture. Taken at face value, these texts do nothing to help us understand the complex dialectic relationship between the powerbase that is the NHS and the citizen who has so much invested in it. It is therefore necessary to examine each element closely, and in combination with others, to ascertain the ideologies working on readers in the texts, as I have done in this study. I have shown that constructing the model citizen is a powerful device, deployed in the transformation of ideologies into common sense social actions for real citizens. The strategy to construct the model

citizen in NHS texts is embroiled in maintaining the status quo of power relations whilst transferring responsibility, and culpability, to individual citizens.

8.3 Reflections on the method

Public information texts are just one of the many technologies through which discourses act on citizens, but they are dispersed into the population, endorsed, often explicitly, by government and the NHS, and reinforced repeatedly through various genres. What is more, they index and are indexed in other widely available texts such as the news media, and have been welcomed into other domains. For example shops, workplaces and universities freely distribute content and materials produced by the NHS to their internal and external audiences. Some of the texts in this thesis have been produced in their millions, others are placed prominently so that they can be viewed by tens of thousands of people, widely accessible via websites, broadcast on national TV channels or posted directly to citizen's homes. These genres of text, frequently employed in Health and other public discourses are becoming more complex, constantly merging and diverging (Machin 2013), so suitable methods of analysis are important, and this study has demonstrated one such methodology. A multimodal approach is the only effective way to analyse such multi-semiotic data, and the MCDA approach, describing in detail the many and multimodal details contributing to semiosis, has proved to be crucial in bringing to the forefront the well-disguised ideologies in the texts.

In their extensive efforts to develop 'grammars' for non-lexical communicative modes, Kress and van Leeuwen (2001, 2006: 266) have concluded that while such grammars doubtless exist, their nature is not such that they can be mapped to spoken or written language, nor indeed to each other. They find that 'sign-making in society is so varied an activity that any attempt to capture it in a general theory must look crude by comparison with the richness of the actual semiotic world'. Indeed this is my experience in this study, and I have found that although all the texts were rich in multimodal semiosis, managing the analysis of multiple texts of different genres was not a straightforward task, due to the variety of qualities and affordances of each text and mode. I mitigated this issue by taking a thematic approach across each dataset,

investigating discourses at a level not just 'above the sentence' (Stubbs 1983:1) but 'above the text', considering each mode and its contribution to discursive strategies in the dataset, rather than the individual text. By considering the affordances of each mode present in each dataset I have demonstrated a way in which MCDA can analyse several texts at the same time, and have applied established (M)CDA tools in new combinations to achieve the analysis of a large and diverse dataset.

It is precisely because non-lexical modes can be used to express ideas without words that they become such powerful signifiers. Ideologies can be communicated without spelling them out explicitly, particularly if an innocuous, widely available and familiar genre is used to do so. Like written and spoken language, non-lexical modes rely upon the reader to make connections between what is perceived, and ideas, because 'ideologies are gradually acquired, developed and changed in and by situated social practices and especially by discourse' (van Dijk 1998: 79). Multimodal communication, and in particular a constant drip of similar messages, or a massive multimedia campaign, may have significant power to impact on ideologies, certainly when compared to a ten minute consultation with a doctor. Studies looking at press media, such as Ledin and Machin (2018: 39-42), often attempt to capture these ideologies but British newspapers are overtly partisan, so their ideological positions are fairly widely understood already. NHS texts, on the other hand, are expected to be impartial and politically neutral, so are more subtly able to exert influence, particularly if they are read as common sense (van Dijk 1998: 244ff.). Importantly in this study I have shown that these meanings are not accidental or imagined by the reader, they are recurring themes, repeatedly produced in multiple texts using combinations of semiotic modes, and repeatedly invoking the construct of the model citizen.

Through this thesis I have developed and refined an understanding of discursive strategies, and the ways in which they operate in multimodal texts, in multi-media campaigns and in other groups of texts which have objectives in common. In answering my research questions I have identified several distinct discursive strategies in each dataset, and I have commented in detail upon the linguistic features and communicative modes that contribute to each strategy, or sometimes disrupt them. My framework for analysis ensured that the focus of the study was upon

people, places, processes and discourses. The iterative process of identifying and critically analysing individual properties of each mode in each dataset, while lengthy, was sufficient to enable a systematic and thorough approach to the data. This framework proved fruitful, as it was through exploring these strategies that it was possible for the first time to identify patterns of repeated strategies, particularly those related to power production and positioning of the subject. In employing this framework and applying it to MCDA I have developed the use of discursive strategies, showing that they are multimodal and can make a valuable contribution not just to Discourse Historical studies (Reisigl and Wodak 2016: 33) but also to other branches of CDA including MCDA. As a result of this study it has become possible to appreciate the scale upon which such strategies work across different texts, and through the many and various semiotic modes which are combined, along with written and spoken language, to influence and control the population.

8.3.1 Issues of interpretation and limitations of the method

It is important to remember that other readings of these data are possible and even likely, particularly given their massive and diverse audiences. I am a member of the population to whom the texts are targeted, however I very willingly acknowledge that my reading is also subjective. Although I do not presume to know the intentions of the writers of the texts in this study, recipients 'continually construct the possible intention of speakers' (van Dijk 1998: 217) so 'naturally occurring' readers of these texts will, like me, be attempting to understand the explicit and implicit intentions encoded in the texts. The work of critical discourse analysts is not only to describe and interpret but also to explain the links between 'background assumptions (and) ideological properties of these assumptions which link them to social struggles and relations of power' which are not generally appreciated by discourse participants (Fairclough 2015: 155).

For the critical discourse analyst there are decisions, and sometimes compromises, to be made about the level of detail into which to go and, conversely how much context to include in the analysis. In a multimodal study there is also a balance to be drawn between the level of analysis of each mode. Had I chosen only one genre of texts, for

example, or examined fewer semiotic communicative modes, then a finer grain of detail would have no doubt been possible. My aim, though, was to investigate the model citizen construct in a range of texts, and while probably not exhaustive, I have conducted a thorough investigation into this fascinating element of such a wide range of health promotion materials to a sufficient level to reveal the main facets of this construct. A qualitative study based upon a limited selection of data cannot be claimed as representative, and neither do I claim that the study is comprehensive. However, I have demonstrated, by looking at several national, regional, local and site-specific texts, and a wide range of communicative channels, the prevalence and characteristics of model citizen constructs.

As with any study, a number of lines of inquiry did not become part of the final study. Two dimensions which to begin with appeared relevant were that of gender and class. Health promotion materials are often gendered, with the responsibilities of mothers in particular, augmented, as they are frequently targeted by public health campaigns, viewed as the gatekeepers to the family' health. Social class is also relevant from the point of view that any depletion of A&E services is likely to have the greatest impact on those from 'lower' socio-financial groups, who are most likely to be A&E users. A higher proportion of people from lower income groups attend A&E with injuries, compared to those from better-off households (Kirkwood et al 2017), and 'people from lower socio-economic groups are more likely to fall ill and are disproportionately affected by the consequences of preventable illness' (PHE 2017a: 7). While either or both of these strands would have been interesting to pursue, they did not appear to be specifically relevant to my texts. Although they depicted stereotypical patients and demographic groups it would have been pushing a point to claim that the texts were relevant only to the poor or to one gender. However this may not be the case in other investigations into the model citizen. Charles (2013), for example, has illustrated how women and girls are a manipulated into a 'novel community of responsible, active biocitizens' in explicitly gendered vaccination discourses. Indeed a future strand of work could investigate whether there are less barriers to the middle classes in becoming model citizens because they may live for example, in a safe, warm home in good location with local facilities, compared to

those left with no choice due to closure of other services, privatisation, lack of public transport, or limited resources.

8.4 Application of the findings in the NHS and beyond

Although discursive strategies have been described as 'more or less accurate and more or less intentional plan of practices .... adopted to achieve a particular social, political, psychological or linguistic aim' (Reisigl and Wodak 2001: 44), I do not believe that all the discursive strategies that I have described here are necessarily 'intentional' to this extent. Employees of organisations are, as I have already argued, often involved in reproducing naturalised ideologies as common sense. I do not believe that communications professionals in the NHS are deliberately reproducing capitalist ideologies, negative stereotypes of vulnerable people, and discourses which shame and blame or asymmetrical power relations. It is, therefore, important that they are aware of their position of power and their role in reproducing ideologies and social practices. Manipulation, whether deliberate or not (van Dijk 2006) is always in the interests of those with power, and the abstraction of NHS staff from their usual workplaces into sanitised, generic, settings, the deletion of discourses of chaos, and the addition of a new process of feedback, replete with graphs and percentage scores, all remove the focus from government failings and shift it to the citizen, who must always do more.

The cumulative impact (Fairclough 2015: 82) of model citizen discourses is beyond the scope of this study, but some insight may be drawn from the behaviour of citizens during the recent Covid-19 outbreak. Citizens of the UK avoided using emergency healthcare in large numbers, and there was speculation that people with serious conditions and other very serious health issues may not be attending. The message that the busier A&E departments become, the more extreme a patient's condition must be before asking for help, and the idea that A&E is far too busy to deal with *your* problem, appears to have been getting through. It is hoped that the findings of this study will be of use to those producing information for the NHS, particularly for urgent and emergency care services. Of most importance, I believe, are the ways in which the model citizen persona is constructed, the power dynamic between the

citizen and the NHS, and the stance adopted in such materials. The writers and producers of NHS publicity must decide whether they are 'us' or 'them', and how they wish citizens to relate to the NHS. This applies not only in terms of an individualist or collective approach, but also in relation to whether the NHS should retain its venerated position as a cherished national resource which belongs to the people, or whether they wish it to become just one of a range of services that consumers can pick and mix, giving star ratings on the customer service they receive. The developers of the information standard should perhaps find ways to test the impartiality of materials from organisations awarded with the standard. These points may also be of relevance to communications staff in other public services.

It may be useful too, for those working in emergency medicine to be aware of the prevalence of these discourses of model citizenship. These practitioners may wish to bear in mind the way patients are constructed and to whether the ideological stance of information about their services is fostering the kinds of patients they wish to encounter. By participating in their proliferation they (unwittingly) defer to the party politics of central government, which may not necessarily be compatible with professional ethical standards, or the principles of the NHS. Reducing the workload of a busy A&E or ambulance department is admirable, but not so the shifting of blame for government decisions onto ill or vulnerable people.

8.5. Reflections on findings and their implications for CDA and MCDA

By carrying out my study in this manner I have evidenced the widespread nature of the model citizen construct, which could not have been achieved by looking at only one or two texts, albeit in closer detail. Furthermore I have shown that the model citizen is constructed by the text producers depending upon their requirements at the time, and while predominantly a neoliberal subject, is also expected to be community-minded and self-sacrificing. The emergence of the model citizen as a neoliberal thinker has relevance for actual citizens and for the NHS. For this reason it deserves further scrutiny by the CDA and MCDA community, along with more frequently addressed subjects such as the subtle annexation of alternative discourses into the domain of health, which has also been evident in this data. I have also provided

examples to illustrate that the resemioticisation of discourses can lead to discursive representations of power relations, and the linking of public services with commercial discourses. Through the hidden demonstration of power relations, governmental or organisational commitments are sidestepped, and responsibility for dereliction of financial and infrastructural problems avoided. All of these themes are the frequent concern of critical discourse studies and my examples contribute to this body of work, providing instances from a previously under-represented genre of texts.

Perhaps scholars have paid less attention to health promotion materials for the public than to policy documents or direct interactions because they are seen as less important or bearing less ideological load. However Kress (1993) reminds us that no sign is ever arbitrary, and it is a mistake to view such materials uncritically or as common sense. Significant resources are invested in production of public health texts, not just through production and distribution but through the employment of teams of specialists and the engagement of consultants and marketing specialists brought in to understand the audience, to mediate discourses into the desired genres to design, plan campaigns and evaluate, ensure organisational messages are dispersed into the lives of the public. None of this is accidental or arbitrary and even when the needs of the reader are served by social action such as information provision it is still motivated by the interests of the producer, and will 'produce a particular account of the world' (Kress 1993: 180) and, it seems, a particular model citizen.

8.6 Directions for future work

The revelations in this thesis must obligate further critical investigation of the production and deployment of the model citizen construct and its role in power relations, which need not be limited to Applied Linguistics but could be taken up by researchers in other social sciences, and beyond. There are, of course, many other services in the spectrum of healthcare about which the NHS produces information, and there is much scope for further work on the phenomenon of the model citizen. My study is generalisable, in that my approach could be applied to other sets of texts. Further study could establish how widely the model citizen construct is deployed,

and could look for patterns in Model Citizen production to discover whether specific constructs are used for specific purposes. Likewise the study is not exhaustive in the range of media channels covered. Future studies could investigate the model citizen in social media posts from NHS trusts, or mainstream news media for example; corpus studies could look for evidence and characteristics of the model citizen in large corpora. The timing of this study did not allow for analysis of texts produced during the Covid-19 outbreak, but the model citizen was certainly invoked in many of them. Communications from the NHS and the UK government, or indeed other governments and health organisations, on the various facets of the outbreak provide excellent opportunities for future application of this work.

The thesis has answered initial questions about the construction of the model citizen but leads to many more. Further work is needed to establish whether, and how (through what mechanisms) the real citizen is influenced by the model citizen. Do people have their own mental model(s) of model citizen(s) against which they measure themselves? This is likely to involve interdisciplinary study involving sociologists or ethnographers. Some citizens are clearly resisting the call to stay away from emergency services. Whether this is a rejection of the discourses in these NHS texts, confusion because of contradictory ideologies, a reaction to the treatment of the citizen, or some other cause, it not possible to know without further work, but this thesis has provided insights which may be a starting point for work in these areas to take place.

To state that a discourse manipulates the reader 'risks incapacitating the recipients' (Reisigl and Wodak 2001: 33), so I do not make any claims about the effects of these texts, which is outside the scope of this study but could form part of future work. The absence of the voice of the reader is, however, resounding, and is part of the power dynamic in the texts. It may be that observing and tracking the ways in which the model citizen is treated in materials for the public could provide further evidence for underhand government policy, including hidden ideology. To this end further studies would be helpful, and it would also be intriguing to know whether the model citizen construct is present in texts about other public services, so critical analysis of texts for the public from other fields may also be fruitful. In these data the model citizen

features frequently in this power struggle, so should also be borne in mind in future investigations into medical power.

8.7 Conclusion

The NHS does an incredible amount of positive and beneficial work, but this is not a reason to be uncritical of texts produced by a branch of government, proliferated so widely among the population, and blending with advertising, customer feedback and other commercial genres. The subject matter of the materials was chosen because of its topicality, and indeed the issue of so called 'overcrowding' or 'overuse' of emergency healthcare has remained in the UK news, particularly during the winter months, throughout the whole time spent upon this study, with the government and NHS seemingly no closer to solving the 'problem'. Undoubtedly there are also lessons to be learned from the behaviour of the public during the Covid-19 outbreak.

Public information does not appear to be solving the problems in emergency healthcare. It is possible that it cannot succeed because the hypothesis put forward by the writers in these texts—that UK citizens are responsible for the demise of their own health service—is not believed by readers. They may already feel that they use NHS services correctly, and may be well informed about the real reasons behind the 'NHS crisis'. There are also contradictions in the texts that have not been resolved. These may be so conspicuous that some readers do not understand which discourses to obey or adopt and how to become a model citizen, or possibly may be actively resisting. Without surveying the public it is not possible to know their feelings about the current situation in the NHS, or about the texts, but the fundamental paradox appears to be that whilst the citizen is mostly encouraged to adopt the persona of an individualist neoliberal subject they are also urged to be sacrificing and selfless, which are notions more aligned with collectivism and certainly not considered neoliberal traits. The presence of these conflicting ideologies sparks hope that although much of the NHS, like other public services, has been subsumed into capitalist market forces, there are still present some vestiges of the original objectives of the NHS. It may be that those producing public information are uncomfortable with promoting neoliberalist ideas in a publicly funded service, or perhaps the NHS is

entering into the capitalist domain reluctantly and resisting the addition pressures put upon it by the drive for choice and free market economies.

The principles behind the NHS were brought to the fore, as is often the case, in the latest UK general election of 2019, when the various political parties tried to claim the moral high ground over stewardship of the NHS, in particular privatisation of NHS services. A recent study concluded that there is still strong public preference for 'the collectivist principles of "everyone contributes" and "everyone benefits" (Sussex et al. 2019) but the discourses unearthed in this thesis point to a confusion between this visualisation of the NHS and one in which neoliberal notions of individualism and commercialism predominate. Published information may not seem as important as face-to-face communication but its ubiquity, range of genres, and ability to respond to new technologies ensure it is never far from the individual citizen. Given the volume of resources dedicated to reproducing the power dynamic between the NHS and the citizen it would be reasonable to conclude that (the whole point of) public information is largely about reminding the public of the power of the medical establishment.

I conclude that small scale MCDA studies can be expanded in order to investigate a phenomenon such as the model citizen, if sufficient texts and a broad enough range of texts are included, particularly where just one or two texts might give only tentative results. The construct is built up in layers which can only be detected under analysis and close attention to both lexis and non-lexical communicative modes. These modes and techniques are combined and operate in conjunction with others to create discursive strategies which work on the reader. I further conclude that a model citizen construct is found to be prevalent in a wide range of health promotion materials, including every dataset in this study about emergency healthcare communication, comprising various genres, producers, geographic zones, circulation figures and cost brackets. Different versions of the model citizen are produced, even within publications related to the single topic of emergency medicine, and the variation in these constructs provides evidence of the manipulation of citizens' actions, in line with the requirements of the government at the time, proving that the texts are technologies of governmentality. In a UK in which 'substantial majorities continue to want public services and expect to see them improved, suggesting some

limitations to the hegemonic claims of neo-liberalism' (Clarke et al. 2007: 23), the NHS has a responsibility to provide information about health and wellness without manipulating the citizen for political gain.

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10. Appendices

Appendix 1: Data sources and additional resources

Photographs and other figures used in the study, and links to web sources are included below, listed by chapter. All supplementary files and materials are available on request.

Chapter 3

Fig 1	Still from *First Signs* advertisement	See Chapter 4 below
Fig 2	Front cover of *Stay Well* leaflet	See Chapter 4 below
Fig 3	screenshot from *Stay Well* website	
Fig 4	A&E Banner	IMG752
Fig 5	Ambulance: context	IMG662
Fig 6	*MIU/Out of Hours* web page	See Chapter 5 below
Fig 7	*About Live Wait Times* web page	See Chapter 5 below
fig 8	A corner of the A&E waiting room	IMG675
fig 9	Front cover of FFT national leaflet	See Chapter 6 below

Chapter 4

First Signs TV advertisement

The TV advertisement is provided in video format. See [1_StayWellFirstSignsTV.mp4)]

It is currently unavailable online although many similar advertisements can be viewed on the Public Health England and NHS England YouTube channels.

Stay Well this Winter leaflet

See Appendix 2.

Supplementary files and materials

- Hard copy of the *Stay Well* leaflet.
- Transcript of the *Stay Well* leaflet
- Extended transcript of the *Stay Well* advertisement
- List of presuppositions made by the writers
- List of information items (Appendix 6)
- List of advice items (Appendix 7)
- List of terms related to Health, Illness, Treatment and Prevention
- List of exophoric references to NHS actors
- Information on TV viewing figures
- Attendance figures for Nottingham A&E
- Comments from the public on the *Stay Well* campaign (Appendix 8)

Chapter 5

Fig 15	A&E Banner	IMG752
Fig 16	Ambulance poster	IMG1435
Fig 17	Derby Hospitals home page	http://www.derbyhospitals.nhs.uk/
Fig 18	Derby Hospitals home page	http://www.derbyhospitals.nhs.uk/
Fig 19	*Live Wait Times* page	http://www.derbyhospitals.nhs.uk/about/live-wait-times/
Fig 20	*Minor Injury Unit/Out of Hours* page	http://www.dchs.nhs.uk/home_redesign/our-services/find_services_by_topic/minor_injury_unit/
Fig 21	*Your Appointment* page	http://www.derbyhospitals.nhs.uk/patients/outpatients/your-appointment/
Fig 22	A&E Banner context	IMG1603

Derby hospitals are now part of the University Hospitals of Derby and Burton NHS Foundation Trust: https://www.uhdb.nhs.uk/home

Supplementary files and materials

- Log of all photographs for the study
- Copies of all photographs taken

Chapter 6

The NHS Friends and Family Test Inpatient and A&E a Short Guide for Patients (the national leaflet) See Appendix 3

How was your care? **Card**

See Appendix 4

Emergency Care Going Home Survey

See Appendix 5

Fig 23	Floor sign ULH	IMG687
Fig 24	Ceiling sign ULH	IMG688
Fig 28	Your observations poster NUH	IMG768
Fig 29	Survey posting box NUH	IMG818
Fig 30	Staff posters	IMG680, IMG797
Fig 31	Posters about the FFT	IMG671, IMG790, IMG795, IMG813
Fig 34	Feedback poster ULH	IMG671
Fig 35	Feedback noticeboard NUH	IMG811
Fig 36	CQC poster	IMG724
Fig 37	Energy poster	IMG725
Fig 38	PALS poster and pop up	IMG692
Fig 39	PALS leaflets	LL21, LL17, LL9
Fig 40	Photocopier sign	IMG807
Fig 41	Going Home poster	IMG788a

Supplementary files and materials

- Transcript of FFT national leaflet
- Log of all photographs taken for the study
- Copies of all photographs taken
- Log of all leaflets and other materials collected
- Hard copies of all materials collected

Appendix 2: Stay Well this Winter leaflet



Page 1/front

Get ready for winter

Winter conditions can be seriously bad for our health, especially for people aged 65 or older, and people with long-term conditions. The cold and damp weather, ice, snow and high winds can all aggravate any existing health problems and make us more vulnerable to illnesses that are more common in winter.

Being cold can raise the risk of increased blood pressure, heart attacks and strokes. But there are lots of things you can do to stay well this winter.

Make sure you get your flu jab

The flu virus strikes in winter and it can be far more serious than you think. Flu can lead to serious complications such as bronchitis and pneumonia, and it can be deadly.

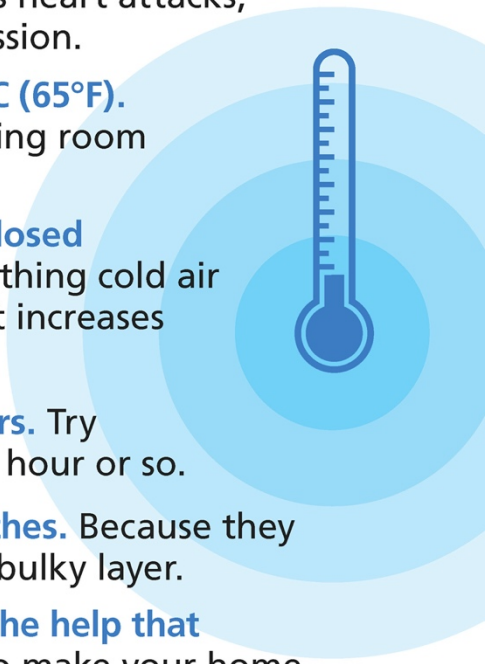
That's why the flu jab is free if you're aged 65 or over, or if you have a long-term health condition. If you have children or grandchildren aged two, three or four, or in school years one or two, they are eligible for a free flu vaccination.

And if you are the main carer of an older or disabled person you may also be eligible for the free flu jab. Just speak to your GP.

Also, don't forget that if you're aged 65 or over, you are eligible for the pneumococcal vaccine, which will help protect you from pneumococcal diseases such as pneumonia.

Keep warm

It is important to keep warm in winter – both inside and outdoors. Keeping warm over the winter months can help to prevent colds, flu and more serious health problems such as heart attacks, strokes, pneumonia and depression.



Heat your home to at least 18°C (65°F). You might prefer your main living room to be slightly warmer.

Keep your bedroom window closed on winter nights. Because breathing cold air can be bad for your health as it increases the risk of chest infections.

Keep active when you're indoors. Try not to sit still for more than an hour or so.

Wear several layers of light clothes. Because they trap warm air better than one bulky layer.

Make sure you're receiving all the help that you're entitled to. Learn how to make your home more energy efficient, improve your heating and keep up with your energy bills at **www.gov.uk/phe/keep-warm**

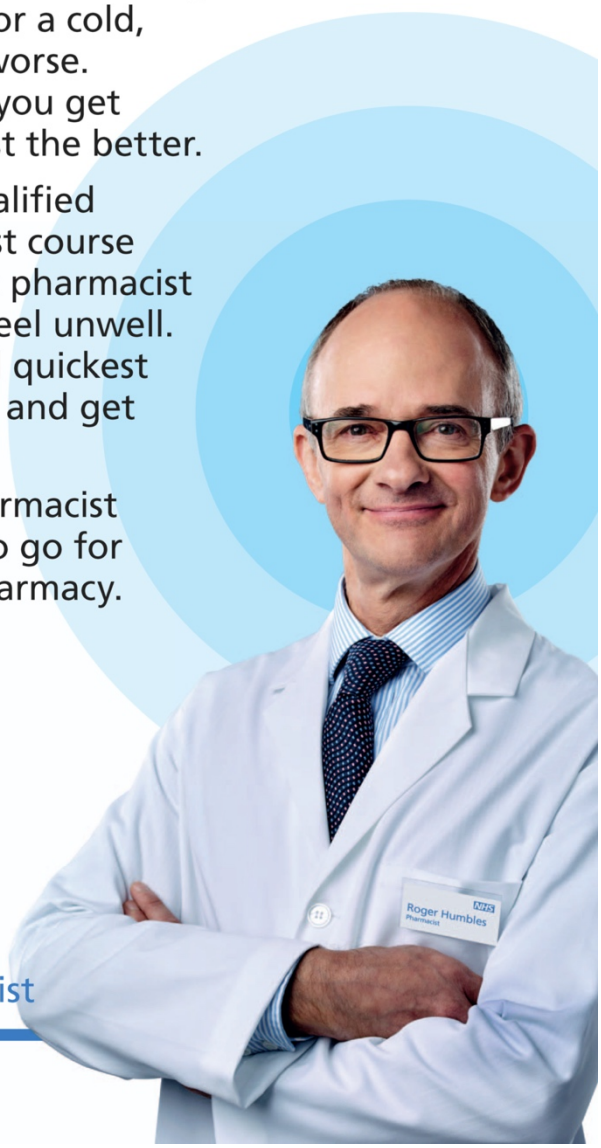
And check your heating and cooking appliances are safe. Contact a Gas Safe registered engineer to make sure they're operating properly.

Feeling unwell? Don't wait – get advice from your nearest pharmacist

Winter can make existing health problems worse. So if you feel like you're coming down with something, even if it's just a cough or a cold, don't wait until it gets worse. Act quickly. The sooner you get advice from a pharmacist the better.

Pharmacists are fully qualified to advise you on the best course of action. So go to see a pharmacist as soon as you start to feel unwell. This can be the best and quickest way to help you recover and get back to normal.

If you can't get to a pharmacist yourself, ask someone to go for you or call your local pharmacy.



Roger Humbles, Pharmacist

Page 4/centre spread

Is your medicine cabinet ready for the winter?

Most common winter ailments, such as a cold, sore throat, cough, sinusitis or painful middle ear infection (earache), can't be treated with antibiotics.

The best thing to do is:

- Rest
- Drink plenty of fluids
- Have at least one hot meal a day to keep your energy levels up
- Talk to your pharmacist for advice on getting any pain relief you need such as paracetamol or ibuprofen.

Your pharmacist can advise you on which medicines you should have in your cabinet, to help get you and your family through the winter season.

Take medicines as directed

If you've been prescribed antibiotics or any other medication, make sure you take them as directed.



Page5/centre spread

Look out for other people

Remember that other people, like older neighbours, friends and family members, may need a bit of extra help over the winter. There's a lot you can do to help people who are more frail than you.

Icy pavements and roads can be very slippery and cold weather can stop people from getting out and about. **Keep in touch** with your friends, neighbours and family and ask if they need any practical help, or if they're feeling under the weather.

Make sure they're stocked up with enough food supplies for a few days, in case they can't go out. If they do need to go out in the cold, encourage them to **wear shoes with a good grip and a scarf around the mouth** to protect them from the cold air, and to reduce their risk of chest infections.

And make sure they **get any prescription medicines before the holidays start on 24 December** and if bad weather is forecast.

If you do need help over the holiday period when your GP surgery or pharmacy is closed, call NHS 111 and speak to a call adviser who will be able to direct you to a local service that is open. You can also visit NHS Choices at **www.nhs.uk**

Five things we recommend you do:

- [ ] Make sure you get your flu jab.
- [ ] Keep your home at at least 18°C (65°F) if you can.
- [ ] Take advantage of financial schemes and discounts to help you pay for heating.
- [ ] Visit your local pharmacist as soon as you start to feel unwell.
- [ ] Look out for other people who may need a bit of extra help over the winter.

Write down your local pharmacy number here:



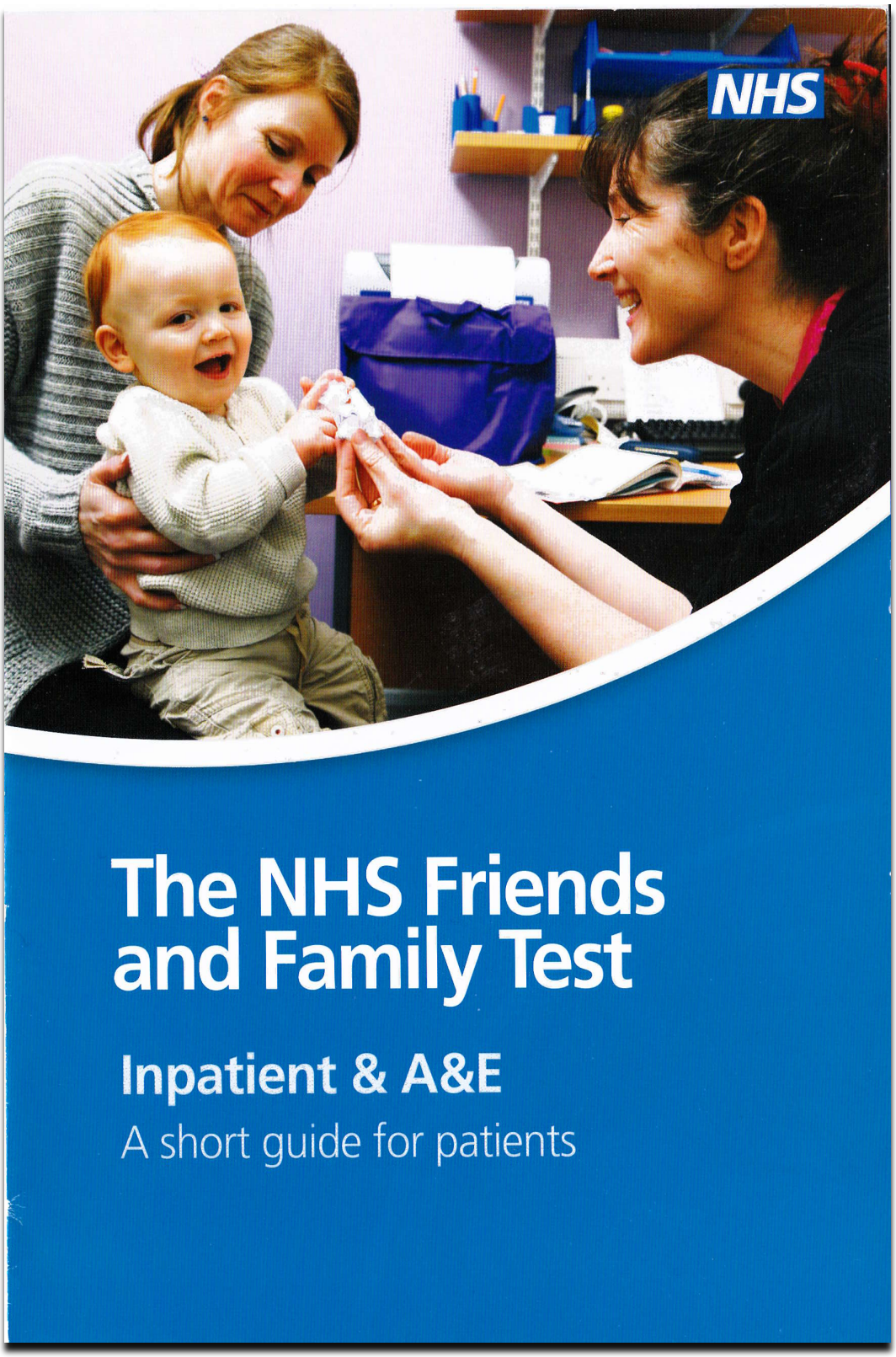
Things I need to remember to do for winter:

Page 7


NHS
Here to help you stay well this winter.
Call 111. If you need medical help fast, but it's not life threatening or you're not sure where to go, a 111 adviser will assess you and direct you to the best placed service in your area. NHS 111 is available 24 hours a day, 365 days a year. Calls are free from landlines and mobile phones.
Ask a pharmacist. They're highly trained healthcare experts, on everything from colds to long-term conditions.
Visit a walk-in centre. They're mainly run by nurses who can treat minor illnesses and injuries on the spot. You don't need an appointment and they're open outside office hours.
Contact your GP. Many GPs can offer advice over the phone and can arrange referral to a hospital specialist if you need it.
A&E departments. They're there for life-threatening emergencies. But if you're not sure whether it is an emergency, call 111 first.
STAY WELL THIS WINTER
For more information and advice visit www.nhs.uk/staywell
© Crown copyright 2015 3094494 1p 13.5m Oct15 (ANT)

Page 8/back

Appendix 3: Text A, 'National' Friends and Family Test leaflet



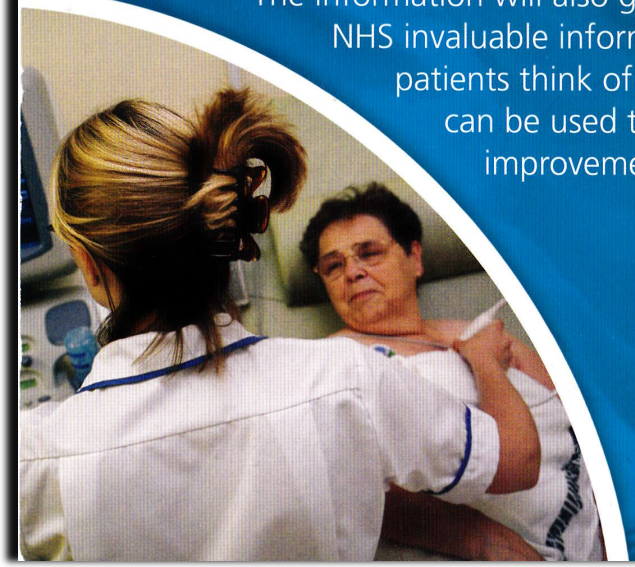
What is the NHS Friends and Family Test?

The NHS wants to ensure that you have the best possible experience of care. **The NHS Friends and Family Test** is a way of gathering your feedback about your experience and helping to drive improvement in hospital services.

When you receive care as an inpatient or in an Accident and Emergency (A&E) department, you will be given the opportunity to give your feedback by answering a simple question about your experience.



The information will also give the NHS invaluable information on what patients think of services, which can be used to help make improvements if required.



How does it work?

When you are discharged, or within the 48 hours that follow, you will be asked to answer the following question:

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

You will be invited to respond to the question by choosing one of six options, ranging from 'extremely likely' to 'extremely unlikely'.

It is really important to us that you tell us why you gave your answer, so please answer any follow-up questions.

You may be asked to answer the question before going home, or you may be invited to do so by returning a postcard, by phone or on our website.

Your answer will not be traced back to you, and your details will not be passed on to anyone, so please tell us exactly what you think. A member of your family or a friend is welcome to help you give your feedback to the question if you are unable to.

Do you have to respond to the question?

You do not have to respond to the question. But if you do, your feedback will provide valuable information for your hospital to help ensure its patients have the best possible experience of care.

Your hospital will be very keen to hear from you so it knows what you think of the care or treatment you have received – whether your feedback is positive, negative or indifferent.

How will the results be used?

Your hospital will gather the results and analyse them rapidly to see if any action is required. It will publish the results and

you will also be able to see results for other hospitals to see how they compare.

Where will the results be published?

The results will be published on the NHS Choices website at **www.nhs.uk**

Hospitals may also publish their results in their annual reports and quality accounts.

Does this replace the existing compliments or complaints procedure, or other forms of feedback used by the hospital?

No, you can still pass your compliments or complaints to your hospital in the normal way. Hospitals can continue to use existing ways of gathering feedback, in addition to the NHS Friends and Family Test.

Where can I get more information?

Your NHS service will ensure you're asked the question at the appropriate time, but if you'd like more general information then please get in touch.

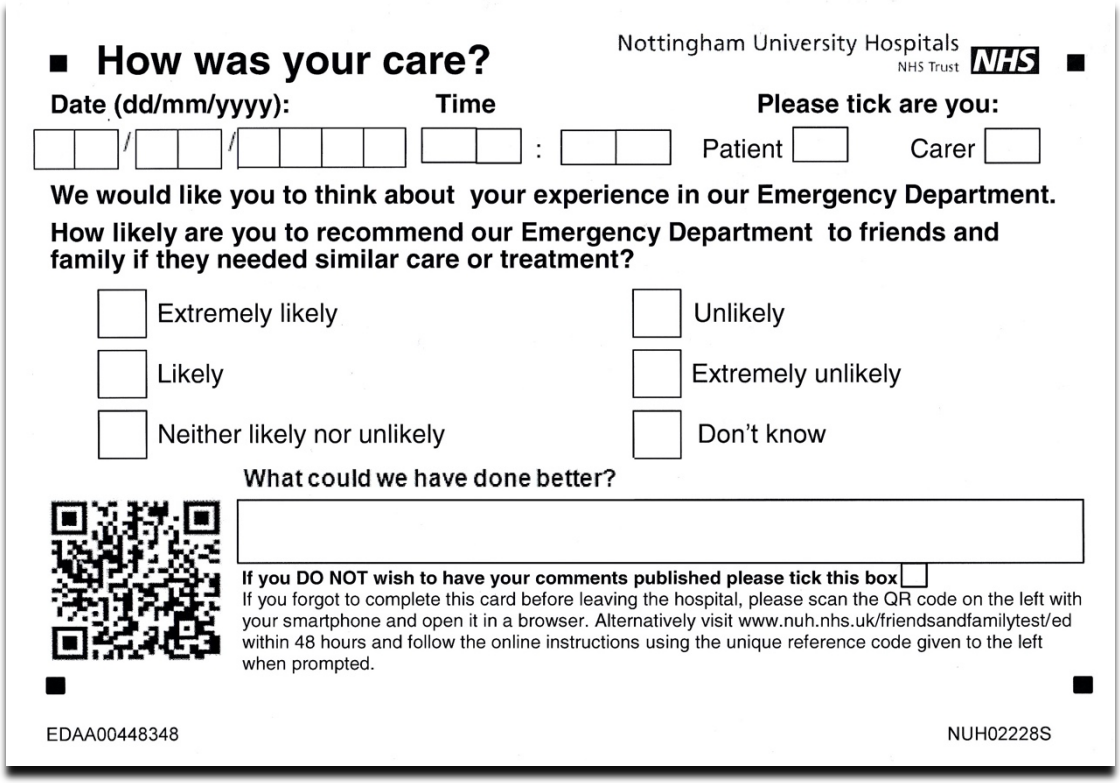


If you'd like to learn more about the NHS Friends and Family Test then please visit **www.england.nhs.uk/ourwork/pe/** or email **england.friendsandfamilytest@nhs.net**

ADM/FFT021

Appendix 4: Text B, *How Was Your Care?* card

Front



■ **How was your care?**

Nottingham University Hospitals NHS Trust NHS ■

Date (dd/mm/yyyy): / / **Time** : **Please tick are you:** Patient ☐ Carer ☐

We would like you to think about your experience in our Emergency Department.

How likely are you to recommend our Emergency Department to friends and family if they needed similar care or treatment?

☐ Extremely likely
☐ Likely
☐ Neither likely nor unlikely
☐ Unlikely
☐ Extremely unlikely
☐ Don't know

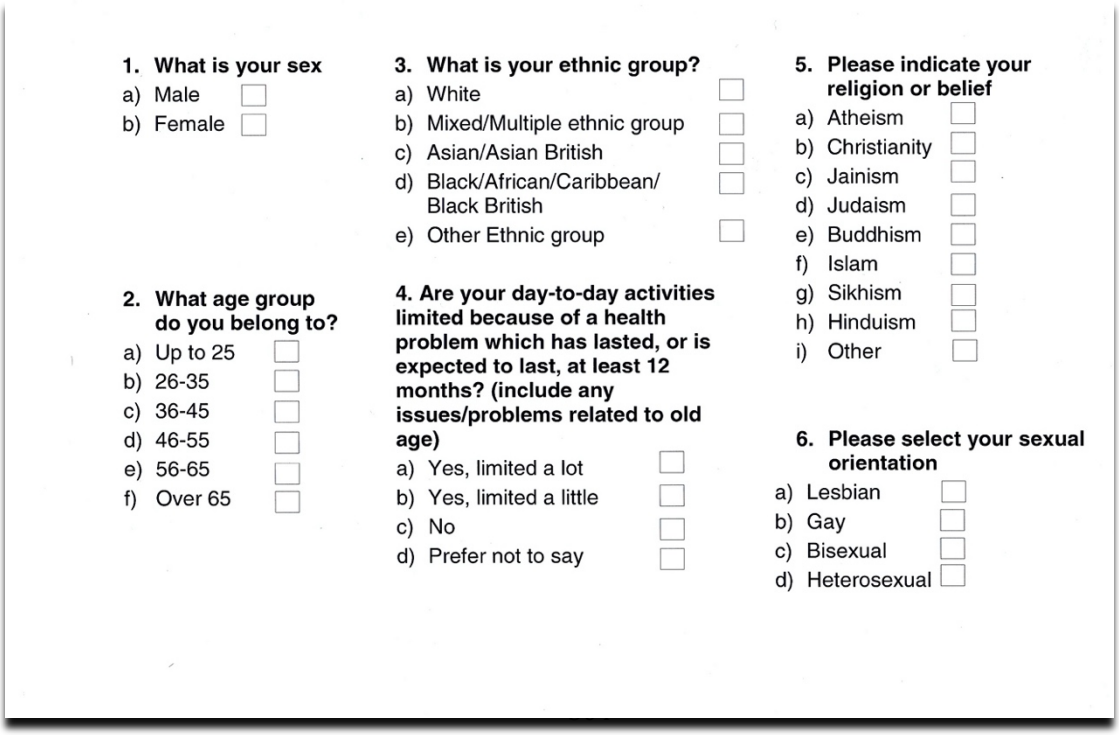
What could we have done better?

If you DO NOT wish to have your comments published please tick this box ☐

If you forgot to complete this card before leaving the hospital, please scan the QR code on the left with your smartphone and open it in a browser. Alternatively visit www.nuh.nhs.uk/friendsandfamilytest/ed within 48 hours and follow the online instructions using the unique reference code given to the left when prompted.

EDAA00448348 NUH02228S

Back



1. What is your sex
a) Male ☐
b) Female ☐

2. What age group do you belong to?
a) Up to 25 ☐
b) 26-35 ☐
c) 36-45 ☐
d) 46-55 ☐
e) 56-65 ☐
f) Over 65 ☐

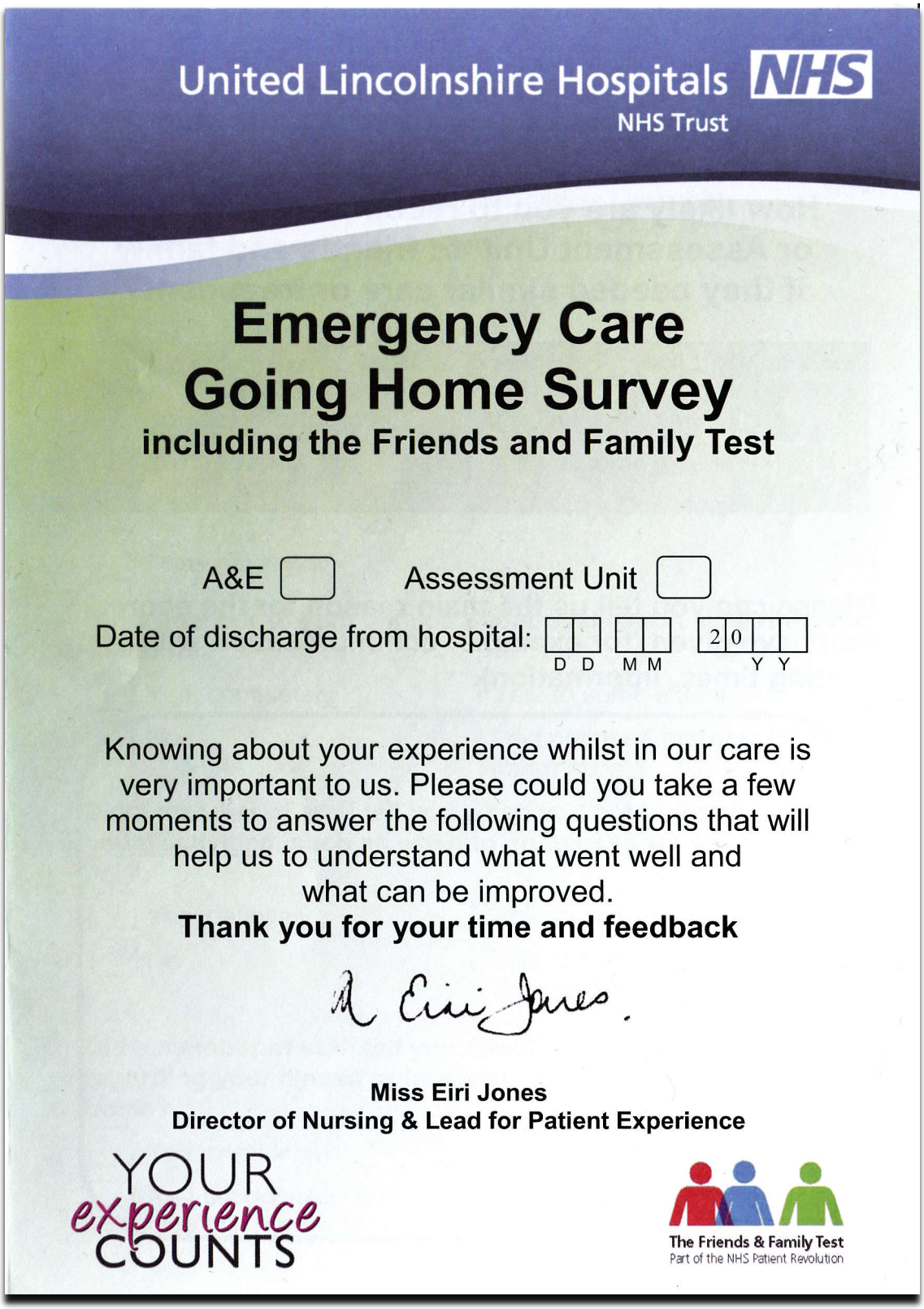
3. What is your ethnic group?
a) White ☐
b) Mixed/Multiple ethnic group ☐
c) Asian/Asian British ☐
d) Black/African/Caribbean/ Black British ☐
e) Other Ethnic group ☐

4. Are your day-to-day activities limited because of a health problem which has lasted, or is expected to last, at least 12 months? (include any issues/problems related to old age)
a) Yes, limited a lot ☐
b) Yes, limited a little ☐
c) No ☐
d) Prefer not to say ☐

5. Please indicate your religion or belief
a) Atheism ☐
b) Christianity ☐
c) Jainism ☐
d) Judaism ☐
e) Buddhism ☐
f) Islam ☐
g) Sikhism ☐
h) Hinduism ☐
i) Other ☐

6. Please select your sexual orientation
a) Lesbian ☐
b) Gay ☐
c) Bisexual ☐
d) Heterosexual ☐

Appendix 5: Text C, Going Home Survey



United Lincolnshire Hospitals NHS
NHS Trust

Emergency Care Going Home Survey

including the Friends and Family Test

A&E ☐ Assessment Unit ☐

Date of discharge from hospital: D D M M 2 0 Y Y

Knowing about your experience whilst in our care is very important to us. Please could you take a few moments to answer the following questions that will help us to understand what went well and what can be improved.

Thank you for your time and feedback

Miss Eiri Jones
Director of Nursing & Lead for Patient Experience

YOUR experience COUNTS

The Friends & Family Test
Part of the NHS Patient Revolution

We would like you to think about your experience in the A&E department or assessment unit during this visit:

How likely are you to recommend our A&E or Assessment Unit to friends and family if they needed similar care or treatment?

Extremely likely	Likely	Neither likely or unlikely	Unlikely	Extremely unlikely	Don't know
☐	☐	☐	☐	☐	☐

Please can you tell us the main reason for the score you have given (for example: communication with staff, waiting times, information).

Were you told how long you would have to wait to be examined?

- ☐ Yes, but the wait was **shorter**
- ☐ Yes, and I had to wait about as long as I was told
- ☐ Yes, but the wait was **longer**
- ☐ No, I was not told
- ☐ Don't know / can't remember

Do you think the hospital staff did everything they could to help control your pain?

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No
- ☐ Can't say/ Don't know
- ☐ I was not in pain

Did a member of staff tell you about medication side effects to watch for?

- ☐ Yes, completely
- ☐ Yes, to some extent
- ☐ No
- ☐ I did not need this type of information

Did a member of staff tell you when you could <u>resume your usual activities</u>, such as when to go back to work or drive a car?

- ☐ Yes, definitely
- ☐ Yes, to some extent
- ☐ No
- ☐ I did not need this type of information

Did a member of staff tell you about what danger signals regarding your illness or treatment to watch for after you went home?

- ☐ Yes, completely
- ☐ Yes, to some extent
- ☐ No I did not need this type of information

Please feel free to add any further comments or suggestions on how services can be improved.

United Lincolnshire Hospitals may use patients comments in publications to share feedback and learning. If you would prefer **NOT** to have your comments used in this way please tick the box.

I DO NOT WISH MY COMMENTS TO BE USED IN PUBLICATIONS ☐

About you:

Gender: Male ☐ Female ☐

Please tick if you live and work permanently in a gender other than that assigned at birth ☐

Age: ☐

Disability: Do you consider yourself to have a disability as defined by the Equality Act 2010?

Yes ☐ No ☐

Ethnicity:

White British ☐ White Irish ☐ Black British ☐ Asian British ☐

Mixed White and Asian ☐ Other ☐

Which language do you mainly speak? ☐

If you require this information in other languages, large print, audio (CD or tape) or Braille please e-mail the Public Involvement Team patient.involvement@ulh.nhs.uk or contact 01476 464560.

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Version 2

Appendix 6: Information Items

	Statement (paraphrased)	**line/script numbers**
1	Winter conditions are bad for health, this particularly applies to people aged 65 or older, and people with long-term conditions.	L5
2	Cold and damp weather, ice, snow and high winds aggravate any existing health problems	L6, S4
3	Winter can make existing health problems worse	L34
4	Cold and damp weather, ice, snow and high winds make us more vulnerable to get illnesses that are more common in winter.	L6, S4
5	Being cold can raise the risk of increased blood pressure, heart attacks and strokes.	L7
6	Flu is a winter disease	L10
7	There are sometimes serious complications of flu, these include bronchitis and pneumonia	L11
8	Flu can be deadly	L11
9	the flu jab is free if you're aged 65 or over, or if you have a long-term health condition because of these risks	L12
10	children or grandchildren aged two, three or four, or in school years one or two can get a free flu jab	L13
11	if you are the main carer of an older or disabled person you may be eligible for the free flu jab	L14
12	It is important to keep warm in winter, whether you are inside or outdoors	L18
13	Keeping warm during the winter months can help to prevents colds, flu, heart attacks, strokes, pneumonia and depression.	L19
14	Heart attacks, strokes and pneumonia are more serious conditions than colds and flu.	L19
15	Breathing cold air can be bad for your health as it increases the risk of chest infections.	L23
16	Several layers of light clothes trap warm air better than one bulky layer of clothes.	L27
17	It is important for people who get minor illnesses like coughs and colds in winter to act quickly because winter can make them worse.	L34, L35, L36
18	The sooner you get advice from a pharmacist the better.	L37
19	Pharmacists are fully qualified to advise you on the best course of action.	L38

20	Going to see a pharmacist can be the best and quickest way to help you recover and get back to normal.	L40
21	Most common winter ailments, such as a cold, sore throat, cough, sinusitis or painful middle ear infection (earache), can't be treated with antibiotics.	L43
22	Your pharmacist can advise you on which medicines you should have in your cabinet, to help get you and your family through the winter season.	L49
23	There's a lot you can do to help people who are more frail than you.	L54
24	Icy pavements and roads can be very slippery	L55
25	Cold weather can stop people from getting out and about.	L55
26	In addition to calling NHS 111 you can 'visit NHS Choices'	L61
27	If you need medical help fast, but it's not life threatening or you're not sure where to go, a 111 adviser will assess you and direct you to the best placed service in your area.	L72
28	The NHS 111 service is available 24 hours a day, 365 days a year.	L73
29	Calls to NHS 111 are free from landlines and mobile phones.	L74
30	Pharmacists are highly trained healthcare experts, on everything from colds to long-term conditions.	L76
31	Walk-in Centres are mainly run by nurses who can treat minor illnesses and injuries on the spot.	L78
32	You don't need an appointment for walk-in centres and they're open outside office hours.	L79
33	Many GPs can offer advice over the phone and can arrange referral to a hospital specialist if you need it.	L81
34	A&E departments are for life-threatening emergencies.	L83
35	We're all here to help you stay well this winter.	S7, S8, L70

Appendix 7: Advice

Paraphrased and hedging removed e.g. *make sure you*, *try not to*

Imperative instructions

	Advice item	line/script numbers
1	Share this today with any relatives, friends, neighbours or anyone else you know who might find it useful	L3
2	Get ready for winter	L4
3	get your flu jab	L9, L63
4	Speak to your GP (about free flu jabs for carers or children)	L15
5	Don't' forget (that you can get a pneumococcal vaccine if you are 65 or over)	L16
6	Keep warm	L17
7	Heat your home to at least 18°C (65°F)	L20, L64
8	Keep your bedroom window closed on winter nights.	L22
9	Keep active when you're indoors.	L24
10	Don't sit still for more than an hour or so.	L25
11	Wear several layers of light clothes.	L26
12	Get all the help that you're entitled to.	L28
13	Learn how to make your home more energy efficient, improve your heating and keep up with your energy bills by going online	L29
14	Check your heating and cooking appliances are safe.	L30
15	Contact a Gas Safe registered engineer to make sure your heating and cooking appliances are operating properly.	L31
16	If you are feeling unwell go to see/get advice from your nearest/a pharmacist immediately.	L33, L39, L66
17	get help from a pharmacist	S6
18	If you start to get ill don't wait, act quickly	L35, L36, S5
19	If you can't go to the pharmacy phone them or ask someone else to go.	L41
20	If you've been prescribed antibiotics or any other medication, make sure you take them as directed.	L50, L51

21	Look out for other people, who may need extra help over the winter.	L52, L53, L67
22	Remember that other people need help may need a bit of extra help over the winter.	L53
23	Help people who are more frail than you	L54
24	Keep in touch with your friends, neighbours and family	L56
25	Ask if your friends, neighbours and family need any practical help,	L56
26	ask if your friends, neighbours and family feeling unwell (under the weather).	L56
27	Ensure that your friends, neighbours and family have enough food in for a few days, in case they can't go out.	L57
28	If friends, neighbours and family need to go out in the cold, encourage them to wear shoes with a good grip and a scarf around the mouth.	L58
29	Ensure that your friends, neighbours and family get any prescription medicines before the holidays start and if bad weather is forecast.	L59
30	If you need help when your GP surgery or pharmacy is closed, call NHS 111 and speak to a call adviser who will be able to direct you to a local service that is open.	L60, L71, L72
31	Take advantage of financial schemes and discounts to help you pay for heating.	L65
32	Write down your local pharmacy number in this leaflet.	L68
33	Call 111 if you need medical help fast, but it's not life threatening or you're not sure where to go.	L71, L72,
34	Call 111 if you are not sure whether it is an emergency	L84
35	Ask a pharmacist (because they are highly trained healthcare experts on everything from colds to long-term conditions). Talk to your pharmacist	L37, L75 L48
36	Visit a walk-in centre.	L77
37	Contact your GP.	L80

Non-imperative advice

	Advice item	**line numbers**
38	The best thing to do is: Rest	L45
39	The best thing to do is: Drink plenty of fluids	L46

40	The best thing to do is: Have at least one hot meal a day to keep your energy levels up	L47
41	The best thing to do is: Talk to your pharmacist for advice on getting any pain relief you need such as paracetamol or ibuprofen.	L48
42	we recommend that you make sure you get your flu jab.	L63
43	we recommend that you Keep your home at at least 18°C (65"F) if you can.	L64
44	we recommend that you Take advantage of financial schemes and discounts to help you pay for heating.	L65
45	we recommend that you Visit your local pharmacist as soon as you start to feel unwell.	L66
46	we recommend that you Look out for other people who may need a bit of extra help over the winter.	L67
47	You can visit NHS choices (online)	L61

Appendix 8: Press Releases and comments from the public.

Comments added to NHS press releases about *Stay Well this Winter*.

Launch of the largest flu vaccination programme marks the start of NHS "Stay Well This Winter" campaign

issued 15 October 2015 . Text of press release accessed on 15.3.18 at

https://www.england.nhs.uk/2015/10/stay-well-this-winter/

One comment

1. *M Slinn* says:

   28 October, 2015 at 11:52 am

   I am very dismayed and shocked that people are being advised to see a pharmacist for diagnosis advice. May I say I am sure pharmacists are NOT competent to perform this service. Only pharma training no diagnostic practitioner training. I can say an elderly neighbour told me she was advised she had a form of skin cancer near her eyes… Apparently a pharmacist at Boots had advised and given her cream to get rid of it.. As a nurse specialist I advised he was incorrect I believed it was Shingles HZV and she must see a GP as it's dangerous near the eye or ear. I turned out to be correct. I have advised her to take legal action against the pharmacist. Now tell me again a pharmacist is NOT a diagnostic expert and if they are full of hubris they will refer. Clearly this is a dangerous policy of advice.

Stay Well This Winter campaign takes to the road

issued 2 November 2015. Text of press release accessed on 15.3.18 at

https://www.england.nhs.uk/2015/11/stay-well/

4 comments

1. *Anonymous* says:

   23 April, 2016 at 4:40 pm

   Totally agree with previous comments. This patronizing approach typifies the NHS who seem to treat all their patients as imbeciles who can only be controlled by treating them all as small children.

2. *Sue* says:

   25 February, 2016 at 3:58 pm

   The problem I have with this ad is not who it's aimed at, people with illnesses or over 65s but the fact that a lot of us who are chronically ill are not able to heat our homes at 18 degrees… We can't afford to!

This ad is government backed yet the same government are slashing benefits for sick and disabled with no regard for how chronic illness effect us and how lack of heating is dangerous especially those with respiratory illness.
So, tell us how to live our lives to stop us getting worse, then take away the ability to do just that!

3. *Anonymous* says:

   21 December, 2015 at 5:20 pm

   having watched your advert aimed at people over the agre of sixty five I can only say to you, how dare you be so patronizing and treat us like four year olds!

   The N.H.S. management need to rethink their attitudes regarding these type of adverts if you wish to avoid angry comments like this.

   - *Marion* says:

     2 January, 2016 at 8:23 pm

     Couldn't agree more. This is the most offensive and patronising NHS campaign to date. Turn 65 and according to this 'advice' one is no longer aware of the fact that pharmacies are closed on Christmas Day. Similarly, sixty somethings can't tell if they're hot or cold and need to be told to heat their homes to a certain temperature.

     Whoever planned this campaign for the NHS appears to consider anyone over 65 as completely clueless, having somehow lost whatever expertise or knowledge he or she once had, so it's appropriate to treat them like children.

National NHS campaign urges people to stay well this winter

Issued 7 November 2016. Text of press release accessed on 15.3.18 at https://www.england.nhs.uk/2016/11/stay-well-this-winter-2/

6 comments

1. *dorothy kazer* says:

   10 February, 2017 at 11:52 am

   I applaud the NHS for this but would like to point out that to advise people to see their pharmacist is not always possible.
   When one lives alone and has a cold or tummy upset surely it is unwise to go out in the cold and to risk infecting other people?

2. *Valerie Edwards* says:

   24 December, 2016 at 10:09 pm

   I really object to your ageist advert. Just because we are retired does not mean we no longer have the power to think for ourselves. The advert is condescending and offensive, particularly the way

that the “nurse” talks down to us. I appreciate that the NHS does not like to spend money on us, but no doubt advertisements etc for this campaign cost a fortune- money would be better spent on treating all those who need it, no matter how old.

3. *Linda king* says:

   18 December, 2016 at 8:07 pm

   What a patronising advert, clear bias towards elderly as if we are all ” old, stupid and unable to take care of ourselves. The po faced nurse is enough to put anyone of the NHS and the overweight gp sends the wrong message. The NHS needs to spend money on services instead of paying expensive fees to produce a worthless dictorial patronising piece of rubbish such as this. Old people can and do look after themselves. By a retired intelligent nurse.

4. *Terry* says:

   5 December, 2016 at 7:22 pm

   Perhaps if people could actually get an appointment with their GP might be a good starting point!

5. *M. Thompson* says:

   16 November, 2016 at 10:11 pm

   Many of us over 60s have brought up families and tended to our childrens many illnesses. Do you think that your stay well tv add is rather patronising towards us.

6. *KASSANDER* says:

   8 November, 2016 at 7:07 pm

   What a self-righteous, mish-mash of verbiage containing the same message over and over again with little if any explanation as to WHY & HOW cold is a killer
   This essay by well paid, well fed people doesn’t mention once the plight of so many older people who have had their hard worked for, and paid for in tax, entitlements (Now called ‘benefits) slashed, slashed and slashed again. Or in some cases stolen by spivs and asset strippers who’ve made fat financial killings by plundering pension funds
   Those are ‘killers’ too.
   Help us to help ourselves by joining with us in calling on the Government to stop slashing ‘benefits’, and tighten the laws to:
   # stop asset stripping of people’s pensions
   # claw back the £bns ‘lifted’ from these funds and trousered by the financial Spiv-ocracy.