

Towards a communicative mentality in medical and healthcare practice

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1. Introduction

Writing the inaugural editorial can be likened to witnessing a birth, epitomized by a feeling of relief as well as excitement. The relief is twofold: the very sight of life which brings to mind the many critical moments leading up to the birth. The excitement is a cautious one, necessarily filled with expectations about future growth and sustenance, which are bound to be caught in a dynamic web of dependency and autonomy.

The birth of *Communication & Medicine* is primarily a scholarly—and timely—gap-filling activity. It is the first journal dedicated to disseminating language and communication studies (in the traditions of discourse analysis, pragmatics and sociolinguistics) in the healthcare setting, and in doing so to connect with other contributory disciplines as signalled in the subtitle (social sciences, ethics and health services). It is both a response to a long-felt need for consolidating language and communication research, and a proactive motivation for setting up new analytic and methodological orientations without reducing healthcare to language and communication matters.

For quite some time health and social care has been the locus of interdisciplinary research in a number of disciplines in the human and social sciences: anthropology, education, law, philosophy, psychology, sociology, literature and linguistics. The different disciplines have engaged with core themes, e.g., social psychological aspects of coping, narratives of illness, cultural models of health belief, sociological studies of medical ideology and power relations, media studies of health and disease representations, public understanding of science and medicine etc. There are many journals with health or medicine in their titles which reflect this breadth of coverage. It is, however, possible to list a number of reasons to justify a new journal in the medical and healthcare domain with a language and communication orientation. For instance, many medical, nursing and allied health curricula worldwide are prioritizing the problem-based teaching and learning of communication skills—as part of both mainstream medical education and continuing professional development. Such training is now being offered from within the healthcare sector,

but without the benefit of the rich field of research in communication theories and processes from sociolinguistic and discourse analytic perspectives (including conversation analysis, text/genre analysis and critical discourse analysis).

As a corollary to the above observation, some sociolinguistics and communication curricula are introducing new modules and programmes in professional and organizational communication, including aspects of health and social care. The boundaries of mainstream applied linguistics are expanding and have potential for future growth (Sarangi and Candlin 2003a). In recent years, for instance, applied linguistics and sociolinguistics conferences have devoted considerable space (in the form of colloquia, workshops) to accommodate ongoing research in the health and social care domain. In 2002–2003, for instance, the Sociolinguistics Symposium in Gent, the British Association for Applied Linguistics in Cardiff and the American Association for Applied Linguistics in Arlington had earmarked special colloquia in the health and social care field. Also in 2003, Cardiff hosted the first conference in the interdisciplinary area of Communication, Medicine and Ethics (COMET), which is set to become an annual event, taking place in Linköping (Sweden) in 2004, in Macquarie, Sydney (Australia) in 2005 and so on. *Communication & Medicine*, in welcoming these developments, will remain actively involved in this conference programme and provide an avenue for dissemination of new research in this interdisciplinary field.

The clinical encounter between doctors and patients, and between healthcare professionals and clients more generally, has long been recognized as a communicative relationship. The notion of communicative relationship is better seen as a continuum, ranging from the pathological to the holistic. At the language/communication end, the pioneering study of Byrne and Long (1976) has paid special attention to the role of language in the form of question-answer sequences. Through an extreme case analysis, by adopting a cause-effect protocol, they show how 'patient behaviour rarely appears to become causative [as] all of the patient's replies to questions have been absorbed by the doctor who has never used any of the information given to develop further responses'

(Byrne and Long 1976: 11–12). In the contemporary clinic, communication issues come to the fore, in light of medical uncertainties about new illnesses defying diagnosis or definitive prognosis. This leads to a shift in healthcare from diagnosis and cure towards prevention and care. Added to this is the coming of age of the literate patient who has unrestricted access to health information via websites and other support networks. In the area of telemedicine and e-health where face-to-face contact is absent, communicative resources are stretched to their maximum potential. The same also holds for dealing with asymptomatic conditions, such as genetic disorders which are family illnesses and have consequences for significant others in terms of decisions about predictive or carrier testing, disclosure about health status etc. One can extend this picture to epidemics in the public sphere such as the recent outburst of SARS where information/communication provision assumes a critical role in containing the spread of disease.

As the onus for good health becomes the responsibility of the individual, health promotion and information services increasingly rely on language as a major communicative tool. We notice an overall shift from a paternalistic model of medical practice towards a patient-centred healthcare firmly based on mutuality, patient autonomy, professional neutrality and shared decision making. This is very well captured in what Tuckett et al. (1985) call a 'meeting between experts'. These new developments make new demands on the professionals' (and clients') communicative resources. Outside of the clinical context, litigation abounds because of communication problems: in the UK, for instance, this has meant the National Health Services being drained of already dwindling resources.

In summary, communication is a central resource for healthcare provision. There have been different communication research traditions which engage with practical issues facing the healthcare profession. It is worth mentioning here the contributions made by scholars focusing on the coding of doctor-patient interaction systems (e.g., Stewart and Roter 1989). Although my own initiation to this field is relatively recent, language and communication studies have contributed immensely over the last thirty years to the study of encounters between health/social care professionals and patients/clients. This is particularly evident in the number of condensed summaries (e.g., Ainsworth-Vaughn 2001; Candlin and Candlin 2003; Cicourel 1981, 1985; Fleischman 2001; Heath 1979; Hyden 1997; Hyden and Mishler 1999; ten Have 1995) and book-length publications (e.g., Atkinson 1995; Barrett 1996; Crawford et al. 1998; Fisher 1995; Fisher and Todd 1983; Goffman 1961; Gwyn 2002; Heath 1986; Hunter 1991; Labov and Fanshel 1977; Mishler 1984; Peräkylä 1995; Pettinari 1988; Radley 1994; Ribeiro 1994; Sarangi and Roberts 1999; Silverman 1987, 1997; Strong 1979; Wads-

worth and Robinson 1976; Waitzkin 1991; West 1984).¹ In addition to regular periodic publication of high quality articles, some journals have published special issues in this area (e.g., *TEXT* [Freeman and Heller 1987] on 'medical discourse', *TEXT* [Beach 2001] on 'lay diagnosis'; *Journal of Language and Social Psychology* [McKay and Pittam 2002] on 'language and healthcare'; and *Research on Language and Social Interaction* [Candlin and Candlin 2002] on 'expert talk and risk in healthcare').

In the absence of a specialist journal devoted to the area of language and communication in the health and social care domain, over the years many researchers have used different journals to report their work. Such reporting has no doubt contributed to interdisciplinary recognition, but in a rather fragmented manner. Following the birth metaphor introduced earlier, it is difficult to consolidate these studies in a meaningful way so as to assess where the discipline stands—in terms of its maturity and its impact—at this point in time. More importantly, this research tradition remains invisible as health and social care researchers and professionals are not always able to locate easily the varied publication sources. Only very recently have a small proportion of discourse and communication scholars started publishing their work in mainstream healthcare journals such as *Social Science & Medicine*, *Sociology of Health & Illness*, *Health, Risk & Society*, *Health, British Medical Journal*, *Medical Education* (see also the special issue of *Health, Risk & Society* [Sarangi and Candlin 2003b] which foregrounds a discourse analytic approach to risk). All this is indicative of the interdisciplinary interest in discourse-based studies.

2. Towards a communicative mentality in healthcare

In order to give some substance to this editorial, I have chosen to focus on what I have termed 'communicative mentality'. In the medical context, for example, it is widely accepted that clinical knowledge is distinct from scientific knowledge. The biomedical model which underpins scientific knowledge not only legitimizes a particular model of explanation at the expense of other possible scenarios, it also prioritizes specific methodologies (experimental as opposed to observational method) and a particular professional-client relationship. The scientific ideology—in itself a contradiction of terms if we take ideology to mean pseudo-science—goes back to the nineteenth century rationalism, with its methodological empiricism. Like alternative medicine, alternative methodologies and viewpoints are likely to be regarded as heretic. In pointing out the reductionist and exclusionist tendencies characteristic of the biomedical model, Engel (1977) advocated for a paradigm shift as a way of stressing what he called the 'ethnomedical perspec-

tive' (Fabrega 1975) that pays adequate attention to the 'biopsychosocial' dimension.

A communicative turn in medical care and healthcare is a recognition of the limitations of a biomedical model of disease and health. It is through particular use of language that the tensions between the medical and social categorizations are accomplished. In mainstream medical practice the voice of medicine interrupts the voice of the lifeworld — this is what Mishler (1984) calls 'routine practice' within a biomedical paradigm, suggesting an unequal relationship between doctors and patients: 'The concept of "voices" is introduced to specify relationships between talk and speakers' underlying frameworks of meaning. Two are distinguished, the "voice of medicine" and the "voice of the lifeworld", representing, respectively, the technical-scientific assumptions of medicine and the natural attitude of everyday life' (Mishler 1984: 14).

The contrastive nature of these two 'voices' is emphasized in terms of contextualization and decontextualization of illness experience. The voice of the lifeworld reflects the patient's personal 'contextually-grounded experiences of events and problems ... The timing of events and their significance are dependent on the patient's biographical situation and position in the social world' (Mishler 1984: 104). Through the voice of medicine 'the meaning of events is provided through abstract rules that serve to decontextualise events, to remove them from particular personal and social contexts' (Mishler 1984: 104).

The two voices Mishler alludes to are to be seen in a much more complex, interpenetrative relationship, to the extent that both voices can be appropriated by professionals and clients in strategic ways. As Silverman's (1987) classic study of Down's Syndrome clinic shows, demedicalization can be part of professional repertoire with an overlay of the social discourse over the medical/clinical as part of a policy of non-intervention or of deferred decision making which assumes lower expectations of the parents. According to Silverman, such 'coercive interpretation' appeals to available social stereotypes of children, while driving towards an ideology of closure. Similarly, decisions about eligibility for screening based on risk assessment are medical and resource-based activities, but mediated by language and communication systems. The main argument here is that the tool of language and discourse is rather complex, as they take on a key role in the business of sorting patients out, including who does or does not qualify for the Parsonian 'sick role' status (Parsons 1951). It is worth noting that the notion of 'sick role' is rather restrictive in its thinking about health and illness, and does not recognize the role of language and communication in the practice of medical and healthcare.

Researchers from traditions of medical anthropology and illness narratives emphasize the subjective, meaning making dimensions of illness experiences.

Kleinman (1988) characterizes the medical system as a 'cultural system', as he warns against the 'category fallacy'—the tendency to consider disease as natural, and therefore outside of culture. From this viewpoint, disease is not an entity but an 'explanatory model' from patients' perspective, which foregrounds what an illness experience means to people: 'The illness narrative is a story the patient tells, and significant others retell, to give coherence to the distinctive events and long term course of suffering ... The personal narrative does not merely reflect illness experience, but rather it contributes to the experience of symptoms and suffering' (Kleinman 1988: 49).

This line of inquiry is taken forward in Frank's (1995) characterization of different illness narratives—restitution, chaos and quest—and the implications these narrative experiences can have for personal coping and for professional intervention.

Notwithstanding the limitations of narratives as an explanatory model, a meaning-centred or interpretive medical anthropology approaches sickness not as a reflection or causal product of somatic processes but as a meaningful human reality. It views healing as transactions across meaning systems—popular, religious, folk, professional—that result in the construction of culturally specific illness realities and as therapeutic efforts to transform those realities. Good (1994) calls this a 'cultural hermeneutic model' which stresses that human illness is fundamentally semantic or meaningful. In its extreme formulation, it reads like a constructivist argument: illness is constituted and is only knowable through interpretive activities. One of the challenges for medical practice is that patients may come to the clinic with different attitudes to their illness (not necessarily culturally determined, but often bound to individual and familial biographies). So it is important that health professionals make an attempt to match the patients' expectations, especially in relation to treatment regimes, which no doubt requires a communicative orientation. As Greenhalgh and Hurwitz (1998) suggest, a narrative-based medicine as opposed to evidence-based medicine in the clinical context can become a counterbalance to the biomedical model.

Against this backdrop, the notion of communicative mentality can be approached from different angles. We can begin with how communication is being seen as a priority in healthcare delivery/management in countries, as discussed above. Professionals are under pressure to prove their communicative abilities, alongside their clinical and scientific knowledge status. But what exactly constitutes communicative expertise in a given medical speciality is far from clear. And whether discourse can be a measure of such expertise is even harder to resolve (Candlin and Candlin 2002). At one end of the spectrum is the view that Good Doctor=Good Communicator. Although it is possible to identify total convergence of professional and communicative repertoire in some

individual professionals, it is far from the case that one skill can be subsumed under the other. At the other end of the spectrum is the view that Good Communicator=Good Doctor. This signals a major threat to the goal and uptake of communication-based research.

My use of the term ‘communicative mentality’ echoes Freidson’s (1970) notion of ‘clinical mentality’ as distinct from ‘scientific mentality’. Freidson (1970: 170) characterizes ‘the clinical mentality’ as ‘a rather thoroughgoing particularism, a kind of ontological and epistemological individualism’. To this particularism, he adds, among other traits, action-orientation, problem solving and ‘moral subjectivity’, all of these as part of a ‘systematic bias’ but not devoid of rationality. As Freidson (1970: 171) goes on to claim, ‘the difference between clinical rationality and scientific rationality is that clinical rationality is not a tool for the exploration or discovery of general principles, as is the scientific method, but only a tool for sorting the interconnections of perceived and hypothesized facts’. When it comes to training of medical professionals, as Byrne and Long (1973: 7) observe, the trainer is ‘more a teacher of application than of theory’.

‘Clinical mentality’ points toward the cumulative consolidation of knowledge and expertise through personal experience and the role language and discourse plays in the mediation of such knowledge and experience. It reminds us of Polanyi’s (1958) notion of personal knowledge as a reaction to the widely held view that scientific knowledge is ‘impersonal knowledge’—as it deals with facts which are there, whether we like it or not. This leads to splitting fact from value, science from humanity. For Polanyi, the scientist’s personal participation in his/her knowledge, both in its discovery and its validation, is an indispensable part of science itself. Even in the exact sciences, knowing is an art and the skills of the knower forms a logically necessary part: ‘The act of knowing includes an appraisal; and this personal coefficient, which shapes all factual knowledge, bridges in doing so the disjunction between subjectivity and objectivity’ (Polanyi 1958: 17).

Polanyi (1958: 49) goes on to claim that ‘... the aim of a skilful performance is achieved by the observance of a set of rules which are not known as such to the person following them’. He illustrates this with the example of a competent swimmer who is unlikely to know that he keeps afloat by systematically ‘refraining from emptying his lungs when breathing out and by inflating them more than usual when breathing in’. If such explicit level knowledge were to be a requirement for swimming, not many people would see swimming as a leisure activity! They would be worried to death in trying to work out whether they were emptying/inflating their lungs as required.

This raises interesting methodological questions: How do communication researchers approach profes-

sional expertise? What does it mean to ask professionals to account for their practices? We can see here the limitations of the method of research interviews, which presumes the Foucauldian notion of the knowledgeable subject, as a means of understanding professional practices.

3. An integrated view of communication

From the above discussion, communicative resources assume significance as part of clinical experience. But a narrow view of language and communication in stressing generic skill sets may fail to take into account individual clinical resources that a given professional-client dyad brings to the encounter. The skills approach in focusing on one-sided, recipe-style ‘what to do’ checklists tends to overlook how professionals and clients competently accomplish their communicative tasks along a diverse range of variables which define the clinical encounter.

Communication & Medicine is committed to a broad notion of language and communication, as well as an integrated notion of medical and healthcare practices. A starting point is the role of language, taking into account its multiple layers of meaning and its linkages with coexisting contexts. From a Foucauldian perspective, the very birth of the clinic is a discursive event—a process of categorization and re-categorization intertwined with knowledge and power issues. At the micro-level, what goes inside a clinic is also a discourse-led activity, much of which is conducted in language. According to Foucault (1973), language plays a prominent role in all stages of the medical process: from noting symptoms, questioning patients and describing physiological functions, to history taking and noting the progress of disease, to writing a prescription (and can be extended to medical case notes and the complaints procedure).

But communication, as is widely recognized within and outside of sociolinguistic, pragmatic and discourse analytic disciplines, is much more than language per se. This can be represented by using communication as a mnemonic:

- C** = Code (linguistic, visual, nonverbal etc.)
- O** = Orderliness
- M** = Message
- M** = Mediation
- U** = Understanding
- N** = Narrative style and structure
- I** = Inferencing and intentionality
- C** = Context (micro- and macro-levels)
- A** = Addressee and audience
- T** = Tone (feeling, evaluation, key etc.)
- I** = Identity, role and participant structure)
- O** = Objective goal
- N** = Norms (social, cultural, interpersonal)

Each point above requires an extensive gloss in its own right, but this is not the place to undertake such a task. In presenting such an overarching conceptualization of communication, I am not suggesting that every piece of communication analysis must attend to all the aspects mentioned above. It is more to draw attention to the need for being cautious in making categorical claims, while avoiding what might be called ‘the communicative fallacy’, i.e., treating language as a monolithic entity and equating surface labels of language with universal referents of meaning and experience. This poses a particular problem in categorizing interaction in order to satisfy the criteria of both empirical validity and ecological validity (Cicourel 1992). It is in this sense that communication is more than a set of generic skills: it is a dynamic and variable set of resources which are context-specific. Meaning is not unilaterally produced, but jointly constructed, often mediated by individual styles of performance. Multiplicity of potential meaning remains a necessary condition for communication and for the purposes of convergence on precise meaning.

From a scientific ideology (whether it is about disease or about language) we thus need to move to a model of communicative ecology. Cicourel (1992) has made the point about the ecology of context with special reference to the medical encounter. In order to go beyond communicative fallacy, a development of analytic sensitivity to the healthcare context is essential (Candlin 2003; Clarke 2003). The ‘communicative mentality’ in the professional sphere needs to be matched by the communication researcher adopting a ‘a clinical mentality’ as part of collaborative interdisciplinarity (Sarangi 2002). This may amount to interrupting one’s analytic stance (Mishler 1984). How, for instance, do we assess different interactional routines in different medical and healthcare practices? What counts as good communication in a primary care site may not be the same in palliative medicine. Active listening in therapeutic encounters can vary from what it means in other healthcare settings. What counts as nondirectiveness in genetic counselling may not be the same in antibiotics prescription. The sociolinguistic notion of ‘communicative competence’ and the conversation-analytic notion of ‘interactional competence’ need unpacking in context-sensitive ways to accommodate the processes and outcomes of different healthcare specialities. Communication research needs to go beyond being a tool box of analysis to produce evidence-based findings, and to contribute to the institutional, socio-moral and psychological understanding of healthcare delivery and management.

4. Wording and warding: A dozen or so challenges facing communication research in healthcare settings

This section is part personal indulgence and part

reflection on some of the ‘direct’ challenges I have confronted in recent years as a communication researcher committed to the crossing of professional boundaries in medical and healthcare settings.² I make an attempt to situate these challenges in the long tradition of discourse analytic and sociolinguistic studies of healthcare settings. It soon becomes apparent that these questions defy any quick-fix resolution; instead they raise serious epistemological and ontological concerns regarding disciplinary expertise, the role of experience in dealing with real-life problems, and the relevance of evidence-based research across professional boundaries and so on. I see these questions as a way of setting up a collaborative interdisciplinary research agenda, while also reflecting on the methodological and analytic practices as a communication researcher, especially dealing with naturally occurring clinical encounters.

The questions that follow cover issues of role relations, access, methodology, discovery and uptake. The short commentaries are not meant as definitive answers but as signalling how I have so far come to terms with them.

4.1. What do you call yourself?

This is a direct question about the identity of the researcher, about their expert status and their interpretive practices—ontologically and epistemologically. Both the source terms—discourse and communication—do not lend themselves to easy suffix extensions as is the case with psychology (psychologist), sociology (sociologist), anthropology (anthropologist). Nor is there the convenience of choosing a double-barrel specialist label as in the tradition of ‘clinical psychologist’, ‘medical sociologist’, ‘medical anthropologist’, ‘health economist’ etc. One alternative which I have discussed elsewhere (Sarangi 2002) is ‘discourse practitioner’ (as opposed to ‘discourse analyst’) as a way of establishing a manageable relationship with medical professionals. However, professionals differ greatly in their understanding of the term ‘discourse’, and may feel, as one medical colleague suggested, more comfortable with the label ‘communication analyst’. In an ongoing pilot study setting, and despite my corrective measures, I continue to be labelled as a ‘psychologist’. In a sense, this shows how from a (bio)medical perspective, the different humanistic and social scientific disciplines may be regarded as one residual category with different manifestations!

4.2. What is discourse (analysis)? We also analyze talk and text, how do you do it differently?

At the surface level this question requires a definition of discourse, but it is also about explicating one’s analytic mentality. ‘Discourse’ can be used very broadly to refer to abstract entities such as discourse of pain,

discourse of prevention, discourse of sexuality etc. In a more analytical sense, it can be paraphrased along the lines of Sherzer (1987: 297):

Discourse is a level or component of language use, related to but distinct from grammar. It can be oral or written and can be approached in textual or sociocultural and social-interactional terms. And it can be brief like a greeting and thus smaller than a single sentence or lengthy like a novel or narration of personal experience and thus larger than a sentence and constructed out of sentences or sentence-like utterances.

Following from this, and in the spirit of the Hymes' (1964) SPEAKING mnemonic (setting, participants, ends, act sequences, key, instrumentalities, norms and genre), the various component of discourse can be represented as follows (Sarangi 2003):

- D** = Description based on different units of analysis (sentence, clause, utterance, speech act, tone unit, speaking turn)
I = Inferences and Intentionality (implicature and presupposition; sense and force; what is said and unsaid)
S = Structure (sequential, thematic, rhetorical mappings); Style (narrative, argumentative, expository etc.)
C = Context (interdependence of micro- and macro-context; physical, behavioural, linguistic/indexical, extra-situational; figure-ground relation)
O = Orderliness (recognizable patterns of structure and style [genre and register]; principles of cooperation, relevance and politeness)
U = Understanding (negotiation of meaning; shared schemas; mutual knowledge)
R = Role-relationships (subject positions; social and institutional identities; power asymmetries; appropriation of voices; target audience)
S = Subjectivity (points of view, stance, authority and authenticity)
E = Evaluation/Evidence/Explanation

As indicated, the question is not just about the scope of discourse, it is also about methodology and how discourse analysis would differ from any other competing traditions of analysis.³ A related issue is to explicate the process of doing discourse analysis (e.g., the need for structural and thematic mapping of critical moments, see Roberts and Sarangi 2002), including the significance attached to data transcripts, the researcher's accountability to the data corpus, the nature of evidence in making claims etc.

4.3. *What are your tools of the trade and to what extent are these transferable across professional boundaries?*

Questions such as these refer to the credibility of discourse analysis as much as to where and how one begins and ends analysis. If we take as a basis of qualitative inquiry the grounded theory approach (Glaser and Strauss 1967) which proposes a constant comparison method in order to generate categories, how do communication and discourse analysts go about their interpretive practices? Parallel to the distinction made between 'scientific knowledge' and 'clinical knowledge', discourse analysis is both a scientific activity (with attention paid to linguistic, psychological, sociological constructs) and a practical resource (cumulative analytical knowledge which is not readily transferable). To what extent then are discourse analytic interpretations imbued with subjective signatures and 'motivational relevancies' (Sarangi and Candlin 2001)? In what ways can discourse analysis be a more objective exercise, allowing for inter-analyst reliability, and subsequently, generalizability and validity of findings?

4.4. *What are the main findings of discourse analysis over the last 3–4 decades?*

This question signals the widespread unfamiliarity of medical and healthcare practitioners with discourse analytic research. It is also a genuine question about discovery within a discipline so that its usefulness can be gauged. Discourse analysis, generally speaking, is better at discovering patterns of occurrence at the descriptive level, which may come across as a reductionist enterprise to be of practical relevance. Equally, an overt critical stance to a limited data corpus can pose problems of generalization and reliability. There is no doubt that many of the core findings of discourse analysis can be extended to professional practice across specialities. Here are some examples: Cicourel's (1987) work on cognitive processes involved in diagnostic reasoning; Maynard's (1991) discovery of a perspective-display-sequence at the stage of delivery of bad news; Heritage and Sefi's (1992) identification of a step-wise approach to advice giving in the health visiting setting; and more generally, Mehan's (1983) finding that 'presentation' and 'elicitation' modes are strategically recruited in the context of institutional decision making. At one level, these sound as generic findings in need of more empirical research, with particular attention paid to specific medical conditions and interactional landscapes.

The general thrust here is the nature of the relationship between discovery and usefulness, i.e., the extent to which discourse-analytic findings are sensitive enough to current modes of professional practice.⁴ On the one hand, it is sometimes likely that

what is painstakingly discovered through a discourse analytic lens was already known to a professional group, thus making the discovery far from newsworthy! Or, what is discovered may not be seen as useful for professional practice. Concerns such as these have their origin in what has been selected by the researcher as a site of engagement. There have been occasions when my very interest in the study of micro-processes of interaction—e.g., in an institutional decision making setting—has not been welcomed. The concerns raised are cast in utilitarian terms: Why should I be interested in the micro-processes of decision making, if the ensuing analysis is not targeted at benefiting the participants in real-life terms. I have been intrigued in some instances by medical colleagues hinting at the irrelevance of analysing clinical encounters in the first place. This may come as a surprise for those of us committed to the analysis of naturally occurring data. Instead the suggestion has been to base studies on interviews and get inside the minds of patients as a way of filling the professionals with what they want to know, although in a social-constructionist mode one may suspect the very nature of such elicited data. But a real challenge remains for communication researchers to report something which is both a discovery and can be potentially useful. This is perhaps better helped through processes of joint problematization, motivational looking and collaborative interpretation (Sarangi 2002).

4.5. *What are you looking for?*

An open-ended research design, including the absence of a rigid study question, can be characteristic of ethnographic and discourse analytic work. But such openness may be responded to by professional practitioners and clients with a sense of discomfort, possibly giving the impression that ‘anything goes’ at the level of data collection, selection of data extracts for close analysis and the analytic orientation that is brought to bear on the data corpus. An overarching flexibility then becomes a potential weakness when it comes to engaging the practitioners and clients during the research process and while making generalizations in order to facilitate the uptake of findings. A possible corrective measure is to maintain purposeful sampling because of practical considerations, but have a rigorous mechanism in the selection and analysis of data corpus, aided by software-based parsing where possible. The anomaly between the recording of naturally occurring interactions and the withholding of specific research questions needs to be minimized as far as practicable.

4.6. *Is this what you call data, and by extension, is this what you call evidence?*

When communication researchers arrive at professional sites, armed with audio/video recording equip-

ment and also armed with answers to questions about the observer’s and equipment’s possible effect on the data, they seem to think that access is negotiated beyond doubt. In a collaborative, interpretive framework, this is only the beginning. The arrangements for recording of a clinic session goes beyond the traditional concerns of the observer’s paradox, i.e., we can only get authentic data when we are not observing an interaction (Labov 1972). To this we can add, the notions of ‘participant paradox’ (the activity of participants observing the observer) and ‘analyst’s paradox’ (the need to obtain professionals’ insights on their practice as a way of informing discourse analysis).⁵ The status of the data transcript based on the recording is another matter for further negotiation. As one of my professional colleagues remarked when I presented her with a transcript of her own counselling session, ‘Is this the transcript you are going to base your analysis on? I can’t see any relation here to what actually happened and what I still remember about this consultation. Where are the emotions, feelings etc?’ By questioning the very data which the discourse analyst has to use to substantiate his/her knowledge claims, the professional practitioner is not only challenging the linking of data transcripts as direct evidence of discursive claims, he or she is already distancing him or herself from the research outcomes and their trustworthiness. This means that one has to acknowledge that a transcript as an artefact is necessarily reductionist, and is interpretively biased (Ochs 1979), while making an effort to initiate the professional into a new mode of research practice.

4.7. *Is this how you categorize our professional practice/identity?*

Coding and categorization are an essential part of communication analysis. While some analytic frameworks impose external categories in their search for systematic patterns, others favour categories internal to the data being analyzed. For instance, both the grounded theory approach and the ethnomethodological approach insist on the emergence of categories from the data. However, notwithstanding how the categories are derived, at times the very labels attached to such categories can be problematic and may require instant negotiation so as not to alienate the practitioner-collaborators and the wider professional readership (Sarangi et al. 2003).

4.8. *Do you think this could have been asked/said differently?*

Following from the different paradoxes listed above, the role relationship between the expert-observer and the professionals and clients in the naturally occurring setting is a tricky one. The researcher may find him or herself in a tension, oscillating between the observer role and the consultant/expert role, especially when

some form of evaluative feedback is requested. This warrants what can be called ‘hot feedback’ in a practically relevant sense (Clarke 2003; Sarangi and Candlin 2003a), thus blurring the boundaries between the spheres of research practice and dialogic participation.

4.9. *Can discourse analysis validate assessment of communication skills in examination settings?*

In light of my observations earlier about communication skills assessment in many medical curricula, there is the opportunity for micro-level discourse analysis to evaluate the criteria professional examiners routinely use to assess the communication skills of medical students. An example of this is reported in Roberts and Sarangi (2002). The strategy here is to look closely at the successful and unsuccessful performances and come up with communicative maps to identify any differences. A more recent experience concerns my involvement in a palliative medicine programme. There are general issues surrounding the appropriateness of validation by outsider experts. The professional examiners are likely to be suspicious about a communication researcher’s exact expertise. The examinees are perhaps less threatened by the presence of an external agent. On this occasion, when I was introduced to the group in the briefing session as ‘a professor in linguistics’, a candidate (from the Middle East) approached me and said: ‘I speak English slowly, would I be marked down for this?’ Although ‘slowness in speech’ was not something I had as part of my appraisal scheme, little did I know then that slowness of speech can be an invaluable asset for active listening in the palliative care context. This ongoing work is already revealing consistently different patterns of thematic involvement across the good and poor performances, and in this sense validating the examiners’ assessment criteria.

4.10. *Does discourse analytic work have predictive validity?*

This question goes beyond the descriptive stance of communication/discourse analysis. Predictive validity presupposes close attention to specific details. The perceived need is one of evaluation of practice, but achieved through sophisticated description. It then becomes necessary to be specific about the study question, being aware of the intervening variables, one’s target users etc.

4.11. *What is the uptake of discourse research?*

In addition to addressing issues of methodology and interpretive frameworks, a related issue concerns the communication of research findings in accessible ways. The language of discourse analysis can become another potential barrier, especially when the analytic stance makes the source data incomprehensible,

whether through the imposition of analytic categories or otherwise. Collaborative interpretation and writing are already evidence of potential uptake. Targeting one’s work to professional colleagues which generates peer appraisal can be one way of receiving feedback on potential uptake (Roberts and Sarangi 2003). Let me mention here a recent experience. A jointly authored article submitted to a professional journal received feedback from a practitioner reviewer along the following lines: ‘I personally found the data heightened my awareness of my own practice. Evidence of struggle to engage clients in reflection was very reassuring! This paper is unlikely to change practice but may provide a framework for people to reflect on their own practice.’ Such feedback is equally reassuring for the communication researcher. This is also evidence of indirect uptake, achieved through reflection.

4.12. *How do I justify relevance and generalization based on my study question and some interview data?*

This final question is on a different footing, as discourse analytic methodology begins to be embraced by healthcare professionals. There seem to be two accompanying difficulties: the lack of systematic training in discourse analytic methodology; and the persistence of a positivist, empirical attitude to research protocol. A medical colleague is in the process of conducting a pilot study about patients’ and carers’ attitudes towards resuscitation based on structured interviews. Her concern was that the sample was not representative, that she only had free time to collect data over the weekends and that not every question was responded to in the same way (in other words, some subjects went off the topic to talk about other concerns). So, is the data of any use? All qualitative research projects generate irrelevant data, and the burden of such data particularly is felt in its complex richness. It is therefore justified to regard any data as valid in a loose way, with the hope that the data will reveal something if analyzed rigorously, that emerging themes can be identified across temporal and spatial dimensions and turned into a coherent finding.

The main points raised by the above questions and commentaries can be summarized as follows:

1. What knowledge do communication researchers bring to bear on their understanding of other professional practices? How can the discourse practices of communication researchers be informed by the personal knowledge of professional practitioners—i.e., what constitutes understanding, belief, experience, practice and action?
2. To what extent are communication researchers able to access the knowledge/belief systems of professional practitioners through a study of their communicative ecologies? How does one avoid

extreme reductionism in the interpretation of local practices?

3. In what ways can communication researchers claim practical relevance for their interpretive and interventionist work? Will a utilitarian research goal require one to go beyond the description of surface-level discourse and to acknowledge the problem of providing an evidential link between observable communicative practices and tacit knowledge systems?
4. What can be learnt by making the communication researcher a part of the process of our inquiry?

5. A word about the title and the subtitle and the first table of contents

During the pre-launch period of this journal a wider consultation was undertaken to decide on the title. It is worth emphasizing that the focus of this journal is on 'communication'—both as a discipline and as a methodology. Although 'medicine' is paired with 'communication' in the main title as a way of signalling the primary addressee, the subtitle encompasses all aspects of social sciences, healthcare and ethics. The table of contents of the inaugural issue—reflecting a thematic and methodological spread—is only partially representative of the journal's ambition. It is very much hoped that the content matter to be covered in the years to come will go beyond a narrow definition of medicine and accommodate different analytic frameworks of communication research in health and social care. The journal will cover as diverse areas as medical discourse, medical education, clinical practice, primary care, specialist care, public understanding of health and illness, psychotherapy, psychoanalysis, counselling, nursing and medical ethics. It also aims to go beyond healthcare as such and include social care and address practical and intellectual concerns at both the micro-level and the macro-level. The forum discussion paper by Mishler in this issue is indicative of not only the breadth of coverage, but also of the style and format of presenting scholarly arguments.

A new journal in this field is a step towards bridging the interdisciplinary gap and in helping to expand health professionals' awareness of communication issues on a holistic and ecological plane. I take this opportunity to invite scholars across disciplinary and professional boundaries to engage with, and extend, the research agenda of *Communication & Medicine*.

Notes

1. This list is necessarily selective. It may be that all the scholars may not categorize themselves as language/communication researchers, but the works listed do have a strong language/communication orientation.

2. I have chosen not to reveal the identity of the questioners, but would like to acknowledge their part in the framing of the questions. I have benefited from discussing these questions as part of two different plenary lectures at two conferences: Knowledge and Discourse (Hong Kong 2002) and Communication, Medicine and Ethics (Cardiff 2003).
3. This is not to downplay the different traditions of discourse analysis, which will continue to receive disciplinary attention. But such debates may be of limited relevance to professional practitioners.
4. The temporal dimension is an important one, as the data corpus under examination may be outdated for any content-based findings. In a recent teaching session on counselling and advice giving based on Heritage and Sefi (1992), which I was sharing with a medical colleague, it was drawn to my attention that the content of analysis about the sleeping position of babies was no longer subscribed to by the medical profession. A more serious point here is that students in discourse/communication classes may inadvertently pick up the content of a given data transcript instead of the analytical stance.
5. I have discussed these three paradoxes elsewhere (Sarangi 2002). It is worth noting that research participants may have more concerns about how their interaction is going to be analyzed rather than about being recorded as such.

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