

**Impact of Applied Linguistics in Healthcare Workshop**

**Janus-Faced Translational Research in  
Health Communication: Some Reflections**

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JANUS-FACED RESEARCH-PRACTICE INTERFACE



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RESEARCH-PRACTICE INTERFACE

- In Roman mythology **Janus** is the god of beginnings and transitions – of gates, doors – two-faced as he looks to the future and the past.
- The month of January is named in honour of Janus by the Romans.
- The imperative to consider **the impact of applied linguistic research in healthcare** affords the opportunity to reflect on our research ethos and professional practice.

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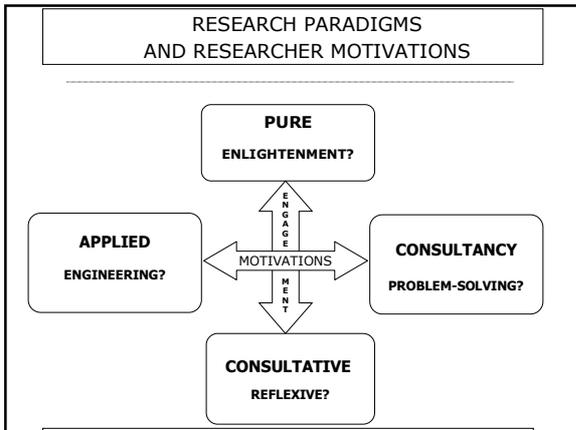
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TRANSLATIONAL RESEARCH

- **'Translational Research'** (Translating Research into Practice [TRIP]) is another name for **'Applied Research'** – the **IMPACT** factor – couched in **the sequential modality** (first find, then apply) that needs critiquing.
- Applied research is the name of our game under **Applied Linguistics** (e.g., forensic linguistics, education/literacy studies; health communication; interpreting/translation studies).
- There is a particular challenge for **translating qualitative research** to inform evidence-based professional practice.

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QUANTITATIVE-QUALITATIVE PARADIGMS

- A close affinity exists between quantitative/experimental research paradigms and knowledge/evidence-based professional practice.
- The claim that quantitative research is reliable: Researchers can attain inter-rater reliability during the coding procedure (etic), but it does not necessarily address issues of validity as far as participants' meaning-making actions are concerned (emic).
- Issues of reliability and validity are equally pertinent for qualitative research as they are for quantitative research – how to make qualitative communication research count!

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QUANTITATIVE-QUALITATIVE PARADIGMS

- In the context of healthcare discourse studies, Waitzkin (1991) summarises the drawbacks of both quantitative and qualitative paradigms:
- Quantification studies, while being costly and tedious to carry out, cannot deal with the complex, deep structure of interaction as they **systematically disregard underlying themes in context-sensitive ways.**
- In qualitative studies the selection procedure and text presentation is not straightforward and **interpretation is difficult to evaluate.**

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TRANSLATIONAL RESEARCH

• **Turning back to Janus-faced:**

What about Translating Practice into Research [TPIR/TraPiR] via joint problematisation, collaborative interpretation, hot feedback?

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REPORTING THE IMPACT VALUE OF SOME STUDIES

- Communication in healthcare curriculum: a scoping exercise at Cardiff University
- Membership examination of Royal College of General Practitioners
- Antibiotics (non)prescription
- Collaborative research as marriage: The case of genetic counselling in Cardiff

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**THE CALL FOR  
(RE)HUMANISING  
MEDICINE/HEALTHCARE**

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REHUMANISING MEDICINE

- A word on **(Re)** – does not have an historical connotation to suggest that past medical practice was more humane and somehow modern medical practice has lost the humane pathway – it's more a rhetorical matter of emphasis.
- **Biomedical research and clinical practice: the dominant paradigm** – Biomedical research is not always driven by a clinical mentality.
- "The emphasis in medical research has slowly shifted from **the study of disease at the level of patients or their diseased organs to the study of their cells and molecules.**" (Weatherall 1995: 228) – a kind of reductionism, possibly biological determinism.

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REHUMANISING MEDICINE

- There is an **anomaly** in terms of success in symptoms management and prognosis but failure in understanding disease causation and prevention/cure – leading to a dehumanising effect.
- Increasing **bureaucratisation** and **biotechnologisation** contribute towards a dehumanising tendency.

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REHUMANISING MEDICINE

- As medical practice moves **from being an art to being a science**, there are adverse effects on patient care.
  
- The era of **post-normal science**: 'soft' scientific facts and 'hard' moral/ethical values, (Funtowicz and Ravetz 1992).

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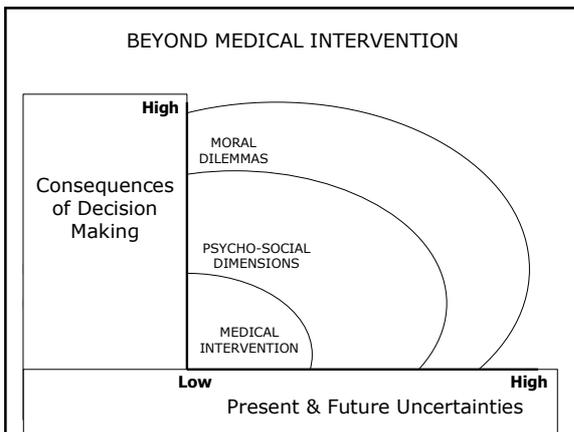
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REHUMANISING MEDICINE

- **Biomedicine and paradigm shifts: humanist and communicative turns**
  
- **Engel (1977)**: In pointing out the reductionist and exclusionist tendencies characteristic of the biomedical model, Engel (1977) called for a paradigm shift as a way of stressing what he called the '**ethnomedical perspective**' (Fabrega 1975) that pays adequate attention to the '**biopsychosocial**' dimension.
  
- **Good & Good (1981)**: the '**cultural hermeneutic model**', according to which 'human illness is fundamentally semantic or meaningful'. (cf. Good 1994)

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REHUMANISING MEDICINE

- **Mishler (1984): Medicalisation: voice of medicine** (the technical-scientific assumptions of medicine) colonising **the voice of the lifeworld** (the natural attitude of everyday life) (see also David Silverman [1987] and Howard Waitzkin [1991]).
- **Demedicalisation** (Silverman 1987) may not be an indication of humanisation/empowerment, but indifference and shifting of responsibilities.

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REHUMANISING MEDICINE

- **Narrative-based medicine** (Greenhalgh and Hurwitz 1998) rooted in the biopsychosocial model (Engel 1977) and the cultural hermeneutic model, gives patients the power and agency to understand and speak about their illness experience (Good 1994).
- A shift in patients being understood as 'unknowing bodies' to being regarded as people with autonomy, subjectivity, agency (Sullivan 2003); Patient-centredness as moral philosophy (Epstein et al 2005)

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REHUMANISING MEDICINE

- Narrative is equated with patient-centredness: Lyotard (1984) distinguishes between **scientific knowledge and narrative knowledge** – the latter requires a three-fold competence: 'know-how', 'knowing how to speak' and 'knowing how to hear' (cf. Clark and Mishler 1992: the case of the 'black-eye').

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REHUMANISING MEDICINE

- The recent calls for narrative-based medicine emphasise the relevance of active listening, but does not recognise the fact that there might be problems with patients' ability to produce coherent, intelligible narratives.
- Patient-centred models are measured by the number of open questions asked (Henbest and Stewart 1990) and assume that doctors can unproblematically elicit symptoms, feelings, ideas and expectations and discuss the nature of the problem and possible action.
- In a linguistically and culturally diverse patient population, talk itself may be the problem.

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REHUMANISING MEDICINE

In 1979, **Shirley Brice Heath** offered an historical overview of the evolution of the medical profession in USA (between 1840 and 1960):

- "The focus on rehumanizing medicine has led to calls for improved clinical practice and greater attention to interaction skills in medical education. Doctors and medical education specialists have tended to view **the patient-physician relationship as a 'social interaction'**... In many ways, the clinical phase of medical training can incorporate research on communication." (p.111)

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THE COMMUNICATIVE RELATIONSHIP  
BETWEEN PROFESSIONAL & CLIENT:  
THE CONUNDRUM

Good Professional = Good Communicator?

CONTEXTUAL VARIABLES

Good Communicator = Good Professional??

Communication is not just 'talk/text' to clients;  
there is also 'talk/text' about clients as well as  
interprofessional communication

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**THE POSTGRADUATE  
COMMUNICATION TEACHING  
SCOPING EXERCISE**

Is there room for communication  
in the PG curriculum?

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PARTICIPATING SCHOOLS

School of Pharmacy

School of Medicine  
Institute of Medical  
Genetics

School of Healthcare  
Studies

**HCRC**  
HEALTH COMMUNICATION  
RESEARCH CENTRE

School of Nursing &  
Midwifery Studies

ENCAP

School of Medicine  
Palliative Medicine

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HOW IS COMMUNICATION CONCEPTUALISED?

- **The first wave:** Communication as a skill-set – confined to oral interaction between professionals and clients.
- **The second wave:** Communication skills cannot be taught independent of consulting skills. There is no evidence that communication skills teaching makes a difference.
- Communication across the curriculum as a response to the limitations of recipe-style skills training: from itemised skills to skills clusters.

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HOW IS COMMUNICATION CONCEPTUALISED?

- In favour of theme-driven curriculum: Communication now integral to other modules (e.g. diagnostic reasoning, compliance, multi agency/multi professional work)
- This marks a shift in communication as a skill to communication as a host of variables (gender, power, expertise, difficult patient etc.)
- The potential disadvantage associated with the shift of communication from 'figure' status to 'ground' status
- The risk of 'taken-for-grantedness' in the midst of professional concerns

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MAKING DISCIPLINARY CONNECTIONS

Progressive calibration of communication competencies expected of students at different end-points

- **'I have done that'** syndrome: the risk of duplication of input, thus making it **non-cumulative**
- **'Communication is a joking matter'**: possible trivialisation when drawing attention to basics without content (e.g., nonverbal, dress code etc.) and ignoring other professional communication trajectories.
- How to ensure adequate communication analytic input?
- Possible solution: Progressively incorporate complex variables: client-professional to multi-party encounters to multi-professional decision making to managing difficult consultations (complex diagnosis, ethnic/cultural differences etc.); joint-teaching

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**RESEARCH CONSULTATION  
WITH THE ROYAL COLLEGE OF  
GENERAL PRACTITIONERS**

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RCGP RESEARCH CONSULTATION

- Researcher as invited vs. imposed upon; value of consultative research
- Issue-driven: Potential discrimination in membership examinations
- Invitation to study the examination process, including the oral interview via audio-/video-recorded data
- Oral examination as a hybrid activity: Tensions between and differential management of three modes of talk: **institutional, professional and personal experience**

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RCGP RESEARCH CONSULTATION

- Assessment of talk about research and practice (institutional) vs. display of practice (professional)
- Challenges faced in communication of research findings: Ambivalence in what the MRCGP examination was assessing: good medical practice or good interview practice?; How does expert communication analysis differ from examiners' evaluation of communication?
- Outcomes: Changes in the mode of the examination: case log books giving way to videos of consultation, followed by examiners being trained in video analysis.

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**ANTIBIOTICS  
(NON)PRESCRIPTION**

**When talk is cheaper**

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CONTEXT

- A group of GPs (with academic interest) approach SS, concerned about over-prescription of antibiotics for upper respiratory track infection (URTI) of children, possibly caused by parental pressure and/or GPs not eliciting patient expectations.
- Preliminary analysis based on 50 each of prescription (PR) and non-prescription (NPR) cases (audio-recorded and transcribed):
  - NPR usually longer in duration than PR;
  - NPR consultations are more loosely structured than PR ones, with elaborate and complex explanation and assessment of symptoms.
  - Physical examination is undertaken sooner in PR compared to NPR cases

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Interactional Trajectory for PR04

- Opening (1-4)
- Symptoms (5-9)
- Treatment (10-14)
- Symptoms (14-16)
- Examination (16-20)
- Diagnosis (20)
- Treatment (20-28)
- Symptoms (28-31)
- Treatment (32-36)
- Closing (37-39)

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Interactional Trajectory for NPR03

- Opening (1)
- Symptoms (2-26)
- Treatment (27-31)
- Symptoms (31-40)
- Examination (41-43)
- Symptoms (44-51)
- Treatment (52)
- Examination (53-54)
- Causal explanation (55)
- Symptoms (56-58)
- Examination (59-63)
- Non-medical (64-65)
- Symptoms (66-72)
- Causal explanation (73-83)
- Treatment (83-85)
- Symptoms (86-92)
- Treatment (93)
- Symptoms (94-98)
- Miscellaneous (99-101)
- Treatment (101-115)
- Closing (116-121)

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STRUCTURE OF PHYSICAL EXAMINATION

- Through thematic and interactive mapping of the communicative trajectories during physical examination, the following six nodes are identified:
  - online commentaries
  - directives concerning modes of examining
  - relational rapport
  - interpretive summaries, indications of potential diagnosis
  - offline commentaries, i.e., general explanations about causation and (non)treatment.

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(NON)PRESCRIPTION OF ANTIBIOTICS

- In paediatric consultations both online and offline commentaries function rhetorically in anticipation of future action plans.
- The offline commentaries seem to anticipate non-prescription.
- Shifts between online and off-line commentaries foreground the doctor's pedagogic role, while positioning the parent as an expert and spokesperson for the children.
- The findings provide useful insights for medical educators and trainers of practitioners.

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**GENETIC COUNSELLING  
RESEARCH IN CARDIFF**

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FAMILY-CENTRED  
RISK COMMUNICATION  
IN GENETIC COUNSELLING

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SELF-OTHER ORIENTATIONS IN GENETIC COUNSELLING

- The familial basis of genetic conditions:  
  
‘When an illness or a pathology is thought of as genetic, it is no longer an individual matter. It has become familial, a matter both of family histories and potential family futures’. (Novas and Rose 2000:487)
- Decisions About Testing (DAT) and Decisions About Disclosure (DAD) are two critical moments in genetic counselling process which involve ‘family others’.

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RISK INFORMATION/COMMUNICATION/COUNSELLING

- Focusing on risk in genetic counselling – we can talk about
  - **risk information/explanation;**
  - **risk communication** (inclusive of understanding);
  - **risk counselling** (inclusive of orientation to clients’ anxieties and concerns, their autonomous decision-making capacities, professionals’ commitment to non-directiveness etc.)

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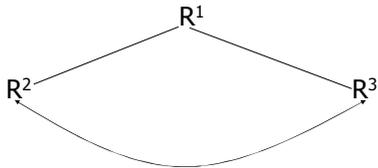
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BETWEEN RISKS OF KNOWING, DISCLOSURE & OCCURRENCE IN GENETIC COUNSELLING

- Unwanted event – Risk of disease occurrence ( $R^1$ ), Risk of knowing ( $R^2$ ) and Risk of disclosure ( $R^3$ ) – Risks of knowing and disclosure requiring a counselling mentality that puts the client at the centre of decision-making.



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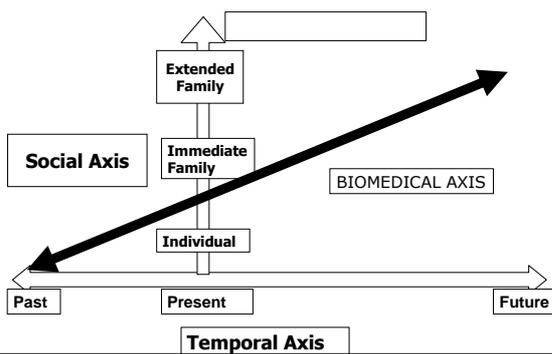
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THREE AXES OF RISK ENGAGEMENT



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**COLLABORATIVE RESEARCH IN GENETIC COUNSELLING:**

**Developing a long-term partnership**

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MILESTONES IN PARTNERSHIPING

- **Interest at first sight:** Accidental meeting under the auspices of The Partnership Board
- **The first date:** Follow-up agenda – shared but unfulfilled interests
- **Stalking:** Motivated shadowing and appropriating each other’s practice (visits to clinics; learning to be social scientist)
- **Engagement:** Successful research grants

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MILESTONES IN PARTNERSHIPING

- **Marriage and honeymoon:** Publications and presentations across disciplinary boundaries, even risking RAE/REF configurations
- **Long-term commitments and compromises:** negotiating coding and interpretive practices; hot feedback; teaching and supervisory input (including joint ESRC-MRC studentship); collaboration with the next generation of professional practitioners
- **Uptake of research** (Continuing Professional Development [CPD] questionnaire) – Journal of Genetic Counselling

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**CONCLUSION**

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CONCLUSION

- Transparency of research practice before translatability of findings
- Different layers of analytic expertise – striving towards discrimination expertise (Collins & Evans 2002)
  - discriminating between **discovery** (professional discourse studies) and **usefulness** (applied linguistics);
  - discriminating between different traditions of discourse analysis in relation to their analytic focus and usefulness;
  - discriminating between variations of professional practice and account for such differences in terms of discursal evidence.

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CONCLUSION

- **Against disciplinary self-indulgence:** Real-life problems do not come packaged in disciplinary nuggets; growing need for dialogic collaboration between researchers and practitioners.
- **Breaking the sequential mould:** first find and then recommend; joint problematisation and provision of hot feedback; negotiation of educational/training programmes.
- **Breaking the individual mould:** in search for cumulative evidence, based on clusters of projects/findings on nominated topics.

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CONCLUSION

- **Unlocking the black box of professional communication:** Transfer of 'key' analytic insights (and methodology) to the profession, rather than findings per se; from knowledge transfer to knowledge exchange.
- **Towards responsible mediation:** Undertaking problem/practice-led (consultative) research; Designating 'communicating research' as a topic of research; need for negotiating different formats and forms of dissemination.
- **Research-led teaching & professional development at the sites of research:** findings arising out of a given site are more likely to lead to uptake (fulfilling both 'discovery' and 'usefulness' criteria).

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CONCLUSION

- Healthcare communication is constitutive (not an additive layer) of expert knowledge manifest in its scientific, clinical and organisational dimensions (Sarangi 2004).
- Healthcare professionals have explicit and tacit levels of knowledge about interactional complexity in their specific professional settings.
- Communication researchers may have analytic expertise, but could lack content- and context-specific knowledge – which can be minimised through long-term ethnographic and collaborative interprofessional research.

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COMMUNICATION IS MORE THAN A SET OF DIY SKILLS

- **Communication is not a PILL:** Limitations of recipe-style training in A-to-Z of communication skills which treats symptoms rather than causes; one-sided view of communication where the patient remains absent; potential for de-skilling.
- **Communicative Competence is not a driving licence that one passes for life:** need for ongoing appraisal to reflect on new challenges.
- **Communicative Fallacy:** Models of medical interaction analysis work with a notion of form-function equivalence (e.g., open questions = patient-centredness) and thus ignore context sensitivity of language use

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COMMUNICATION IS MORE THAN A SET OF DIY SKILLS

- Following Schön (1987): **communication ... becomes over-proceduralised** through which 'we drive out wisdom, artistry and the feel for the phenomena' all of which depend on 'judgment' and 'discretionary expertise'.

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CONCLUSION

- Returning to Shirley Brice Heath (1979):
- "The need is there for both linguists and medical personnel. Firth (1978) suggests that the fact that both anthropologists and physicians share a common curiosity about 'the human condition' brought their research together. Professionals in human services delivery systems and linguists share a common curiosity about communication – what it is, how it works, how we learn to make it work. Perhaps in the next decade, this common curiosity will bring them together..." (pp.114-115)

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CONCLUSION

- There is a common thread between clinicians and ethnographers. As Kleinman (1988) says: 'Master ethnographers and clinicians, though their work is quite different, nonetheless tend to share a sensibility. They both believe in **the primacy of experience**. They are more like observational scientists than experimentalists. Like the poet and the painter, they are strongly drawn to the details of perception'.

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CONCLUSION

- Clinicians place themselves 'in the lived experience of the patient's illness', and 'this experiential phenomenology is the entrée into the world of the sick person'. Kleinman (1988:232), however, warns that unlike the master ethnographer, the clinician-turned-mini-ethnographer has '**a therapeutic mandate** demanding that he must choose and act in behalf of his patients'.

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CONCLUSION

- According to Weatherall (1995: 329):  
“Achieving the balance between a scientifically based medical education and one that introduces these new approaches to training more caring and socially aware doctors – all without overcrowding the curriculum – is the major problem that faces medical education today.”

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