

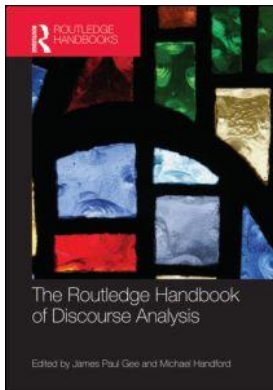
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Discourse and healthcare

Kevin Harvey and Svenja Adolphs

Introduction

In this chapter we explore the interrelation between discourse and healthcare. Health communication is a broad field of enquiry and practice, and so we will restrict our focus to health communication research that is concerned with naturally occurring linguistic routines (as opposed to more abstract, theoretical approaches to health communication and approaches which seek to identify and describe, if possible, what constitutes effective health communication). We take the phrase ‘discourse’ to refer to stretches of ‘contextually sensitive written and spoken language produced as part of the interaction between speakers and hearers and writers and readers’ (Candlin *et al.*, 1999: 321). Thus our focus is on discourse as a linguistic practice rather than on discourse as conceived by social theorists—that is, on discourse ‘as ways structuring areas of knowledge and social/institutional practices’ (p. 323). Like other linguistic practitioners who interrogate discourse (Kress, 1988; Fairclough, 1992), we, too, conceive of language as not merely reflecting ‘entities and relations in social life’ but actively contributing to their construction and constitution (Candlin *et al.*, 1999: 323). With regard to healthcare and health communication, language plays a significant part in constituting practices that take place within a range of medical settings, and, as we seek to demonstrate in this chapter, discourse can be seen as a central activity within the context of healthcare that helps to determine successful (or otherwise) outcomes and patient satisfaction.

What is health communication?

Health communication, by definition, refers to all aspects and modes of communication that take place within medical contexts or broadly relate to the subject of health and illness. Accordingly, health communication is an all-embracing concept, which takes into account a huge and diverse range of communicative activities touching on health and healthcare, ranging from personal accounts of health and illness and encounters with medical professionals through to health policy documentation and side effects information presented on drug packaging. Notwithstanding its broad subject matter, health communication also constitutes various modes of communicative practice, including spoken and written language, as well as new and emerging forms of communication, such as email, electronic bulletin boards and online health forums: electronic modes of communication that could be characterized as being ‘hybrid’ or ‘centaur’ (Baron, 1998), discursive forms that possess textual characteristics of both the spoken and written modes.

Alongside the sheer amount of discursive activities that potentially fall under the umbrella of health communication, it is also important to note that healthcare (and, concomitantly, the communication that takes place within healthcare contexts) is constantly in flux, and it is through

discourse that it is possible to see exactly what changes are taking place and in which direction. For example, in the context of US and UK medicine, the last decade has witnessed some profound changes in healthcare policy and practice, changes, in particular, stemming from the concepts of patient empowerment and patient-centred medicine (Brown *et al.*, 2006: 30), and such changes are realized in shifts in contemporary discursive practices. For instance, the term ‘client’ has, in some domains of healthcare, supplanted the more traditional, if paternalistic, appellation ‘patient’, a linguistic shift that reflects the consumerist and choice-inspired ideology at the heart of much western healthcare practice. Similarly, although the GP-patient consultation is, by necessity, restricted to a short period of time (in the UK, for instance, the average time is typically no more than 10 minutes), counselling-based approaches to medical interaction are being adopted by a range of health professionals. Such approaches place emphasis on the autonomy of the patient (or ‘client’) and on shared decision-making, involving, in some instances, the practitioner’s use of open questions that allow the patient to take the floor and set the topical agenda and the professional’s showing of empathy towards the patient (Fairclough, 1995: 192; Babaul-Hirji *et al.*, 2010). Contemporary healthcare, then, can be seen to be moving from a paternalistic model of medical practice, in which the healthcare professional is seen as responsible for the health of patients/clients, to a patient-centred practice, in which the patient shares in the decision-making process. These changes can be examined with regard to how communication actually takes place in clinical settings.

Whatever the changes that are affecting contemporary medical practice may be, the very nature of healthcare unavoidably involves communication between various participants. As Sarangi (2004: 1) observes, the clinical encounter between professionals and patients is a communicative relationship. Communication is a central aspect of health and healthcare provision, especially, as Sarangi points out, in terms of how discourse produces a cause and effect, given that the professional causes the patient to adopt or modify certain behaviours. The contemporary focus on discourse and communication in healthcare (both from practitioner and scholarly perspectives) has witnessed a ‘communicative turn’ in medical practice, which recognizes the limitations of a biomedical model of health and illness (Sarangi, 2004: 3). Consequently, rather than emphasizing the technical, scientific assumptions of medicine, much contemporary research in health communication now emphasizes patients’ voices and perspectives, personal narratives of health and illness. Such research prioritizes the role of discourse in patients’ accounts of health and illness, exploring the discursive means by which people articulate and make sense of their condition. In this chapter we will consider some of this discourse-based research, examining the function and significance of discourse in medical exchanges.

What are the key studies in the area?

There exists a wide-range of discourse-based research into health communication. Consequently, in this section we will confine our attention to identifying a limited number of studies, studies nonetheless that aim to provide a representative survey of the type of research that is currently being conducted in the field. We conclude this section by providing a more in-depth overview of a specific example of health communication in the context of mental health, illustrating the practical relevance of discourse-based research in contemporary healthcare.

Health communication has attracted attention from a wide range of disciplines such as health services, ethics, psychology, social sciences, anthropology, media studies and linguistics—to cite but a few. In particular, research on communication in healthcare settings has, over the last 30 years, contributed significantly to the study of health practitioners and patients (Sarangi, 2004: 2). Although, as many commentators have pointed out, the analytical focus of a substantial amount of this research has been exclusively on doctor–patient interaction (ten Have, 1995; Atkinson,

1999; Candlin, 2000), there exists a diverse and ever-increasing body of enquiry into medical discourse. Such diversification, for example, has considered the verbal routines of a variety of non-physician personnel, including nurses (Crawford *et al.* 1998), physiotherapists (Parry, 2004) and pharmacists (Pilnick, 1999)—as well as exploring written medical discourse in various communicative contexts such as medical note taking (Van Naerssen, 1985; Hobbs, 2003), case histories (Francis and Kramer-Dahl, 2004) and patient information leaflets (Clerehan and Buchbinder, 2006). Though these discourse-based studies are diverse and wide-ranging, what they have in common is a close focus on language *in situ* and the consequent pointing up of the role of discourse in the practice of medicine and health care (Sarangi, 2004: 2).

Methodologically, much of the aforementioned research has taken, broadly, an applied linguistic perspective (featuring conversation analysis, text analysis and critical discourse analysis). These perspectives have provided promising points of entry into the interrogation of medical practice. Moreover, many health discourse studies have combined perspectives, utilizing theoretical eclecticism in order to understand complex human communication better (Jeffries, 2000). There has been, for example, as McHoul and Rapley (2001) observe, a recent tendency for conversational analysis and interactional sociolinguistic methodologies to be supplemented by a strain of critical discourse analysis, the research impetus being as much to criticize and change practices in healthcare settings as to describe and understand them (e.g. Loblely, 2001; McCarthy and Rapley, 2001; Francis and Kramer-Dahl, 2004).

A good illustration of this strain of research, which seeks to alter clinical practice, can be found in discourse-based studies that interrogate mental health communication, particularly in psychiatric and counselling-based contexts (e.g. Telles Ribeiro, 1996; Palmer, 2000; Madill *et al.*, 2001). Given that a number of key therapeutic activities such as assessment, diagnosis and intervention within mental health are conducted through face-to-face interaction, analysis of spoken discourse is well suited to empirically examining the verbal exchanges that constitute these various activities. Indeed both researchers working outside mental health and practitioners within have increasingly utilized discourse approaches to provide descriptions of a broad range of interactional routines, as well as addressing specific practical problems in order to promote smooth and effective practice (ten Have, 2001: 3).

A seminal and often cited discourse-based study in psychiatric discourse is that conducted by Bergmann (1992), who examines the discourse of psychiatric intake interviews. The purpose of such interviews is to assess whether candidate patients, interrogated by psychiatrists, should be hospitalized on the basis of their ‘observable behaviour during the interview’ (1992: 137). Bergmann reveals how psychiatrists, apart from using questions to assess formally the mental well-being of candidate patients, also frequently present interviewees with information about themselves in order to elicit further responses from them. Bergmann, after Pomerantz (1980), describes this process of psychiatric exploration as ‘fishing’, an interactional phenomenon whereby a speaker, in this case the psychiatrist, does not construct a direction question but produces an assertion, referring to the patient’s personal state of affairs (state of health, mood) to which s/he, as an outside observer, has only limited access (1992: 142). Such ‘fishing’ or ‘information-eliciting telling’ (1992: 142) invites the patient to ‘formulate private problems, to disclose personal feelings, and to talk about their troubles’ (p. 155). Psychiatrists’ use of this type of rhetorical strategy avoids questioning patients directly and obliging them to answer; instead patients are gently solicited to give authentic descriptions—and to talk about issues they would have been reluctant to broach in the first place (*ibid.*).

However, this interactional strategy on the part of the psychiatrist is far from equitable, trapping patients in what Bergmann describes as a ‘double-bind’. If patients provide information voluntarily, then that is to accept what the psychiatrist is insinuating in their (typically negative) assertions concerning the patient’s personal predicament. Yet to reject the insinuation is to risk confronting the

psychiatrist and being assessed as requiring treatment, and ultimately being hospitalized. Bergmann, therefore, identifies the contradictory meaning structure of psychiatric discretion, relating such contradiction to the institutional character of psychiatry itself. He powerfully concludes by contending that psychiatry as an institution is (as are the candidate patients it assesses) ‘caught and twisted between medicine and morality’ (1992: 159). This essential underlying tension, or contradictory structure, exhibits itself at the level of discourse, the moment-by-moment unfolding of interaction and, consequently, is only exposed through detailed attention to the participants’ use of language *in situ*.

To summarize this section, then, discourse-based research in health communication is extensive, covering a wide range of health and health communication themes. Most research has clustered in the area of professional–patient relations, in particular consultations between doctors and patients. In the following section we offer a detailed exposition of the function in such encounters, as well as considering the discursive routines of personnel (which are often overlooked in health communication research).

What can discourse analysis tell us about health communication?

As mentioned in the section ‘What is health communication?’ above, much discourse-based research in the field has sought to highlight patients’ perspectives. In the case of the medical encounter, researchers such as Mishler (1984), Fisher (1991) and Fairclough (1992) critically expose the interactional asymmetries that arise between doctors and patients, in particular how the perspective of the patient (the personal and social context of their illness) is marginalized by the doctor in pursuit of a medico-technical understanding of the patient’s condition. In order to illustrate the type of analyses emblematic of these seminal and often dramatic discourse studies, we will consider a sample of discourse analysis conducted by Fairclough (1992) on the basis of clinical data first presented and discussed by Mishler in his 1984 pioneering work *Discourse of Medicine: Dialectics of Medical Interviews*. Fairclough’s analysis serves as a fine illustration of how attention to discourse structures can expose power and dominance at work in the medical consultation.

P = Patient; D = Doctor

- 1 D: Hm hm (.3) now what do you mean by a sour stomach?
- 2 P: (1.1) What’s a sour stomach? A heartburn
- 3 like a heartburn or someth[ing.
- 4 D: [Does it burn over here?
- 5 P: Yeah
- 6 It li- I think- I think it like- If you take a needle
- 7 and stick [ya right [...there’s a pain right here [
- 8 D: [Hm hm [Hm hm [Hm hm
- 9 P: and and then it goes from here on this side to this side.
- 10 D: Hm hm does it [go into the back?
- 11 P: [It’s a:l up here. No. It’s all right
- 12 [Up here in the front.
- 13 D: [Yeah And when do you get that?
- 14 P: (1.3) Wel:l when I eat something wrong
- 15 D: How- how soon after you eat it?
- 16 P: Wel:l probably an hour maybe [less.
- 17 D: [About an hour?

- 18 P: Maybe less I've cheated and I've been
 19 drinking which I shouldn't have done.
 20 D: Does drinking make it worse?
 21 P: Ho ho uh ooh Yes (1.0) especially the carbonation and the alcohol.
 22 D: Hm hm how much do you drink?
 23 P: (1.5) I don't know enough to make me
 24 sleep at night and that's quite a bit.
 25 D: One or two drinks a day?
 26 P: O:h no no no humph it's more like ten [at night
 27 D: [How many drinks – a night.
 28 P: At night.
 29 D: Whaddya ta- What type of drinks? I [(unclear)]
 30 P: [Oh vodka yeah vodka
 31 and ginger ale.
 32 D: How long have you been drinking that heavily?
 33 P: (1.4) Since I've been married.
 34 D: How long is that?
 35 P: ((giggle)) Four years. ((giggle)). (Mishler, 1984)

As Fairclough (1992: 140) observes in his commentary on this medical consultation, the encounter is organized around the doctor's questions, to which the patient then responds, and thus the doctor closely controls the organization of the dialogue by opening and closing each interactional cycle while acknowledging/accepting the patient's answers. Consequently the doctor is controlling the turn-taking system. The patient's contributions are therefore restricted, since she talks only when the doctor prompts her – for example by asking her a question. The doctor, conversely, is not granted turns at talk but takes them when the patient has finished her answers or when she has provided sufficient information to answer the doctor's query.

Another feature of the interview is the introduction, maintaining and changing of topic. The doctor sets the topical agenda since, typically, it is he who introduces new subjects or chooses whether to ignore the pursuit of new topics initiated by the patient. For instance, at line 18, the patient mentions that she has 'cheated' – that is 'drinking', which she 'shouldn't have done'. The doctor, however, does not follow up this potentially revealing and significant personal admission, instead concentrating on the medical details of the patient's alcohol consumption. Fairclough suggests (1992: 141) that, given his narrow focus on medical aspects as opposed to the patient's social and personal concerns, the doctor is limiting topics in accordance with a pre-set agenda, which the patient is prevented from disrupting. Moreover, as well as severely restricting the patient's access to new topics, the doctor further constrains her turns through the consistent use of closed questions. Such questions (e.g. 'Does it burn over here?' and 'Does it go into the back?') produce only information-limited 'yes/no' responses and do not allow the patient to take the floor in the same way that question such as 'Tell me about your concern' would do. Yet, for all that, the doctor does employ a number of more open questions that, in theory, would provide more substantial access to the floor: 'How many drinks a night?', 'What type of drinks?'. But these questions are tightly focused on specific details (e.g. the type and quantity of alcohol) in relation to the patient's drinking and do not encourage her (as her responses demonstrate) to introduce new topics germane to the personal and social context of her troubles.

It is also telling how the doctor's questions often interrupt and overlap the patient's as still incomplete prior turns. This would seem to indicate that the doctor has received all the

information he considers necessary from the patient's particular reply and is simply cleaving to the pre-set agenda or routine mentioned above, an agenda through which he passes swiftly and efficiently (at least in terms of speed and verbal economy). According to Fairclough, this routine, from the patient's point of view, can appear as a series of disjointed and unpredictable questions, a strategy of interrogation that might well account for the patient's hesitations before she produces her answers.

This analysis is, as Fairclough himself concedes, one-sided in its focus upon interactional authority and control. Nevertheless, it insightfully and powerfully demonstrates how the doctor interactionally dominates the encounter, limiting the conversational resources of the patient in order to pursue a pre-determined medical agenda. The doctor's authority is manifested in linguistic features (such as turn-taking or topic shifts) that are used to enact interactional control. Controlling the discourse in this way allows the doctor to respond to the scientific, medical aspects of the patient's complaint, without appealing to the condition in the context of other aspects of the patient's personal, social life. In this sense the doctor manifests the voice of medicine (Mishler, 1984), whereas the patient's responses mix the voice of medicine with the voice of 'the lifeworld' (Habermas, 1984), the voice of ordinary experience. The voice of medicine, according to Fairclough (1992: 144), 'embodies a technological rationality which treats illness in terms of context-free clusters of physical symptoms, whereas the lifeworld embodies a "common sense" rationality which places illness in the context of other aspects of the patient's life'.

Critical analysis of the doctor-patient relationship (for example research by Mishler, 1984 and Todd, 1989) has commonly characterized the exchange as an asymmetrical encounter between the two parties, the doctor exhibiting almost exclusive concern for medical topics at the expense of attending to the social, biographical context of patients' lives (Fisher, 1991: 158). According to Fisher, this medical relationship rests on a medical model of health and illness which sees disease as the organic pathology of the individual patient. The problem to be targeted exists in the patient's body – organs and body parts malfunction in mechanistic fashion – and, accordingly, non-organic problems and hence the social contexts of patients' lives do not fit comfortably into this medical account of illness (*ibid.*).

What discourse analytic interrogations of provider-patient exchanges are able to expose, then, is how diverse and contrasting perspectives are commonly brought into being during the health care interaction. As Fairclough (1992: 144) concludes close critical analysis of the doctor's controlling medical interaction and the ideological voices that shape it are means by which to grasp routine, standardized health practices at a micro-analytical level, affording penetrating insights into health care as a mode of professionalism and social practice.

Although the doctor is undoubtedly a central figure in the healthcare system, many other personnel play a crucial, if less public and authoritative, part in the delivery of healthcare. At the expense of other medical staff, discourse studies interrogating the practitioner-patient encounter have tended to focus on the doctor-patient relationship. Yet the range of discursive practices that takes place in healthcare settings is diverse indeed and, of course, no less significant than the communicative routines of physicians. To illustrate the point, let us consider a stretch of discourse featuring a hospital chaplain interacting with a patient who had recently suffered a stroke. The exchange, taken from a study into the discourse of spiritual and pastoral care (Harvey *et al.*, 2008), aimed, among other things, to illustrate the role that members of non-physician personnel play in the healthcare system. The extract represents just one of the many routine conversations conducted by the chaplain with patients during the course of the priest's regular spiritual and pastoral duties at a British hospital.

C=Chaplain; P=Patient

- 1 C You were saying that you were er feeling a bit bored today.
- 2 P ((unclear)) that's right yeah.
- 3 C Uh uh.
- 4 P Because it's pretty boring in the hospi
- 5 C Yeah. Just lying in in in the
- 6 P Bed fed up
- 7 C Uh hu yeah.
- 8 silence
- 9 C You finding it a bit frustrating to be
- 10 P Yeah because I had a stroke.
- 11 C Yes.
- 12 P That makes it a lot worse.
- 13 C Yes uh uh.
- 14 C Would you be able to tell me a little bit about how that affects you?
- 15 How having this
- 16 P ((unclear))
- 17 C having had this stroke affects you?
- 18 P It affects in just about everything honest.
- 19 C Yeah.
- 20 P I can't talk properly ((unclear)) speech got brain damage
- 21 so I can't explain just like that.
- 22 C Yes uh uh. I understand. But it has always seemed to me
- 23 that you you you explain things very well.
- 24 P Oh if you say so ((laughs))
- 25 C Uh hu. Yeah.
- 26 P I try to
- 27 C Yes.
- 28 P explain as best I can.
- 29 C Uh hu.
- 30 P ((unclear))
- 31 C Yes.
- 32 P See what happens.
- 33 C Yes.

Unlike the somewhat predictable structure of physician–patient discourse, the patterns and dynamics of interaction here resemble those of everyday conversation more than a predetermined, institutional exchange. There doesn't appear to be an obvious pre-allocated sequence or agenda, which characteristically informs the more standardized doctor–patient consultation. Indeed, looking at this stretch of discourse without recourse to precise contextual details, it would be difficult to identify precisely the genre (and consequently the participants) of the extract; it could relate to a range of communicative situations, for instance a lay visitor (such as a family member or friend) speaking to a patient. The interaction has a more informal, less institutional flavour—an observation borne out by the regular and relatively equal distribution of turns at talk. Moreover, though the chaplain appears to be in a position from which to ask questions and focus on particular topics in relation to the patient's wellbeing, he nevertheless takes on a 'relaxed' listening role, seemingly encouraging further free, expansive responses from the patient (note the backchannelling at lines 3, 7, 11, 13, 19, etc.—those minimal utterances such as 'yeah' and 'uh uh', which indicate listenership and encourage further disclosure).

Yet, for all its discursive uniqueness, the above extract nonetheless overlaps with other forms of spoken interaction. For instance, the sequence contains properties of discourse common in counselling discourse (for example, the emphasis on encouraging personal disclosure), as well as in everyday informal conversation. However, chaplain–patient interaction, though displaying properties of various genres, is still a form of institutional discourse, and therefore is organized towards a specific end (Telles Ribeiro, 1996); and there are interactional features present that evince an institutional character. Note, for instance, how the chaplain, apart from orienting to his official roles (through his eliciting personal disclosures from the patient and the patient responding accordingly), encourages the patient to talk about his illness, specifically the syntactical structure of elicitation: ‘Would you be able to tell me a little bit about how that affects you?’ (line 14). Taking the grammatical form of a question, this utterance is, though indirectly constructed, a request for the patient to disclose personal information. Its indirect, polite form presupposes some distance between the participants and potentially displays awareness that it is a face-threatening request, an imposition on the patient that requires his disclosing personal information that is almost certainly uncomfortable and intimate. Such a tentative, attenuated request would most likely be out of place or unnecessary between intimates in everyday non-institutional conversation, where requests for information typically take a more direct, less polite form. If, for example, the chaplain were conversing with a friend at home who was ill, a marked polite request for details concerning his or her wellbeing (such as ‘Would you be able to tell me how that affects you’) would most certainly be inappropriate, or at the very least somewhat unusual.

What kind of/how much data do you need to study health communication?

Many studies in health communication are purely qualitative in their approach to analysis, and are based on relatively small databases and do not originate in large collections of data. This has led to another recent development in health language research, which has seen a number of researchers calling for studies to make greater use of more substantial datasets, while at the same time recognizing that quantitative inquiries alone, which deprive linguistic data of context, are unlikely to be sufficient for providing an understanding of communication (Skelton and Hobbs, 1999a, b). Consequently there has been an increase in health language studies that integrate both qualitative and quantitative approaches to data analysis, employing, in the first analytical instance, corpus tools as their primary methodology, supplementing these approaches with a range of theoretical and methodological perspectives (Thomas and Wilson, 1996; Skelton and Hobbs, 1999a, b; Skelton *et al.*, 1999, 2002; Adolphs *et al.*, 2004).

Adolphs *et al.* (2004) provide a detailed illustration of how a combined quantitative and qualitative methodology that draws on corpus technology can enhance our understanding of a particular healthcare setting. Their research is based on a sub-sample of the Nottingham Health Communication Corpus (NHCC). The NHCC is a one million word corpus comprising of a variety of different communication contexts and including a number of different groups of health professionals and patients. The corpus is unique in that it contains both written and spoken (though mainly spoken) modes of communication and represents the communicative routines of non-physician personnel: pharmacists, nurses, midwives, mental health workers and chaplains. Since doctor–patient discourse studies have dominated health communication research, with the consequence of helping to contribute to the marginalization of certain non-physician service providers (Hak, 1999), the NHCC aims to represent the neglected communicative routines of such providers and describe their contribution to health care. Adolphs *et al.* (2004) investigate the language used in a 50,000 word sample of the NHCC that features transcribed recordings of

interactions between health advisors for the UK National Health Service telephone helpline NHS-Direct and callers to this service. A corpus linguistics approach is used in the first instance to develop a profile of the sub-corpus. An analysis of keywords, or words that occur with a significantly higher frequency in the target corpus when compared to a reference corpus reveals the following 10 most significant keywords in the NHS-Direct data:

1. OK/Okay
2. Your
3. Antibiotics
4. Diarrhoea
5. Call
6. Direct
7. NHS
8. Information
9. You
10. Help

The comparison was carried out with a 5-million-word corpus of mainly casual conversation (see also Adolphs, 2006). The list of keywords contains references to medication (*antibiotics*), ailments (*diarrhoea*), the nature of the discourse (*information*), the mode of the discourse (*call*) and the medical context (*NHS, Direct*). All of these items contribute to the characterization of this corpus. At the same time, we find keywords that mark listener responses in an advice-giving setting (*ok, okay*) and the pronouns *you* and *your*, which indicate the ‘other-oriented’ nature of the discourse, in this case towards the patient. Subsequent analysis of extended stretches of discourse confirms this tendency in the text through the health advisor’s carefully explaining the interactive process and eliciting information from the caller [HA = health advisor and C = caller].

- HA: Yeah, you see you have to do the whole course, you see. Right. What I’m gonna do is just take some details of you for our confidential files.
- C: Eh ha
- HA: If I may, and then get a nurse to call you back it will be
- C: OK
- HA: Approximately around about 40, 45 minutes at the moment. Or, a little later
- HA: [...] Thank you very much. Right, have you called us before about yourself?

This extract also illustrates the need for the health advisor to strike a balance between the almost mechanical elicitation of information and putting the caller at ease with the advice giving process (Adolphs *et al.*, 2007). The latter is achieved through the use of modal markers and mitigating devices (just, may, little, approximately) and a series of politeness strategies. Modal terms such as ‘just’ and ‘may’ introduce optionality and tentativeness into the conversation, giving the appearance of allowing the patient to make their own decision on whether or not to follow the advice that is given. In the NHS-Direct exchanges ‘may’ is used mainly to soften the more or less categorical listing of side effects of certain treatments or conditions, or to suggest further action on the part of the patient. As such, it serves a dual role—as an epistemic softener and, perhaps less obviously, as a politeness device. It also worth noting that ‘may’ is also used in conjunction with other modalizers which encode further politeness and help to prevent the operative from sounding too authoritative, a consequence that would probably distance the two parties interpersonally.

Using a corpus-based approach as a way into the data, or indeed (subsequently) into discourse analysis at any level, can thus provide interesting insights that neither of the two approaches could generate when used in isolation. The question about the size of the data set thus has to be answered in relation to the research question that is being pursued. Given the difficulties associated with gathering health communication data due to privacy, confidentiality and ethical issues that often arise from such an endeavour, it is reassuring to know that the analysis of even very small data sets, both in terms qualitative and quantitative approaches, can be very revealing and can lead to new insights about this particular domain of discourse. Indeed patterns of communication are liable to emerge from interrogating only very small corpora, particularly if such corpora represent a very a unique and specific area of discourse (O’Keeffe *et al.*, 2011).

Conclusion

This chapter has aimed to provide an overview of some of the key studies that examine the inter-relation between discourse and healthcare. This exciting field of enquiry is broad indeed, as the reader will hopefully appreciate by now, and still continues to expand rapidly, as discourse analysts (and in some instances professionals themselves) interrogate ever refined and marginal spheres of health communication and thereby shed light on discursive practices that have hitherto avoided linguistic scrutiny. What a number of the studies examined in this chapter demonstrate is that use of discourse in healthcare is not simply a means of conveying information and representing particular states of affairs. Discourse in fact constitutes medical procedures and hence helps determine certain clinical outcomes, outcomes that are liable in some instances to have a profound impact on patients (consider, for example, the role of discourse in the psychiatric intake interview and how some specific, negatively evaluated linguistic responses may lead to patients’ being hospitalized).

Accordingly, analysing medical discourse not only contributes to our knowledge and understanding of the various social and clinical activities that take place in healthcare settings—not to mention the role that discourse plays in conveying and shaping individuals’ personal experiences of health illness—but also has very practical consequences with regard to engendering more equitable and humane practices in healthcare. Among its many functions, the discourse analysis of healthcare affords rich opportunities for exploring the situated routines of health professionals and is thereby able to draw attention to potential asymmetries between professionals and patients— asymmetries and other interactional tensions that might not be apparent to the participants at the time of interaction. It is revealing that a number of health professionals themselves are showing increasing interest in discourse analysis and in the insights it offers, conducting their own discourse-based research (often in conjunction with discourse analysts) to help improve clinical communication and to enhance patient satisfaction in a range of medical contexts.

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