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Developments in Health Communication in the 21st Century

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Abstract

In this article, five papers that formed the Special Issue for the fourth IALSP Taskforce on health communication are revisited. Our starting point is Gallois' epilogue and the six themes she identified from those papers. These themes are invoked to explore where health communication is moving in the 21st century. Burgeoning work on intergroup communication in this context, patient voice, minority groups and the role of the carer are highlighted.

Keywords

intergroup communication, interprofessional communication, health communication, older adults, health disparities,

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Volume 28 (2) 2009 of *Journal of Language and Social psychology (JLSP)* was a Special Issue on health communication devoted to the fourth Taskforce organized by the International Association of Language and Social Psychology (Jones & Watson, 2009). The remit of all Taskforces is to use a language and social psychology (LSP) approach to investigate important societal issues such as health communication. Weatherall, Watson, and Gallois (2007) argued an LSP approach sees communication as a dynamic psychological process, where the affect, motivations, and cognitions of each speaker play out in interactions with others across different contexts. There is also an emphasis on the intergroup, in addition to the interpersonal, dynamics in an interaction. The five Taskforce papers placed varying emphasis on the importance of the intergroup or interpersonal aspects of communication, but each saw communication as a dynamic process. They focused on the issues individuals confront across a diverse range of health contexts including interactions between different health professionals, and between health professionals and patients and their families. Moreover, the Taskforce papers examined different group memberships such as professional status, age, ethnicity and disability.

The Special Issue concluded with an epilogue by Gallois (2009), who identified six major themes connecting the papers: the importance of LSP in health communication, the intergroup nature of health communication, patients negotiating the health sector, the quality of care and adverse events, patient voice, and patients dependent on carers. In this paper, we revisit these themes as a springboard for examining where health communication is moving in the 21st century. Because of the recency of the 2009 Special Issue, we have chosen to include research that appeared contemporaneously with our Special Issue (and thus was not included in the Taskforce papers), as well as subsequent research. While our review was broad ranging in order to appraise the literature, the final review provided here is necessarily

selective. We provide examples of research demonstrating the directions for each of Gallois' themes rather than a complete review of all work conducted.

Revisiting the Health Communication Taskforce Research

First, we revisit the foci of the papers in the Special Issue. Iedema, Jorm, Wakefield, Ryan, and Sorensen (2009) and Hewett, Watson, Gallois, Ward, and Leggett (2009) focused on the patient's experience in the hospital system and how adverse events occur and are subsequently dealt with in the hospital system. Hewett et al. investigated how patient care can be adversely affected through ineffective communication between health professionals. In hospitals, a diverse range of health professionals work together, but come from different professions, specialities, as well as cultural backgrounds. This focus has recently been taken up by Watson, Hewett, and Gallois (2012) and is discussed later in this paper.

Iedema et al. (2009) described the tension and distress underlying open disclosure of adverse events. The 'unpredictability' (p. 154) that surrounds the discourse between a patient and clinician, when the latter is explaining how care or procedures went wrong, is clearly alien and open disclosure is counter-intuitive for health professionals.

Kalbfleisch (2009) examined the challenges of health communication with Native Americans in the U.S. as a particularly difficult form of intercultural health communication. She described the poorer health outcomes of Native Americans, and identified key barriers to Native Americans having voice in their communication with health professionals: the language difficulties and different styles of communication more generally between non-Native American health professionals and Native Americans, and the differing perceptions of health and illness.

Young and Manthorp (2009) investigated how to improve communication for dementia sufferers and their carers. They developed a three-step Code of Practice that unpacked what effective communication means for those with dementia and how interactants

can feel empowered by an examination of beliefs about dementia, the components of effective communication, and guidelines for actively managing communication. Finally, Nussbaum and Fisher (2009) focused on the older adult. They presented a model of communication that linked three important dimensions within the older adult's existence: the social support networks of older adults, health care professionals, and the health care organizations, arguing these dimensions strongly influence the older adult's quality of care.

The papers covered many issues that reflect the complexity and challenges of health care in the 21st century. We have an aging population that expects to live longer than previous generations and, with advanced medical technology, individuals survive many more diseases than before and, with medication, live with comorbidities. In the 21st century, many countries are becoming more multicultural, and face a higher proportion of patients (and health professionals) with language or cultural barriers. If not appropriately addressed, language barriers increase the risk of medical errors and inefficient use of medical services (Schybe, 2007). It is important to study health communication because it links to the quality of health care provided and outcomes for patients and families in terms of physical and psychological health.

The Special Issue papers covered different health matters, used different perspectives and came out of three continents, which have different business and funding models. Nonetheless, Gallois' epilogue identified six overlapping themes across the papers. The first two represent the heartland of LSP (Weatherall et al., 2007). First, the importance of a language and social psychology approach to health communication, that describes the dynamic interplay between interactants in health communication, whereby individuals in the health setting shape and are shaped by communication. In our review, we sought to find new papers that reflected either explicitly or implicitly this focus. Second, is the need to

recognize the intergroup dynamic that exists in the healthcare arena. We detail Taskforce papers that specifically highlighted these themes, together with recent research.

Alongside these two themes, Gallois identified four other themes: the importance of patients being able to negotiate the health sector in which they find themselves; the role of patient voice, whereby patients should be heard by their health providers and influence the care provided (e.g., Trummer, Mueller, Nowak, Stidl, & Pelikan, 2006); (informal) carers, often family but sometimes close friends, who must speak on the patients' behalf; and how communication impacts on a patient's quality of care and miscommunication leads to adverse outcomes. Gallois' themes provide a future research agenda for health communication.

Intergroup Communication in the Healthcare Setting and Quality of Patient Care

We revisit here the Taskforce papers by Hewett et al. and Iedema et al., and discuss new work emphasizing the importance of the intergroup relations between different health care professionals. We also incorporate Gallois' theme concerning quality of care and adverse events, because we argue quality of patient care is linked to intergroup communication.

A key message from Hewett et al.'s paper was the need to examine how the hospital system can work more effectively to ensure patient care is not compromised by the organizational dynamics that play out. Iedema et al.'s paper showed that the same dynamics make it hard for clinicians to allow patients a voice during open disclosure discourse, in part because clinicians find it confronting to step back and question their clinical practise and procedures. Walshe and Shortell (2004) stated that a culture of secrecy and protectionism in health care is the most important barrier to health professionals admitting their mistakes to patients. .

These two papers were pivotal in linking health communication to effective patient care. Hewett et al. (2009) provided us with the insights to recognize the problems that exist into the 21st century, where a diverse range of health professionals increasingly find

themselves having to work together to provide effective health care (Gaboury, Bujold, Boon, & Moher, 2009), for instance teamwork is now often mandated for patient care. Health professionals come from different professional, specialty and cultural backgrounds, and each health profession has its own language rules and norms that are rarely shared with other professional disciplines (Watson, Hewett, et al., 2012). This makes communication between health professionals intrinsically intergroup and often conflictual. Researchers who are not from an LSP perspective have started to recognize the intergroup nature of health communication, whereby professionalism, as examined in several Australian studies, engenders tribalism, in which like professionals such as clinicians stick together and create communication or professional boundaries (e.g., Bartunek, 2010).

Nowhere is conflict more evident than in maternity care, even though maternity care is an area where collaboration between midwives and obstetricians is vital. Berridge, Mackintosh, and Freeth (2010) found examples of a regulation of communication that signalled interprofessional tensions, with junior doctors excluded from care and decision-making by nurses, and nurses also deliberately withheld information from senior obstetricians. Communication between doctors and other health professionals was infrequent, terse, and task focused, with little negotiation evident. These communication problems in part reflected different models of maternity care. Berridge et al. argued this is a reminder that simple standardized communication interventions to improve quality of care may be ineffective if no account is taken of the particular communication context or organizational culture.

Unlike many other specialties and sub-specialties in the delivery of health care, Geriatric Medicine and cancer care have accepted the multidisciplinary health care team approach. However, Nussbaum and Fisher (2009) argued that executing this health care team approach is impeded by the structure of health professions. Fleissig, Jenkins, Catt, and

Fallowfield (2006) found that within multi-disciplinary teams (MDTs) in cancer care “historical enmities, hierarchical boundaries and personality styles that are not conducive to harmonious exchange and respect of different viewpoints can make teams dysfunctional and participation can be stressful” (p. 941). The emphasis on intergroup relations in healthcare in recent years is encouraging and progress has been made towards understanding intergroup conflict and, in some instances, resolving it.

Of course, acknowledging the interpersonal connections between health professionals and their patients should not be ignored, and is also part of the LSP perspective. Indeed, it is still the case that much health communication research focuses on the individual health practitioner, taking a relatively interpersonal approach to communication between health practitioners and patients (see, for example, Kreps (2012) on the need to increase immediacy in such communication). An interpersonal approach can focus on communication competence training as a critical part of improving health communication. In particular, there is ongoing research into the effectiveness of communication skills training for both health professionals and patients (see Cegala, 2006). We know that it works well in both intercultural and within-cultural contexts; for example, in training doctors to give bad news -often a difficult and unfamiliar situation for them (Iedema et al., 2009) - or in history-taking (e.g., Kaldjian, Jones, Rosenthal, Tripp-Reimer, & Hillis, 2006).

Although teaching basic communication skills in terms of cultural differences and active listening is a valid approach, Watson, Gallois, Hewett, and Jones (2012) argued that by itself it is insufficient, and does not take account of the specific health context, the goals of the patient and health practitioner, and the attitudes held by each interactant in the consultation. Albrecht, Penner, Cline, Eggly, and Ruckdeschel (2009) similarly argued the importance of locating and understanding the context.

Importantly, research examining the role of context needs to be “well-grounded in comprehensive theory” (Gallois, 2009, p. 214). Theories enable researchers to both understand the dynamics of health communication, as well as the mechanisms by which health communication affects patient outcomes (Street, Makoul, Arora, & Epstein, 2009). We focus here on theoretical work with an LSP basis.

Using social identity theory, Villagran and Sparks (2010) outlined a typology of the role of identity and stigma in patient-provider communication that provides some avenues for future research to test how strength of identity with the patient role and negative stereotypes affects communication with health providers. Teal and Street (2009) argued that “at the most basic level, patient-physician encounters can be intercultural...” (p. 534). We contend that this intercultural focus extends beyond patient-physician communication to health communication more generally (see Watson, Gallois, et al., 2012). In line with their argument, Teal and Street devised the culturally competent communication (CCC) model directed at physicians, which focuses on physicians being both patient-centred and culturally competent. CCC requires physicians to have skills in the different functions of a medical encounter (building relationship, assessment, and management or treatment of patient problems), situational awareness (including self), adaptability, and knowledge about core cultural issues. This development by Teal and Street demonstrates how the issue of context can be tackled. Cegala (2011) built on Street’s (2003) ecological model of communication, extending it further to examine cultural, organizational, and interpersonal factors that predict patient participation. Moore, Wright, and Bernard (2009) also extended Street’s ecological model to examine how individual factors and system perceptions and expectations, in addition to patient-provider interactions, predict patients’ satisfaction with physicians and the hospital system.

Another avenue of health communication research attracting attention is a focus on power and status differentials between health providers and patients (e.g. Baker, Gallois, Drieger, & Santesso, 2011). From this vantage point, communication accommodation theory (CAT) has been applied to foreground the importance of context and status in communicating across health encounters (e.g., Street, 1991). CAT acknowledges both the interpersonal and intergroup nature of health communication and the importance of shared perspectives. Researchers using communication accommodation theory (e.g., Gallois, Ogay, & Giles, 2005) have investigated how the intergroup and interpersonal dynamics that exist between different health practitioners, as well as health practitioners and patients, become apparent in both written and spoken communication. Jones, Rowe, and Woodhouse (2007) used CAT to identify how mothers and fathers of neonates in intensive care differed in the strategies they considered effective when talking to the nurses about their babies' care. For mothers, face and interpersonal control were highlighted, whereas for fathers, the focus was on interpretability. These differences are important in understanding how effective and ineffective communication (or perceptions of such communication) differs across parents. Albrecht et al. (2009), using the related concept of convergence (defined as shared understandings and perspectives), cited a number of studies showing that convergence is central to quality cancer care and improved outcomes, such as participation in clinical trials, treatment compliance, and levels of pain and distress..

In sum, we have emphasized the intergroup dynamics in health care and touched on health communication research that concentrates on the interpersonal dimensions. In the next section we turn our focus away from emphasizing intergroup salience – although it will still be evident at times – to examine the importance 'voice' plays in health care.

Negotiating the health sector and voice

The 2009 Special Issue addressed how patients (and their families or informal carers) negotiate the health system through communication and the challenges it presents. While health practitioner-patient communication continues to be widely researched (see Kim, Park, Yoo, & Shen, 2010), Gallois (2009) argued the importance of enabling patients to have voice. Indeed, there has been a growing emphasis internationally on empowerment of consumers/patients in health communication, which seeks to equalize power and promote their active participation in health care (Kreps, 2011). We discuss some recent work on patient voice in open disclosure before addressing voice for the specific stigmatized groups featured in the 2009 Special Issue.

An emerging new area of research concerned with patients' voice is the work on open disclosure. Iedema et al. (2009) presented an inquiry into how health professionals realize open disclosure. More recently, Iedema and his colleagues have considered open disclosure from the perspective of patients who have experienced an adverse event, and their carers. They conducted interviews with patients and carers examining their experiences and their perceptions of open disclosure, and identified five domains of concern which implicate the lack of voice or power patients and carers experience (Iedema et al., 2011). Interviewees described the challenge of whether the incident was noticed or acknowledged, the absence of dialogue that would enable patients or family to have a say in what would constitute a satisfactory explanation, and the framing of findings in service-centric rather than patient-centric language. Interviewees described the need for open disclosure to be "a 2-way exploratory dialogue that produces a mutually satisfactory explanation" (p. 4). It is important to elucidate differences in perceptions of health professionals and patients and their families of the seriousness of adverse events and what that means for effective open disclosure. Fallowfield (2010) concluded more research is needed on doctor and patient preferences around communication following an adverse event, including whether particular groups have

special needs or preferences for communication following an adverse event. Chafe, Levinson, and Sullivan (2009) also described how we need to consider the communication process for disclosing errors that affect multiple patients. Such communication involves more stakeholders, longer time periods, risks greater breaches of trust, and thus requires more comprehensive communication strategies.

Patients from stigmatized groups

We now revisit the particular groups examined in the 2009 Special Issue and their need for an active voice as patients: those who are members of a minority ethnic group, who are also more likely to be from a low socioeconomic status (Kalbfleisch, 2009), older adults, and those with a cognitive impairment such as dementia. We argue that each of these groups is, to some extent, stigmatized and their interactions with health professionals are often intergroup. While much of the research has been conducted on these groups separately, the Special Issue identified many commonalities in their experience that are at the heartland of LSP research: language barriers, differing cultural codes for communicating, stereotyping, status and power differentials between majority and minority groups, and the lack of cultural awareness of health professionals. These communication difficulties are implicated in poorer health service delivery and poorer outcomes for these groups (Kreps, 2006).

In line with Kalbfleisch's (2009) research on the communication challenges Native Americans face, other researchers similarly argue that specific ethnic groups around the world are particularly disadvantaged. For example, Basu and Dutta (2007) described the tension between tradition and modernity in how tribal Indians both understood and responded to illness and the implications for how they sought out and responded to treatment. Johnstone and Kanitsaki (2008) argued that, in Australia, people of minority cultural and ethnic backgrounds are underserved by local healthcare services, experience unequal burdens of disease, confront cultural and language barriers to accessing appropriate healthcare, and

receive a lower level and quality of care when they do access healthcare compared to the majority population. Other researchers have focused on particular diseases. Diette and Rand (2007) demonstrated the link between communication between health providers and ethnic minorities and poorer care for those with asthma compared to the majority groups. They cited evidence that patient factors (language barriers, low health literacy, and lack of self-efficacy, compounded by low SES), health professional factors (racial biases in interpreting symptoms and decision making, poor understanding of patients' models of disease, and expectations of health professionals), and system factors (time constraints and lack of culturally and literacy appropriate educational materials) all affect health professional-patient communication and, in turn, outcomes for minority asthma patients.

Language

The first barrier to having voice faced by those from an ethnic minority group is, for many, a language barrier. Recent research documents how language barriers continue to affect patients' health care in a range of ways. Dressler and Pils (2009) studied post-accident rehabilitation of migrant and ethnic minority patients in Austria. They found the language barrier affected patients' understanding, resulted in interactions with health professionals taking longer, hindered or completely impeded some therapies, and affected assessment, particularly of functional capacities. Patients often did not undertake rehabilitation because they did not understand the importance or objectives of rehabilitation. Garrett, Dickson, Whelan, Klinken, and Forero (2008), in a qualitative study of non-English speaking background patients' perspective on cultural competency, found that while the majority were positive about their hospital and discharge experiences, patients also expressed significant dissonance related to their inability to directly communicate with providers. Their limited English proficiency resulted in a feeling of powerlessness, and was linked to anxiety, fear,

lack of confidence, and a sense of dependency. In turn these feelings resulted in problems in care, administration of medications, compliance, and treatment.

Language barriers extend beyond patient and health professional interactions. Kreps and Sparks (2008) identified how language and health literacy barriers challenged an individual's ability to access and make sense of health information. Zhao (2010) found that foreign-born Hispanics were less likely to seek information about cancer than U.S.-born Hispanics, and foreign born people more generally were less likely to have someone else seek information for them than US born people.

Older people, especially those with dementia, can also face language barriers that prevent them from having voice. Sparks and Nussbaum (2008), consistent with our likening health communication to intercultural communication, described the level of health literacy needed by older people to negotiate the health system. The increasing number of older adults living with comorbidities highlights that this group needs to be able to effectively communicate with health professionals. In particular, Rao, Warburton, and Bartlett (2006) described the particular challenges for older people from ethnic minority groups, who have both lower language proficiency and may lose the ability to speak a second language.

Communication styles

The 2009 Special Issue also argued that patients and health professionals differ more generally in their style of communication. Schouten and Meeuwesen's (2006) review established that there are major differences in communication as a consequence of a patient's ethnic background. Compared to non-ethnic minority patients, doctors treating ethnic minority patients behaved less affectively, expressed less empathy, engaged in less social talk, were less friendly and concerned, and patients' comments were ignored more often. They noted that ethnic minority patients were less verbally expressive, less assertive, and less affective than white patients, and expressed less friendliness and less social talk. These

findings appeared unrelated to linguistic factors. These differences are consequential, with Meeuwesen, Harmsen, Bernsen, and Bruijnzeels (2006) arguing that, in The Netherlands, more misunderstanding between doctors and ethnic minority patients than Dutch patients resulted in more inappropriate use of health services, greater risk of incorrect diagnoses, lower compliance with advised treatment, and less satisfaction.

Many of those from a minority cultural group are also likely to be either low socioeconomic status (SES) and/or from a rural background. This interaction is acknowledged by few researchers, resulting in less research on those from a low SES and/or rural background. However, current research suggests that being either low SES and/or from a rural background are also risk factors for poorer health communication, which may further limit the voice of minority ethnic groups. For example, Clemans-Cope and Kenny (2007) found that low SES parents, particularly foreign-born and those interviewed in Spanish, reported poorer communication with health professionals. Garrett et al. (2008) similarly found that social and economic circumstances exacerbated challenges faced by non English speaking background patients. Collins, Villagran, and Sparks (2008) illustrated how poverty and Latino cultural beliefs interacted to create barriers to communication about both cancer prevention and cancer treatment and, in a further study, showed the compounding effects of membership of multiple stigmatized groups, Ramanadhan and Viswanath (2006), in a study of information-seeking by Americans with cancer, found that nonseekers had lower income and education levels than information seekers and that Hispanic Americans and older people were more like to be nonseekers. See Rintamaki and Brashers (2010) for an in-depth discussion on understanding the behaviours and cognitions associated with stigmatization.

Minority group patients and health professionals may also differ in their perceptions of what is effective communication and what are the barriers to communication. Ruan and Lambert (2008), in a study comparing nurses' and older patients' perceptions of

communication barriers, on the one hand found many similarities in the barriers they identified in nurses' behavior. However, nurses gave higher ratings than patients to barriers related to how the discourse was managed (e.g., not enough explanation, interruptions), whereas patients gave higher ratings to relational aspects of communication (e.g., not liking the elderly). Nurses also rated barriers in patients' behavior higher than did patients, including being hearing impaired and pretending to understand.

Stereotyping

Johnstone and Kanitsaki (2009) highlighted the problem of 'new racism' or 'cultural racism', the largely unacknowledged resistance to principles and practices of cultural diversity in health care, which result in tokenistic responses to cultural diversity that do not threaten the status quo. As Smith and Hipper (2010) argued, stigma is the leading barrier to health treatment and support. Social psychologists have long known the problem of stereotyping of stigmatized groups, including those from minority ethnic and racial groups, minority religious groups, older adults and those with a disability. The Special Issue highlighted how health communication between health professionals and those from stigmatized groups is influenced by the stereotypes health professionals have of stigmatized groups (see Nussbaum & Fisher, 2009; Young & Manthorp, 2009), their lack of comfort in interacting with people from stigmatized groups, or their lack of cultural awareness, in essence intergroup communication.

Researchers continue to identify that health communication is influenced by stereotyping, which may decrease patient voice for each of the specific groups focused on. For example, Johnstone and Kanitsaki (2008) documented the individual language prejudice described by health care professionals and patients across a range of healthcare organizations in Australia. Sparks and Nussbaum (2008) included in the barriers faced by older adults not only physical and cognitive functioning, but also negative stereotyping of older adults and the

resulting negative behavior. In turn, negative self-stereotypes can affect physical and cognitive functioning negatively in older people (with positive self-stereotyping having positive affects). Savundranayagam and Ryan (2008) outlined more specifically the ongoing negative representations of elderly people in the media, which contributed to negative stereotyping of older people by both the young and old.

Stereotyping frequently results in patronizing speech which is most often depicted through carers of elderly people (see Coupland, Coupland & Giles, 1991). Williams, Herman, Gawjewski, and Wilson's (2009) study into the impact of elderspeak found a higher probability of resistance to care by dementia patients when carers were using elderspeak. Controlling communication was also found to increase resistance to care (Williams & Herman, 2011).

Voice is also affected by perceived power in interactions between patients and health professionals (see Kreps, 2012; Young & Manthorp, 2009). Peiris, Brown, and Cass (2008) cited studies showing the sensitivity of indigenous people to power imbalances within health care interactions. Peiris et al., like Kalbfleisch (2009), linked this to the dominant biomedical paradigm of many health professionals, which places indigenous people as the cause of poor health outcomes. They argue for the concept of cultural safety which "shifts the role away from a check-list approach based on a person's ethnic background to a critical examination of the power imbalance in health care encounters between indigenous patients and non-indigenous health care providers" (p. 985). Where health professionals promote a nonbiomedical approach, based on trust, reciprocity and shared decision-making, the result, Peires et al states, is better health outcomes.

A further barrier to patients having voice is the level of cultural awareness of health professionals. Despite clear evidence of the health disparities experienced by those from an ethnic minority group, Vanderbilt, Wynia, Gadon, and Alexander (2007) talked about

doctors' recognition of racial and ethnic disparities being low. Those doctors who were highly engaged in reducing health care disparities were mostly either members of racial or ethnic minority groups (50%) or another minority group (e.g., religious or white raised in minority neighbourhood). Strategies for improving care were treating patients with respect and understanding (what CAT would describe as accommodating vis-à-vis strategies of interpretability and interpersonal control), whereby health professionals accepted accountability for ensuring patient understanding.

Overall, we concur with Johnstone and Kanitsaki (2008) who talk about institutional language prejudice, highlighting that change needs to occur at the system level as well as in individual health practitioners. Watson et al. (2012) talked about this kind of communication problem as being so entrenched in a culture that it is invisible; socio-structural power inequalities lie at the heart of such miscommunication. In other words, the hospital system, as an unseen force, drives communication.

Interventions and patient empowerment

There have been a number of recent intervention studies addressing the challenges outlined in the previous pages, as well as how health professionals may empower patients. At the same time, other studies address the challenges of trying to tackle communication problems. We provide examples of both in this next section.

A key part of addressing the language barriers described earlier is access to interpreters. Karliner, Jacobs, Chen, and Mutha (2007) found that professional interpreters were associated with improved clinical care compared to ad hoc interpreters, with professional interpreters raising the quality of clinical care to approach or be equal to that for patients without language barriers. Yet there is also evidence that what seems a simple intervention to introduce can prove challenging, with implications for patient care. Garrett et al. (2008) reported that professional interpreter usage was lower than desirable, particularly in

the Emergency Department. Professional interpreters were crucial but absent at key points such as doctors rounds, Emergency Department, or unscheduled consultations. Instead, the family were critical for negotiating hospital care and assumed much responsibility for decision-making, a significant burden of time, and resulting in issues about patient confidentiality and potentially conflict in family relations. Cristancho, Garces, Peters, and Mueller (2008), in a study of rural Hispanic immigrants in the U.S., found that there was both a lack of availability of medical interpreters and inadequate training of interpreters. Dressler and Pils (2009) argued that it is the lack of institutional plans to deal with language difficulties that result in ad hoc individual responses to language problems.

CAT emphasizes the importance of interlocutors accommodating to the communication needs of their conversational partner. For example, Savundranayagam and Ryan (2008) argued the importance of health professionals adapting their communication to reflect the heterogeneity of older adults. There has been some research examining the role of the health professional in adapting his/her communication with patients, an approach Savundranayagam, Ryan, and Hummert (2007) labelled “enabling environments”. Williams (2006) demonstrated the effectiveness of a training program designed to reduce ‘elderspeak’, although some of the effects found post intervention had disappeared two months later, highlighting the challenge of maintenance experienced by many training programs

While much of the research focuses on changing the behavior of health professionals, our Special Issue argued the importance of developing patients’ health communication competence (see Kalbfleisch, 2009; Nussbaum & Fisher, 2009). There has been a growing body of research using an LSP perspective addressing empowerment for older people. Savundranayagam et al. (2007) advocated communication as a means of empowering older adults, especially those with a physical, cognitive, or sensory impairment. They described the use of selective assertiveness as a strategy to empower older adults, where older people

identify the situations when to voice desires or concerns or not. Ryan, Anas, and Friedman. (2006) demonstrated the benefits for older people of selective assertiveness in difficult interactions with health professionals. However, while older people were rated more positively when they were assertive, health professionals were rated most positively when older people were passive. Ryan, Anas, and Mays (2008) found that the assertiveness advantage varied according to whether it was in a hospital setting or the community, with less advantage of assertiveness in the hospital setting.

While some researchers focus on interventions targeting health professionals or patients, others advocate a more holistic approach to interventions. An LSP approach always emphasizes the importance of context. Savundranayagam et al. (2007) reflected on empowerment being facilitated by the move to see disability as an interaction between a person and the context rather than residing in the individual alone. Blacksher (2008) similarly argued that cultural competency programs need to acknowledge the effects of SES in addition to ethnicity, and that social class should be seen as a process, rather than a static entity, which nests individuals within families and communities that affect their access to resources. Focusing specifically on communication with people with dementia, Young and Manthorp (2009) presented a proposed Code of Practice to address the communication needs of people with dementia and their formal and informal carers. Young and his colleagues have continued their development of the renamed Dementia Toolkit for Effective Communication (DEMTEC: Young, Manthorp, Howells, & Tullo, 2011a, b). Health professionals and people living with dementia and their informal carers all regarded the structure of DEMTEC as accessible and fit for purpose. Interestingly, some health professionals thought that the social psychological foundations of DEMTEC (vs. discourse or conversational analysis approaches) risked people living with dementia being recipients of communication rather than active partners. People living with dementia and their informal carers did not share this view,

emphasizing again that the perceptions of health professionals and patients/carers of effective health communication may differ. An important feature of DEMTEC is that its development was guided by both health professionals and patients and their informal carers. Young and his colleagues (2011a) stated that the aim now is to develop a version of the program specifically for care workers for whom English is not their first language.

In related work, Haberstroh, Neumeyer, Schmitz, and Pantel (2009) developed and evaluated a skills training program aimed at caregivers of nursing home residents suffering from dementia. The program focused on problems and strategies for communication with both residents and other carers, and demonstrated the training had benefits for both residents and carers.

Carers

Finally, the Special Issue highlighted the role of carers in health communication.

Nonetheless, historically “there has been little or no consideration of the role of carers and family members in theory (much less practice) in health communication” (p. 212) (Gallois, 2009). However, in recent years there has started to be an increase in research on carers, including their communication needs and experiences.

Nussbaum and Fisher (2009) argued that carers need to be systematically integrated into the health care team approach but the challenge is how to achieve this integration. The importance of such research is that carers of chronically ill patients experience significant physical and psychological stress, depression, and anxiety. Caregiving places extensive demands on the carer physically, emotionally, financially, in existential and social domains, and can affect health, well-being, and life expectancy, with high rates of depression and anxiety (Wilkinson, 2010). There is often an unstated assumption that carers will take on the caring role (Linderholm & Friedrichsen, 2010) but they may be anxious, ambivalent, or begrudge the role they find themselves in. Thomas and Morris (2002) argued that how carers

cope psychologically has been associated with the degree of information carers receive from doctors and other health professionals about the disease, its treatments options, its trajectory, and prognosis. Moreover, the ability to care is contingent on material, informational and educational, social and professional guidance and support received from health professionals (Wilkinson, 2010). Research has focused on the informational needs of carers. For example, Beaver and Witham (2007) examined the information needs of informal carers of patients with breast cancer, and found carers wanted more information about the likelihood of cure, the spread of disease, and treatment options. End of life carers specifically require information about the patient's prognosis and disease progression, practical and nursing patient care education, understanding of the goals of treatment and awareness of approaching death, and what to expect at the patient's death (Wilkinson, 2010).

At the same time, carers experience a number of challenges in communication with health professionals that are indicative of a lack of voice. Many of these challenges mirror those of patients, others, however, are unique to the carer role. Medical systems rely on carers, yet carers can find medical systems factory-like and bureaucratic (Olson, 2009). Communication between health professionals and carers is also framed within an assumption that carers will care for the patient. Yet, Jones, Leach, Cahill, Colquist, and Harden (2010) found that cancer carers felt isolated and as though all attention by health professionals and friends and family was on the patient. Carers explicitly spoke of the challenge of having voice in the context of being a carer. Luttik, Blaauwbroek, Dijker, and Jaarsma (2007) similarly described the problem of partners of heart failure patients carers not feeling involved by health professionals in care, not being involved in conversations with health professionals, or their presence not always being acknowledged even when they were present. Linderholm and Friedrichsen (2010) found that when health professionals failed to notice the caregiver's feelings of insecurity and inexperience, caregivers felt powerless, leaving them

feeling insecure, isolated, and vulnerable. Where carers built a relationship with health professionals, they experienced a clear distribution of responsibility and support. The quality of the relationship between carers and health professionals is important for patient outcomes. For example, Ford, Davenport, Meier, and McRee (2011) found partnership building between health providers and the parents of adolescent children undergoing health treatment was an important part of improving the health of adolescents.

Beaver and Witham (2007) describe the challenge for carers to get information directly rather than through the patient or overhearing. In part this may be because medical personnel rarely recognize carers as in need of inclusion and information on treatment and psychosocial support (Olson, 2009). Moreover, Olson found that there was both a lack of information and a lack of co-ordination of information. Even where information was provided there was the challenge for carers, like patients, of understanding the information, indicating a lack of accommodation by many health professionals. Carers do not just want to be provided with information, they want guidance as to how to apply the information to their situation and they want a trustworthy person to whom they can ask questions.

Importantly, most attention has been directed at carers without focusing on the perspective of health professionals. Research has, however, identified that health professionals underestimate the level of carer needs and overestimate the availability of services (Wilkinson, 2010). A further challenge for health professionals in interactions with carers is the finding that caregivers misunderstood the informational needs of their patients (Giacalone et al., 2008). They argued that health professionals cannot use relatives to determine the informational needs of elderly patients about both diagnosis and treatment.

There is also the challenge for health professionals to balance patients' rights and needs while negotiating families' concerns. Both nurses and family want the best for the patient, but 'the best' is based on skills and experience by nurses and knowledge of the

patient by the family. Thus the family and nurse may be viewing patients from different belief systems which interferes with effective communication – for researchers this is an LSP problem. Maxwell, Stuenkel, and Saylor (2007) found differences between nurses and family members in their perceptions of needs of family members of patients in critical care. Nurses and family were not in agreement about the importance of families knowing a wide range of topics including prognosis, daily nurse contact with daily patient updates, knowing why things were being done, being called at home about changes in the patient's condition, knowing exactly what was being done for patient, transfer plans, and specific facts about patient's condition.

In summary, while there is increasing research on communication with carers we argue that LSP could usefully inform future research. Current research is generally a-theoretical; yet an intergroup lens is clearly applicable to communication between carers and health professional, particularly where carers are members of minority groups.

Conclusion

We have argued that an LSP approach is useful for both increasing our understanding of communication that occurs in the health context, as well as informing interventions to improve health communication between patients and health professionals, and between different groups of health professionals. We have provided examples of recent research in this area that have implicitly or explicitly invoked an LSP approach and that take account of both the broader context and intergroup dynamics in healthcare, key themes highlighted by Gallois (2009). In addition, the other four themes noted by Gallois have directed us to examine developments in research on patients negotiating the health sector, the quality of care and adverse events, patient voice, and patients who are dependent on carers. The papers discussed here demonstrate that health communication research that focuses on patients and health providers encompasses a broad range of issues about patient voice, minority groups,

and carers. This is encouraging. However, there is still much work to be done. Our literature search identified that there are still too few studies that include the diverse and larger context within which patients and health providers exist. We argue that it is not sufficient to look at one aspect of care, the interactants, their backgrounds, and the context of the interaction must be included. Such an examination requires in-depth and interdisciplinary research. Mixed methods and qualitative and quantitative approaches are needed; all this takes a lot of time, a luxury some researchers do not have in the current climate. Thus we propose that researchers need to work in multidisciplinary teams so that all parts of the elephant are included in the study.

There continues to be a need to theorize our work. Kim et al. (2010) identified over 104 different theories being used in research published in the journal *Health Communication* since its inception in 1989. Yet 32.3% of articles published in the journal between 2007 and 2010 were a-theoretical. We argue, in particular, for the need to use theories such as Communication Accommodation Theory, that highlight the role of context, the dynamic nature of communication, and both the interpersonal and intergroup nature of health communication. Such theories will provide more explanation of the difficulties in intercultural communication, including both intergroup and institutional barriers to effective health communication, and address issues of power and control in health communication (see Dutta, 2010).

Health communication currently employs a diverse range of methods, including multimethodological designs (Kim et al., 2010). However, we must continue to develop the methodologies and methods we use. For example, an LSP perspective emphasizes the need to examine the relationship between perceptions and behaviour, whereas much research examines only one. Research on behavior needs to include the range of nonverbal and verbal behavior. Thus more use of videorecording rather than audio would enrich and inform the

research on, for example, health practitioner-patient communication (Albrecht et al., 2009), especially when coder judgements of health interactions differ depending on whether audio or video data code). There is also a need to examine more written communication between health professionals, particularly given increased use of technologies in communication between health professionals.

Researchers also need to consider the samples they are using. Most health communication research is from a West-centric perspective/foundations (Dutta, 2010 ; Kim et al., 2010). While there continues to be substantial research attention paid to those from culturally and linguistically diverse backgrounds much of the research is on white health professionals communicating with patients of other ethnic backgrounds (primarily from the U.S. and with Hispanics and Black American patients). This is despite most western countries relying on an increasingly ethnically diverse health workforce. Such findings cannot necessarily be transferred to people from other backgrounds and may result in limited constructions of communication competency. There are, however, signs of change. South Korea has become the first Asian country to start publishing a health communication journal in December 2009, and Paek, Lee, Jeong, Wang, and Dutta (2010) identified a growing emphasis on postcolonial theorizing in health communication research in Asia, which addresses the unique characteristics of different Asian countries. Schulz and Hartung (2010) also noted the increasing interest in health communication in Europe.

Researchers also need to acknowledge the compounding effects of multiple group memberships, such as being from an ethnic minority group and low SES and/or rural. While the social psychological literature has increasingly acknowledged the importance of examining multiple group memberships health communication has tended to focus more on single group memberships (Watson et al., 2012). This limits our understanding of how different group memberships interact to shape health communication and miscommunication.

We propose that health communication scholars must continue to extend their horizons to include contributions from researchers with expertise across a range of social science disciplines (and also include health professionals). There needs to be more mixed methods in the research design and data analysis and more acknowledgement of the range of contextual factors influencing health communication. An LSP approach can accommodate these research advances. Scholars must also adopt more translational research than ever before and, rather than highlighting problems, look to finding solutions that improve health care management.

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