

## 8. HEALTH CARE COMMUNICATION: A PROBLEMATIC SITE FOR APPLIED LINGUISTICS RESEARCH

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In this chapter, we address, selectively, how applied linguists and those concerned with discourse analysis in particular, have recently approached the study of health care communication, especially in intercultural contexts, and relate these approaches to studies undertaken by researchers in other academic disciplines such as the sociology of medicine and by health care practitioners in the course of their own work. At issue will be questions concerning selected sites and themes, the degree of distinctiveness of research methodologies and different understandings of what counts as data, and questions concerning reflexivity and practical relevance in terms of the use to which findings can be put. Appreciating areas of difference and similarity is a necessary basis for establishing the desirable, but potentially problematic, partnerships among academic disciplines and between such disciplines and the work of professional practitioners, both in research and in professional development. As a sample site in the delivery of health care in the framework of cultural and linguistic diversity, we identify nursing, and use this site and its practices to advocate the collaboration of applied linguists, professional practitioners, and researchers from other areas of social science in the exploration of health care communication in multilingual/multicultural contexts and elsewhere.

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Applied linguists, and in particular those concerned with the analysis of discourse in professional contexts, would do well in our view to look outside their own professional literature for studies that direct themselves at health care communication, especially where this involves issues of intercultural communication.<sup>1</sup> Until relatively recently, mainstream applied linguistics journals have to an extent ignored this field, although among journals in the field of discourse analysis (broadly understood) there is now something of a tradition, and an increasing interest, in exploring health care sites in journals like *TEXT* and *Research on Language and Social Interaction* in particular, and in *Discourse and Society* and *Discourse Processes* (although it has to be said, not all necessarily take an intercultural focus). Of interest in this context is the planned *Journal of Medical Communication* scheduled to appear in 2004, to be published by Mouton de Gruyter. In other more core applied linguistics journals, for example, *Applied Linguistics*, *International Journal of Applied Linguistics*, *English for Specific Purposes Journal*,

and in journals on the periphery of applied linguistics with their own constituencies, such as the *Journal of Sociolinguistics* and the *Journal of Pragmatics*, one finds the occasional paper, but no real sense of ongoing commitment to the health care communication field. Given the broad scope of applied linguistics and these other disciplines, this is understandable; but it suggests that applied linguists wanting to explore health care communication would do better, at present at least, to address journals in the fields of the sociology of medicine, of health care and illness, of culture and psychiatry, of medical humanities, and of health and social behavior, such as the *Journal of Medical Education; Sociology of Health and Illness; Culture, Medicine and Psychiatry*; the *Journal of Medical Humanities*; the *Journal of Health and Social Behavior; Health Communication*; and, in particular, *Social Science and Medicine*. It is notable, in the latter case, that the editorial inaugurating the new millennium for the journal explicitly promotes submissions drawing on qualitative paradigms, including those involving discourse data (Blaxter, 2000).

Moreover, given the very strong and consistent commitment to issues of health care communication, and, particularly, in the intercultural context, in the field of nursing, applied linguistic readers would do even better to access journals such as the *Journal of Advanced Nursing*, the *Canadian Journal of Nursing Research*, the *Journal of Transcultural Nursing*, and *Nursing Research*, to discover resources of clear interest to applied linguists interested in communication research in the professions. We address this nursing focus in a brief section later in this chapter. Another site where concern with intercultural professional communication in language contact contexts is increasingly an issue is that of speech pathology and communication disorder. Collections of papers such as that of Battle (1993) focus on communication disorders in multicultural populations, as does Roger's recent work on exploring social and cultural factors in clinically oriented research (Roger, 1998) or Cheng's study on the effect of cultural diversity on assessment (Cheng, 1997). Other collections in this field, such as Kovarsky, Duchan, and Maxwell (1999) while not specifically so focused, have clear relevance for intercultural communication contexts. Seminal studies such as that of Wadensjø of interpreter-mediated interaction (Wadensjø, 1998) have broadened the audience for current research in this health care field, as has that of Isaac and Hand (1996), although working with interpreters has long been an issue for speech pathologists as books by Duncan (1989), and Battle (1993) and papers in the journal *Topics in Language Disorders* amply attest. Notable among such studies is the implication they carry for professional development in intercultural awareness, based on interactional data, as quite specifically drawn upon in Isaac's pioneering book (Isaac, 2002a) with its focus on training speech pathologists to accommodate to cultural and linguistic diversity.

Exploring other fields, even neighboring ones, runs the risk, however, of assuming greater overlaps and synergies than is warranted. In what follows we briefly explore the themes and sites, the methodologies and typical data sets that have been the focus in what one might broadly call the sociology of health care and the practices of health care, on the one hand, and applied linguistic approaches to health care communication on the other. We also address issues of relevancy, in particular the extent to which such research is a collaborative and co-constructed enterprise

(Sarangi & Candlin, 2001; Sarangi, 2002), and the extent to which the research is directed at outcomes of practical relevance to those engaged as participants (Sarangi & Roberts, 1999) rather than merely at the enhancement of disciplinary knowledge.

### **Themes and Sites**

Taking a particular intercultural and language contact perspective, themes concerning the breaking of bad news at critical moments (Dosanj, Barnes, & Bhandari, 2001; Gillotti, Thompson, & McNeulis, 2002) highlight how contributions from researchers in communication studies and medical education can concur. Such studies, in turn, connect with those without necessarily a specifically intercultural focus, such as the relaying of news about illness to lay participants outside the clinic (Beach, 2001a, b; Frankel, 2001) with their discussions of the potential for misalignments between lay diagnoses and professional ones. In its own way, of course, this is an intercultural issue, albeit not an ethnolinguistic one. Medical education has a tradition of engagement with the intercultural, with special issues of, for example, *Medical Education* in 2001 being devoted to this theme; see in particular Prideaux and Edmondson's (2001) discussion of the relationships between cultural identity and issues of the interaction of patients with health care systems, and that of other papers in that special issue, especially Dogra (2001); Hardoff and Schonmann (2001); and Spencer and Silverman (2001), which address the issue of designing specific training and professional development for medical students and practitioners in treating culturally and linguistically diverse patients.

The need for such training itself arises from a number of sources. Examples include the reported problems of ethnic minority patients interacting with their general practitioners with consequent implications for patient compliance with treatment routines—see van Wieringen, Harmsen, and Bruijnzeels (2002); the potential for negative impact on health care quality resulting from the need to use interpreters—see Visandjée and Dupère's (2000) study of interpreter-mediated nursing interactions; to a more generally felt need for greater awareness of how illness and health are constructed diversely in different societies—see Dowell, Crampton, and Parkin (2001) with respect to Māori patients in New Zealand; or, not necessarily intercultural, as a consequence of the obstacles to understanding and cooperation arising from gender differences between practitioners and patients in professional encounters—see the articles by Parks (1998) and Williams (2000). It should be noted in this context that there is a view taken by some studies in the medical education literature that research into medical and health care communication is seen as having a predominantly Western orientation (e.g., Kai, Spencer, & Woodward, 2001; Skelton, Kai, & Loudun, 2001).

### The Use of Interpreters

We have already alluded to this in our reference earlier to the speech pathology field, but the use of interpreters in health care delivery contexts is a theme of note in medical education and the sociology of medicine, and one centrally engaging with the intercultural, as Putsch discusses in the United States health care

context (Putsch, 1985). As we note later, it is particularly so in relation to nursing. Pöchhacker's study of the language barriers arising in Viennese hospitals between practitioners and patients mediated by interpreters is a case in point (Pöchhacker, 2000), as is Elderkin-Thompson, Silver, and Waitzkin's (2001) study of Spanish-speaking nurses doubling as interpreters for Spanish-speaking patients in U.S. primary care contexts and Poss and Rangel's (1995) study of nurses working with interpreters in the primary health care setting. Lau, Stewart, and Fielding's (2001) report of interpreter role-play training for Cantonese-speaking first year medical students points up the need for medical practitioner training in the use of interpreters, but, equally, there is a severe lack of available trained and specialist interpreters—a situation which is almost endemic in health care worldwide—such that pragmatic, ethical, clinical, and ideological issues inevitably arise.

This is particularly so in the employment of untrained persons, as Cohen, Moran-Ellis, and Smaje (1999) report in the context of a study of the use of children as informal interpreters in GP consultations in the United Kingdom, or more generally, Kaufert and Putsch's (1997) analysis of ethical dilemmas which arise in any interpreter-mediated context in health care as a consequence of issues of differences in class, culture, language and power (Kaufert & Putsch, 1997). The use of interpreters in health care is a theme which is also taken up in valuable doctoral research in the United States (see, for example, Carol's 1991 dissertation for the University of California, and, more recently, Davis's 2000 dissertation for Teachers' College), and in Australia (in the speech pathology context, see Isaac's 2002b dissertation for the University of Newcastle, and Roger's dissertation for the University of Sydney, 2003). Emerson's (1995) dissertation for George Mason University addresses underlying issues of the cognitive knowledge, affective attitudes and behavioral skills seen as vital for effective inter-cultural communication in primary health care; Hand's (2003) dissertation for Macquarie University addresses issues of intercultural communication in speech pathology interview practices.

### Narratives

Undoubtedly, however, the theme most addressed in the sociology of health care literature is that of illness as narrative, or narratives about illness. Such a theme has obvious resonances with applied linguistic interests and in part overlaps with our discussion of issues of data and methodology. Hydén's (1997) review article in *Sociology of Health and Illness* usefully discusses four aspects of illness narratives: a proposed typology giving three different kinds of illness narratives—what he terms “illness as narrative, narrative about illness, and narrative as illness,” considerations of what is accomplished with the help of illness narratives; problems with the organization of illness narratives; and, finally, the social context of the narrating and how this influences the form and structure of the narrative and its themes.

Apart from some interesting anthropologically oriented studies, such as Mogensen's 1997 report of narratives of AIDS among the Tonga in Zambia, it seems that less attention has been directed in non-psychiatric health care at intercultural

aspects of health care narrative. This is something of a gap since there are many studies which take up Hydén's four aspects of narrative, but not in a language contact situation. As examples we can identify Little's work and that of his colleagues in Sydney in the field of the assignment of meanings in epidemiology, in particular in respect of expressions of outcomes from health care treatment (Little, 1998), or in relation to patients' experiences of cancer and cancer treatment (Little, Jordens, Paul, Montgomery, & Philipson, 1998). Both these studies suggest the potential for a valuable extension to the intercultural context, as among many other studies, does Kugelmann's 1999 report of patients' experiences of chronic pain. Studies that direct themselves at gendered constructions of illness narrative, for example, that of Johansson, Hamberg, Westman and Lindgren (1999) dealing with women's descriptions of symptoms of biomedically undefined musculoskeletal pain, or Gjerberg and Kjølørød's (2001) study on difficulties in professional cooperation experienced in gendered interactions between doctors and also suggest ways in which the intercultural could be addressed within a narrative framework.

In the field of psychiatric medicine and health care, however, the existence of journals such as *Culture, Medicine and Psychiatry*; *Transcultural Psychiatric Research Review*; and the *Journal of Transcultural Psychiatry* suggests a very rich resource of studies of great interest to applied linguists concerned with the intercultural (as all in a sense are!). Exchanges between Barrett (1998) and Sass (1998) into the interpretive construction and construal of schizophrenia, raising as they do issues of culture and the problematic surrounding the socially relative positioning of patients as socially liminal, reminds one forcibly of Rampton's work in applied linguistics and sociolinguistics (Rampton, 1995, 2001), while Ladson Hinton and Levkoff's (1999) study of the "lost" identities of Alzheimer's patients explicitly addresses the intercultural in its discussion of how African American, Chinese American, Irish American, and Latino caregivers differentially draw on their cultural and personal resources to create stories about the meaning of illness and in its exploration of how ethnic identity affects the kinds of stories family caregivers tell.

### Risk

Interestingly, where one does find something of a priority given to the intercultural is in the theme of health care risk, at least in the field of health care policy. Studies stimulated by the concern of the World Health Organization (WHO) to construct a quality of life questionnaire sensitive to cultural difference are cases in point; see, for example, the broad international comparative study of attitudes to and feelings about quality of life among HIV patients reported in Skevington, Bradshaw, and Saxena (1999). Interestingly, such studies point up an issue to which we return below, namely, whether researchers with a concern for discourse do better to derive their data from more quantitatively designed questionnaires, as with Skevington, Bradshaw, and Saxena (1999), or rely more on qualitative narrative data, as in the study, again in the WHO quality of life context, of HIV patients and their professional and nonprofessional caregivers in Hong Kong reported in Jones, Candlin, and Yu (2000). Applied linguists certainly have something useful to

contribute in the systematically grounded analyses of narrative, as the latter authors point out. Moreover, such studies can reveal personal constructions of cultural relevancies that more quantitative, questionnaire-based studies do not. An example of this is the study of Hamadeh and Adib (1998), which explored Lebanese doctors' variable willingness to disclose truths about cancer to their patients. A more ethnographic, narrative-based account might have augmented their useful results considerably. Overall, however, themes such as risk still remain insufficiently reflective of cultural differences and variations in understanding, notwithstanding their potential for applied linguistic engagement on this and other grounds. Some examples are Rhodes's (1997) study on the social organization of "risk behavior" with its data drawn from interviews and focus groups; Lauritzen and Sachs's (2001) study of the meanings of terms such as 'risk', 'normalcy,' and 'deviance'; and Plumridge and Chetwynd's (1999) parallel study into issues of identity and the social construction of risk among injecting drug users (on a similar theme, see McIntosh and McKeganey, 2000).

### Applied Linguistic Studies

When one examines the applied linguistic and discourse analytical literature in terms of preferred themes and sites, what strikes the reader, surprisingly, is a similar comparative lack of attention to the intercultural to that we have noted above in the sociology of health care, allied health disciplines, and medical education (although in the latter case now less so, as noted earlier). Of course, there are notable exceptions in the applied linguistic and discourse analytical literature, such as Cameron and Williams's (1997) study of communicative "success" in nonnative–native interactions in hospitals, where the authors identify the triggers for "success" in such interactions in terms of a combination of informed inferencing and enabling communication strategies on the part of the practitioner. This analysis resonates strongly with the calls noted earlier in this chapter in the medical education literature for improved health care practitioner awareness training and suggests a connection to more recent applied linguistic and discourse analytical work on the links to be made between discursive ability and professional expertise; see Candlin and Candlin (2002a). Oddly, the *English for Specific Purposes Journal* devotes little space, in the recent past at least, to the health care theme, although Frank's (2000) study of (non) understanding in native–nonnative interactions is something of an exception, as is Ibrahim's (2000) study of doctor-centeredness and its discursive realizations in hospitals in the United Arab Emirates.

### Patient–Practitioner Interaction

Of interest to applied linguists and discourse analysts is the highlighting of the practitioner–patient interaction as a major theme, predominantly it must be said in the doctor–patient clinical setting. Ten Have's valuable commentary in a special issue of the journal *TEXT* in 2001 devoted to lay diagnosis, (Ten Have, 2001), identifies two trends in medical interaction research: on the one hand, a focus on doctors' behaviors in the course of performing particular professional communication strategies, for example, *inviting*, *allowing*, or indeed, *discouraging*

patients from expressing their ideas or feelings; and, on the other, a focus on the medical encounter as an activity type or genre, with a focus on delineating its phases or moves. This contrast is one that resonates with a wider and current applied linguistic and discourse analytical debate on models, well captured and discussed in a recent chapter by Sarangi in relation to data drawn from genetic counseling, where he offers the construct of discourse types and their attendant strategies as an alternative to the Levinsonian focus on generic structure (Levinson, 1979; Sarangi, 2000). At a risk of a bet, however, the interactional focus is now heavily foregrounded, see, for example, the special issue of *TEXT* referred to above, and in particular, the papers in that issue by Frankel (2001); Gill, Halkowski, and Roberts (2001); and Stivers and Heritage (2001). Indeed, Drew's commentary in the same issue (Drew, 2001) explicitly identifies co-construction of the interaction as a key theme.

This interactional focus is taken up elsewhere, for example, in the study by Dijkstra, Bourgeois, Petrie, Burgio, and Allen-Burge (2002) of nursing-home residents with dementia; in Moore, Candlin, and Plum's (2001) study of doctor-patient interaction in the negotiation of the meanings of viral load in consultations with HIV patients; and in a series of papers over the recent past in *Research on Language and Social Interaction*, whose focus as a journal naturally prefers this orientation. As examples we can cite Leppänen's study on advice-giving among Swedish district nurses and their patients (Leppänen, 1998); and Buttny's work on the joint construction of clients' problems in client-therapist encounters (Buttny, 1996). At a remove, perhaps, but nonetheless interactional in character, is Coupland, Robinson, and Coupland's 1994 work on frame negotiation in doctor-elderly-patient consultations arising out of a major sociolinguistic study of older persons in interaction with health care practitioners. This particular paper, indeed, serves as a classic contribution to anyone interested in the field of institutional discourse studies in health care.

### Critical Accounts

Current interest in critical discourse analysis suggests the possibility of engagement by applied linguists and discourse analysts in this theme in the health care context, although so far not one taken up generally from an intercultural perspective. An exception to this would be Davidson's (2000) study of contrasting interpreter roles in Spanish-English medical encounters that speaks of setting the interpreter as 'institutional gatekeeper' against the interpreter as 'active partner' in the diagnostic process. The study initiated by the UK Royal College of General Practitioners (RCGP) into issues of equity in the oral examination of nonnative doctors seeking entry to Memberships of the RCGP, reported in Roberts, Sarangi, Southgate, Wakeford, and Vass (2000), is notable not only for its critical focus on issues of fairness in relation to ethnicity but that its results were reported in the *British Medical Journal*. This critical orientation is not limited to applied linguistics and discourse analysis, but also resonates strongly among writers in the sociology of health care, as, for example, in Nijhoff's (1998) study of naming as a naturalizing process whereby practitioners exercise dominance over patients. Indeed, taken more broadly, themes of autonomy, challenges to authority, and subjectification occur in

both literatures, as, for example, in Warren, Weitz, and Kulis's (1998) work on the relationship between patients' challenges to practitioner authority and their effect on patient satisfaction; Fahy and Smith's (1999) feminist study of patients as subjects; or Parks's (1998) critical analysis questioning whether the 'therapeutic relationship' embodies some equally entered-into "contract" by practitioner and patient. As a further example, the collection of invited papers by Kovarsky, Duchan and Maxwell (1999) takes a critical perspective on the ways in which patients' displays of communicative ability can be systematically inhibited—or constructed as incompetent—by the interactional management strategies of the professional caregiver or health worker.

Perhaps surprisingly from this critical perspective, the classic call by Cicourel (1992) for "ecological validity" in discourse analytical research, especially the need to site the explanation of health care interactions in both their local micro-interactional contexts and in the macrocontext of the historical-social-structural seems to have been taken up less in the recent literature either by applied linguists concerned with interaction (although see Candlin & Candlin 2002a, b), or by health care practitioners and medical sociologists with a similar focus. Once again, however, there exists a classic text which argues against too sweeping a judgment in Atkinson's seminal study of medical talk and medical work (Atkinson, 1995).

### **Methodologies and Data Sets**

Although one might expect that given the reasonably circumscribed array of methodologies available to the human and social sciences there will clearly be considerable overlap among disciplines in terms of methodological choice, this need not imply unanimity or coincidence in terms of current directions in research. This is so in the field of health care. In the field of medical education; the key methodological paradigm is that of qualitative, grounded theory (Glaser & Strauss 1967; Strauss & Corbin, 1990) involving careful and iterative analysis of taperecorded (usually audio-recorded) and transcribed narrative, experiential data drawn from focus groups, workshops, and individual semistructured interviews. We have already referred to this focus on narrative as a key theme in medical education and the sociology of health care more generally. Studies such as that of Kai, Spencer, and Woodward (2001) and Nochi (1998) are typical in this sense. However, not all so-called grounded theory is as grounded as Miles and Huberman's work (1994) would stipulate. It is important therefore to distinguish between studies that perform perhaps rather superficial content analysis from those, such as that of Armstrong, Michie, and Marteau (1998) in the field of genetic counseling or Johansson, Hamberg, Westman, and Lindgren (1999) in the field of women's experiences of pain, who subject their carefully selected data to exhaustive coding. The quality of the data thus collected is clearly as important as the methodologies employed in its processing; even more so, one might argue. Therefore, it is worth noting exceptional instances, such as that reported in Katz, Conant, Inui, Baron, and Bor (2000) where, in a study of communication in elderly care settings, the researchers set up what they called a "council of elders" in which community elders served as a sounding board to whom medical residents could present their dilemmas

in caring for older patients in that community. From this emerged a truly collaborative and cooperative research process, with a range of crossing, interwoven, and compared data, creating what the authors call “a community of resources,” which led to the institutionalizing of the referencing process in the primary care residency education program. We will return to this key issue of collaborative research, reflexivity, and practical relevance in the final section of this chapter.

Of course, grounded theory does not preclude the association of more quantitative, questionnaire-driven approaches, or the use of quasi-experimental designs involving Likert-scale evaluations of attitude and beliefs; see Lau, Stewart, and Fielding (2001). Narratives obtained from semistructured interviews can themselves be deliberately focused on the retrospective account, as in Kaufmann’s 1997 study of reconstructed health dilemmas and voices of different participants can be artfully contrasted, and at times opposed, within a structured design, like that employed by Crossley and Crossley (2001), in their comparison of patient anthologies of psychiatric illness collected in the 1950s and the 1990s.

What may be of interest to applied linguists and discourse analysts is to estimate how much in recent years research in the sociology of medicine and health care has taken a discursive turn, and what opportunities now exist (although not as yet fully taken up) for a synergistic combination of methodologies involving textual analysis, analyses of interaction, ethnographic narratives, and social-historical and structural accounts of the institutions and their associated ideologies that give rise to the data in question. Studies such as that of Barry, Stevenson, Britten, Barber, and Bradley (2001) exploring doctors’ differential communication strategies in general practice drawing on Mishler’s (Habermas’s) distinction between the voice of medicine and the voice of the lifeworld (Habermas, 1984; Mishler, 1984) rest firmly on discourse data, but also make reference to a social theoretical framework. However, while Stivers’s (2002) conversational analytical study on participation in treatment decisions involving children in the context of pressures for antibiotic medication in pediatric encounters is firmly based on discourse data, it might readily have included an ethnographic as well as a critical discourse analytical dimension. Notable in both these cases is that they derive from medical school departments of general practice, pediatrics, and pharmacy, not from departments of applied linguistics or discourse analysis, although they clearly acknowledge the discourse analysis dimension.

Bridges do of course exist, increasingly so where the institutional conditions are favorable, and where there is an agreed and mutually valued methodological agenda. The work of Little in the Centre for Values, Ethics and Law in Medicine at the University of Sydney with linguistics colleagues in a systemic–functional linguistic framework is a case in point (see Jordens, Little, Paul, & Sayers, 2001), as is the collaboration of Sarangi and colleagues at the Centre for Health Communication Research at Cardiff University in the United Kingdom with colleagues in the Department of Medical Genetics at the University of Wales College of Medicine (see Sarangi & Clarke, 2002) drawing on discourse analysis, conversational analysis, and interactional sociolinguistics, or that involving shared

analytical resources where the Department of Communication Studies in Linköping, Sweden and the Clinical Epidemiology Unit in the Department of Family Medicine at Uppsala (see Johanson, Larsson, Säljö, & Svärdsudd, 1998) collaborate in researching discussions on lifestyles in relation to health care provision.

Among all such research one can detect a gradual shift from the analysis of the one-on-one interaction between professional and patient, or between researcher and patient, perhaps classically represented by Hamilton's (1994) study of an Alzheimer's patient, toward analyses that locate such encounters within a complex institutionally governed framework of social interactions, relationships, and situations, whether or not studies overtly make appeal to relevant social theory. For some discussion of this issue of the linkage between sociolinguistics and social theory, readers are referred to Coupland, Sarangi, and Candlin (2001), and in particular in that collection, to Sarangi and Candlin (2001). Nonetheless, it is important not to be too sanguine about this shift, since as Atkinson makes very clear (Atkinson, 1995) whatever the methodology, there has been (and still is) a considerable bias in social-scientific studies of medical work towards the individual doctor interacting with (usually) his patients. He offers some considered reasons for this, not least those of accessibility to data and the privileging of talk (in this context, see Hak's 1999 cautionary chapter on talk bias in health care work and the potential such encounters offer for exploration of collaborative action).

If this is the bias in the microsociology of health care, it has also certainly been the case in applied linguistics and discourse analysis. Work in the 1980s typically had such an interactional, dyadic, clinic-focused orientation; see Fisher and Todd (1983); Silverman (1987); and West (1984) as key examples. We note now a move to promote a careful mix of methodologies, each offering particular perspectives on the data, grounded in an analysis of the institutional context. Marriages between qualitative and quantitative methodologies are proving productive and explanatory. In the study by Dijkstra, Bourgeois, Petrie, Burgio, and Allen-Burge (2002), drawing on conversational transcripts, utterance- and discourse-level data identified by a range of previous studies into language and dementia, researchers have related these features to stages in the development of dementia, coded and checked their analyses for inter-coder reliability, and processed the data statistically with the aim of assessing the facilitative effects on patient interaction of different discursive types of nursing interventions with different classes of patient. A further example of this combined qualitative (discourse analytical) and quantitative methodology is the series of studies currently being conducted by a research team from Cardiff University, United Kingdom, and the University of Wales College of Medicine also in Cardiff, into decision-making by general practitioners; see Atwell, Coupland, Edwards, Elwyn, and Smith (2002). Here, an emphasis on the co-construction of the discursive expertise of general practitioners in interaction with their patients has involved researchers not only in exploring the interactions between researchers and 'researched,' but also interactions between the 'researched participants' themselves, for which discourse analytical and conversational analytical methodologies, together with the use of patient narratives of experience, have proved insightful.

### Nursing: A Key Research Site

As a way of bringing together what we have explored so far, and to highlight the value of interdisciplinary collaboration, we select nursing as a key site of engagement. This also reflects the position of nurses as the group with the greatest representation in health service delivery. Given this, what is surprising is that few studies of nursing interaction have been conducted by, or in association with, applied linguists and discourse analysts. The focus, as Atkinson (1995) and S. Candlin (1997) point out, has largely been on the doctor–patient relationship. Whether this is related to the prestige and power which doctors hold, or the autonomy they are thought to enjoy, are moot points. What is clear is that other health professionals in nursing and allied health do not always all enjoy the same degree of autonomy as medical practitioners, and their interactions are neither of limited duration nor discrete events (S. Candlin, 1997, 2000). Nursing, especially, is an ongoing 24/7 activity, with interactions often requiring long periods of time and occurring in stretches which may occur over many days and weeks. This makes the task of data collection formidable. Nonetheless, numerous studies with a communication focus have been conducted at nursing sites by nursing professionals (see S. Candlin, 1997; Gibb, 1990; Macleod-Clarke, 1984; Tan, Fleming, & Ledwidge, 2001) and published in professional nursing journals, but these are typically not referenced in applied linguistic and discourse analytic studies.

A number of such studies address the complexities of communication in contexts of cultural and linguistic diversity—an increasingly common situation in societies with high rates of immigration—in particular focusing on the crucial nature of the nurse–patient relationship with its need to accurately identify patient needs, determine goals, and achieve desired outcomes. The achievement of any of these areas is jeopardized if the communication between interlocutors is not clear and unambiguous, hence the potential value of an applied linguistic and discourse analytical contribution to such research. As one example, in a study of Aboriginal patients and their health care providers, Cass et al. (2002) found that not only was a shared understanding of key concepts rarely achieved, but instances of miscommunication often went unrecognized. Sources of such miscommunication included not only a lack of patient control over the language, timing, content, and circumstances of the interactions, but differing modes of discourse, cultural and linguistic distance, and a lack of professional training in intercultural communication.

This is an issue we have highlighted earlier, and the value of appropriate professional development programs in nursing is similarly recognized; see Davis (2000), with a focus on communication made central. As Ulrey and Amason (2001) argue, such programs have the potential not only to benefit patients but also to benefit health care providers in terms of reducing their levels of stress. This need for professional education, grounded in understanding of professional interaction in intercultural contexts lies at the heart of studies involving nurses and interpreters, as is clear from the research by Pöhhaker (2000) and Visandjée and Dupère (2000) referred to earlier. The point of concern is that barriers of language and associated lack of knowledge of patients' cultures can inhibit the delivery of safe and effective

care by nurses, as Boi (2000) found in her study. Unless post-registration courses address cultural differences, health beliefs, and practices, and ground these in the study of interaction, it will be almost impossible for nurses to deliver, and for patients to receive, holistic care. The potential for a contribution from applied linguists and discourse analysts familiar with issues of language contact and intercultural communication to existing emphases within nursing education on the crucial nature of intercultural understanding (see Leininger, 1978, 1983, 1990)—whether in terms of ethnicity or social group membership—is evident.

### **Reflexivity and Relevance**

One issue that runs through this chapter is that of the stance taken by researchers in the health care professions (whether from a sociological or a linguistic orientation) vis-à-vis practitioners working in such professions. Associated with this is the issue of the practical relevance of such research.

The formulation of the former issue has received general critical inquiry in the applied linguistics field through the arguments of Cameron, Frazer, Harvey, Rampton, and Richardson (1992) into the question of researching on, by and with, and as Sarangi and Candlin point out in a recent chapter, the need is to strike a relationship between participants' and analysts perspectives on social data (Sarangi & Candlin, 2001). Either the perspectives are distinct, with the likely outcome that researchers impose or transform the data into a form of order aligned with their disciplinary interests, as in some objectivist mode of inquiry; or participants and researchers seek to bring their perspectives into alignment by hermeneutically exploring and co-constructing common interpretive accounts. To achieve the latter requires some considerable mutuality, of experience, of knowledge, of modes of accounting, of modes of saying and reporting. This is so whether one is discussing alliances between health care professionals, researchers from a sociological perspective, and applied linguists or discourse analysts. As we have seen, the studies identified here offer a variable response to this issue. In the main, such interprofessional collaboration has been the exception rather than the rule, although in the disciplines surrounding the sociology of medicine, and among some health care professionals, this collaboration is becoming more common. Applied linguistics has some way to catch up, although there are notable exceptions, as we indicate, and they display the advantages of such a collaborative stance.

The issue of practical relevance is more contentious. At one level, it is a matter of first achieving at least candidate or adjunct membership in the communities of practice where practitioners are engaged. In general, applied linguists and discourse analysts are condemned to outsider status in such practitioner communities, unless (rarely so far) they are co-members of both. As Sarangi and Candlin (2001) point out, considerable time and effort, and considerable negotiation, are needed to access and achieve even the modest mutuality needed to make sense of the contexts of interaction. Where the issue is the potential research gains for the ultimate participants (as it ought to be in applied linguistics, namely, for those seeking health care), then achieving practical relevance becomes much more problematic.

We can, however, make a beginning; we can adopt a more open methodological stance; we can avoid using health care data merely to serve refinements to *our* theories; we can learn to code our results conceptually and in terms of language understandable to our professional colleagues and to the end-users; we can begin from the problematic as defined by our collaborators and address not just questions of *how* but also questions of *why* and *to what purpose*. Applied linguists might aspire to become discourse practitioners, in Sarangi's happy phrase (Sarangi, 2002). In the circumstances of this chapter, this should have been easier to guarantee than it has been. If applied linguistics is truly problem driven, then it needs to be equally outcome focused, and collaboratively undertaken with professional practitioners. This is no more important than in the area of intercultural communication in health care, working from within at understanding the nature of the relationships among interaction, diagnosis, treatment, and care, and conscious also of the implications of such analyses for institutional and organizational change. As S. Candlin (2000) emphasizes, any discourse analytical work in applied linguistics presupposes understanding professional practice. At the same time, of course, it has to be true to its own scholarly practices, as Sarangi and Roberts (1999) in turn emphasize, acknowledging how its own academy defines and values research. The centrality of communication in health care provision justifies efforts to meet the simultaneous challenges of achieving both disciplinary reflexivity and practical relevance.

### Note

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### ANNOTATED BIBLIOGRAPHY

Cameron, R., & Williams, J. (1997). Sentence to ten cents: A case study of relevance and communicative success in non-native speaker interactions in a medical setting. *Applied Linguistics*, 18(4), 415–445.

One of the very few studies in the applied linguistics literature that seeks to marry awareness of second language acquisition with an exploration of what counts as communicative success in health care contexts, this article has implications for professional development.

Candlin, C. N., & Candlin, S. (2002a). Expert talk and risk in health care [Special issue]. *Research on Language & Social Interaction*, 35(2).

This specially edited collection of papers focuses on the relationship between discursive competence and professional expertise. As such, it offers clear models for research involving interactional data into a range of health care and other sites, in first language, or in language contact situations.

Cass, A., Lowell, A., Christie, M., Snelling, P. L., Flack, M., Marrnganyin, B., & Brown, B. (2002). Sharing the true stories: Improving communication between Aboriginal patients and health care workers. *Medical Journal of Australia*, 176(10), 446–470.

This study offers a prime example of how qualitative research can lead to the identification of key factors that limit the effectiveness of communication between Aboriginal patients with end-stage renal disease and health care workers, and shows how such research can also identify strategies for improving communication. Trained interpreters can only provide a partial solution; rather, what is needed are greater educational resources to facilitate a shared understanding of the cultural, social, and economic dimensions of the illness experience of Aboriginal people.

Hydén, L-C. (1997). Illness and narrative. *Sociology of Health and Illness*, 19(1), 48–69.

An extremely valuable article for applied linguists, setting out as it does different perspectives on illness narrative from which it is possible to construct a range of interconnected methodologies designed to explore the theme from different perspectives. A classic case study for bringing together research traditions in applied linguistics and discourse analysis.

Isaac, K. (2002a). *Speech pathology in cultural and linguistic diversity*. London: Whurr Publishers.

This book provides a valuable study of the relationship between culture and communication in speech pathology practice in contexts of cultural and linguistic diversity, addressing in particular issues of assessment and management of patients. A great strength of the book is its comprehensive account of ways in which professional development for practitioners engaged in intercultural health care can be designed, especially in the context of interpreter-mediated interaction.

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