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Chapter 60

Qualitative approaches to clinician–patient communication

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In *The Country Doctor*, Kafka's central character laments that writing a prescription is easy, but coming to an understanding with people is hard.¹ If the practice of medicine were as simple as sending a clear message, then the practitioner's job would be reduced to correctly formulating the right words. The reality, however, is that patient care is not simply about message transmission, it is about a dynamic interplay of information, emotions, expertise, goals, beliefs, and so on. To study the artful management of the complexities of healthcare communication, qualitative approaches can be highly productive and can stimulate new insight: 'how' may be a more relevant question to begin with than 'how much'.

In oncology and palliative care, as in any medical domain, both physicians and patients have concerns, though perhaps somewhat different ones, regarding preferred trajectories and outcomes of the medical visit. Whether or not these preferences are realized during a consultation, patients come away with information about the nature and course of their illness, as well as with recommendations on how, or whether, to proceed with treatment. Physicians, from their side, face the tension of maintaining the delicate balance between informative yet hopeful communication (1). They deftly navigate the line between recommending treatment and avoiding guarantees (2). For those concerned with understanding these kinds of communication tensions in the practice of medicine, the inductive and interpretive approaches presented in this chapter may prove useful. The methods outlined here have particular relevance for face-to-face communication, though reference will also be made to studies in the wider healthcare setting. The final sections of the chapter reflect on the special ethical challenges facing researchers engaged in field-based studies, and a brief discussion is offered concerning the trade-offs between reliability and validity in qualitative research.

Unique contribution of qualitative methods for studying clinician–patient communication

Engaging in health communication research presumes a wide range of goals: to discover something new or to understand a phenomenon more fully; to make the world better in some way; or to advocate for a position in a manner that is acceptable to a community of practitioners, scholars, or policy makers. Regardless of the research goal, each person engaged in the process brings preconceptions of how the world works, what constitutes knowledge, and what is the most appropriate way to find answers to his or her individual questions. The trade-offs between

1. This is a close paraphrase from a translation by Willa and Edwin Muir in *Selected Short Stories of Franz Kafka*, New York, NY: Random House, 1952, p.152.

quantitative and qualitative approaches have been extensively debated—see Heritage and Maynard (3) for a brief review in the context of medical encounters—but there is no *best* way to study clinician–patient interaction. If, however, one determines that a qualitative approach is most appropriate for his/her research goals—see Silverman (4) for guidance in this regard—then one is embarking on a project that demands close attention to participant orientations and understandings of their own activities.

What distinguishes the qualitative study is its commitment to understanding lived experience by privileging the dialogic nature of human life. From this vantage point, understanding is created in concert with others; it is not the result of a correct message being sent down a correct channel. Hence the lament of Kafka's country doctor who recognizes that it is our discursive involvement with others that produces the challenges of everyday life. For doctors, as for all of us, meaning is created socially; we cannot produce understanding in isolation. But, it is that very essence of creating meanings through talk that can also lead to misunderstanding. If it were as simple as writing prescriptions, medical visits would be much shorter.

Although there is agreement that talk is at the centre of the social, diagnostic, and therapeutic work of medicine, approaches for understanding face-to-face communication vary substantially. The process of coding interactions into countable units can help to establish the basis for standardized comparisons, but there is the risk of turning participants' communicative acts (the talk) into a by-product of the physician–patient relationship (5). Those quantitative approaches that centre on unitizing the countable verbal and non-verbal elements of an interaction, introduce a level of abstraction that can compromise a transactional understanding of the nature of communication. The talk and embodied action are no longer viewed as dynamically constructing meaning and the researcher can lose sight of how understanding is constructed as an ongoing process.

It may go without saying, but is worth repeating, that just because a strategy for data collection is observational does not mean that the method is qualitative. Loosely structured observation of lived activity, highly structured interviews, and electronic recording of interaction are simply ways of corraling and making manageable the study of the seamless processes of human interaction. For example, focus groups are often included in discussions of qualitative methods even though there is nothing qualitative, *per se*, about a focus group; it is simply a technique for eliciting stories, beliefs, conversations, and so on. These could be quantified (coded and counted) or, conversely, qualitatively examined. Taking a qualitative approach, the researcher is committed to being reflexively aware of his or her own meanings as an analysis emerges of the participants' orientations. The aim is to reconstruct the sense-making practices of the participants, not necessarily to confirm a theoretical concern of the researcher.

In addition to providing rich interactional detail, which can be an end in itself, qualitative approaches can also serve as groundwork for further exploration. For example, Garant (6) provides an informal report of her experience as a psychiatric nurse who, in the course of her work (though not as a formal study) asked patients what it means to have cancer. Several conceptualizations emerged concerning impediments to the coping process (e.g. fear of incapacitation, alienation, contagion), which could be followed up in additional studies, whether qualitative or quantitative. Thus, field techniques, such as observation, interviews, and recordings can provide data for qualitative analysis of participant orientations or they can provide the necessary rich grounding for informed development of testable hypotheses.

Representative approaches and relevant empirical studies

In this section, data collection techniques and interpretive approaches are discussed with examples from relevant empirical healthcare research. The goal is to present a variety of frameworks

that share grounding in terms of basic field techniques for data collection (observation, interviews, recordings) but which differ in scope, focus, or fundamental philosophy. First, field-based frameworks are presented that draw on a traditional scientific approach of observing and describing real entities. Gubrium and Holstein (7) have termed this the 'naturalist idiom' in qualitative research because it adheres to a belief in a discoverable truth, one which will 'truly' represent participant lives. Included here are ethnography, grounded theory, conversation analysis, and ethnography of communication.

In contrast to these naturalistic approaches, postmodernism is also presented because it offers a different philosophical basis, one which highlights paradoxes, thus disrupting the traditional sense of a shared or monolithic truth that can be captured and represented. The value of this form of scholarship is that it can provide openings for new insight. Healthcare researchers need not shy away from postmodern philosophy just because it seems to lack the traditional notions of shared or observable reality. On the contrary, a postmodern approach may well offer a way into understanding the healthcare setting that would be inconceivable from more traditional vantage points.

Whatever the philosophical grounding (e.g. naturalist vs. postmodern) researchers using these approaches are generally interested in patients' and practitioners' beliefs, practices, and understandings of health and illness. They are attempting to derive participants' understandings from the researcher's detailed observation, description, and analysis of behaviour and artefacts. For a comprehensive discussion and critique of the philosophical grounding and practical implementation of these research approaches, see Gubrium and Holstein (7).

Ethnography

'Ethnographic methods' has become an umbrella term for a wide array of procedures for data collection, analysis, and description of findings. Under this heading, interviewing and focus groups will be discussed, though these techniques are not unique to ethnographic studies.

Steeped in an anthropological tradition, ethnographic description can evoke contrasting impulses: on the one hand, there is the risk of treating individuals and groups as 'exotic', while on the other hand, there is a sincere concern with understanding participant viewpoints. This tension provides a productive dialectic in which to explore the world of health and healthcare. For studies of medical interaction, an ethnographic approach can provide a wide scope, taking in a setting as large as an oncology unit within a hospital (e.g. Germain, 8) as though it were a unique culture, or studies can be more focused on particular segments of a culture. For example, Linnard-Palmer and Kools (9) examined nurses' attitudes and interactions in the context of paediatric oncology. In this study, thematic analysis of field interviews and observations addressed the ethical complexities embedded in nurses' interactions with parents who refuse treatment for their children. These sorts of studies provide descriptive and empirical detail as a basis for deeper understanding of lived patterns of activity as well as for participants' understanding of their own and others' actions.

Engaging in ethnographic research has traditionally entailed extensive (up to, and beyond, a year) participant observation in a particular group or organization. The goal has been to minimize presuppositions about the group, giving rich descriptions and analyses that provide some sense of what 'really' goes on at the level of daily practice. This analytic stance, to capture reality in the quotidian, is probably 'the predominant language of qualitative research' (7, p.6) and is most characteristically embodied in ethnographic studies. A classic study in medical anthropology, the description of medical student life in the freshman and clinical years (10), is presented almost as if the medical students were an isolated group in a far-off land, yet another early ethnographic study contributed tremendously to our conceptualization of 'hospitalized dying' (11, p.xii) as

an orchestrated process. These classical approaches to ethnographic research in medical settings provide an overview of particular cultures or segments of the culture in a way that is primarily intended to suggest the cognitive contours of the participants' experience (12).

Other forms of naturalistic inquiry move beyond description of knowledge and beliefs to paint participants' experiences in their 'full emotional colour' (7, p.9). There is still use of the same fieldwork and data-collection techniques (establishing rapport, building trust, observing, and interviewing), but analysis is focused on feelings as opposed to beliefs. The representation of these emotionalist studies can draw on unconventional formats, such as poetry and drama. While this may seem at odds with a scientific orientation, it could provide an interesting avenue for clinician researchers who may wish to delve into the complexity of emotions in their field, perhaps allowing them to better address their own as well as their patients' needs.

Technological advances have brought audio- and video-recording into the researcher's toolkit. While early medical field studies also used recordings (e.g. Glaser and Strauss; 11, 13) the effort was primarily to record interviews with participants, not necessarily the medical visit itself. Nonetheless, using recording technologies, the traditional immersion approach of the ethnographer can be supplemented by the close analysis of participant activities as recorded by an electronic device. In this way, the observer can reconstitute meaning through detailed description as well as analyze how participants manage and create meaning in the process of actual interaction (see below, Conversation analysis).

Interviewing

In many field-based approaches, interviewing is a core technique; it is a conversation with a purpose, but one that primarily benefits the researcher, not the participant (14). From an ethical standpoint, and in terms of informed consent, it is important to recognize the different types of interviews because not all of them lend themselves easily to the consent process.

Interview types are delineated based on the depth and range of the conversation and the type of relationship one has with the participant (15). 'Ethnographic interviews' are those conversations that can just happen when the researcher is in the study setting and something serendipitously prompts a question related to the research project. There is nothing purposive about this type of interview; the researcher simply makes use of the moment to elaborate on some point of interest. In contrast, 'informant interviews' are designed with a purpose. Participants comment on their experiences and may be contacted several times to discuss various topics of interest to the researcher. These can be open-ended conversations, but they are entered into with a general purpose in mind. Further along the continuum, 'respondent interviews' are brief, stand-alone interactions that generally have pre-set questions in a particular order. These are the least naturalistic and are likely to provide superficial, even socially desirable, responses that do not reflect actual attitudes and behaviours.

Focus groups

Focus groups provide an excellent format for understanding the world of the patient or the practitioner through their own stories, accounts, and experiences. For example, Zimmerman and Applegate (16) use this technique to examine the ways in which hospice teams communicate. In contrast to individual interviews, and contrary to conventional assumptions, focus groups provide a setting in which people are more likely to disclose their health or professional concerns (see Wilkinson for a review, 17). This group activity can stimulate deeper thinking and participants may reveal a broader spectrum of meanings. Whereas an individual may be reluctant to disclose deeper feelings to a researcher who does not share their experience, the focus group encourages people to share in a supportive atmosphere.

Focus groups have been used in a wide variety of health research and allow researchers to observe, if not wholly natural and spontaneous discussions, then at least the process of how beliefs are presented and possibly altered in concert with others (17, p.338). In addition to promoting greater disclosure, focus-group data can also foreground ways of speaking that are natural to the participants. Since the focus-group participants often share some health or professional concern, this approach can help researchers get deeper and more detailed insight into meanings that might otherwise be missed in individual interviews.

Grounded theory

Grounded theory is a research strategy for inductively developing concepts and theories. Glaser and Strauss (11, 13), who developed this approach, were among the first to use field observations and in-depth interviews in order to 'grasp the actor's viewpoint' (18, p.6) in the medical setting. Triggered by an interest in medical sociology, Glaser and Strauss first attempted to describe and understand the process of dying as it occurred in a hospital setting (11, 13).

In grounded theory, analysis proceeds as a coding process that is intended to open up an initial understanding and allow core categories to emerge. The purpose is not to deconstruct an interaction into countable units, but to understand and integrate what is available from interviews and observations. As analysis proceeds, there is a movement away from literal meanings and toward the relationships among concepts (18). It should be noted that grounded theory has evolved in two directions: one characterized by a more agnostic stance towards data (19) and the other by a more question or theory-driven approach (20). Regardless of the strand that one follows in a grounded theory approach, the focus is always on discovery as opposed to hypothesis testing. While the notion of 'hypothesis' is used in an informal way in grounded theory, it develops in terms of plausibility, not testability.

Clair (21) used this approach to study the end of life among oncology patients in a hospital setting. From data collected in the oncology unit, Clair inductively generated the concept of 'regressive intervention', demonstrating how physicians withdraw, whether abruptly or gradually, once the patient has been re-cast, by the physician's diagnosis, from the sick role to the dying role. While medical staff are still expected to maintain humane, palliative treatment, the patient relies less and less on medical staff and families become more accountable for the patient's activities. Using recordings of interactions along with observations, this study demonstrates a grounded theory approach in that analysis is used to develop theory rather than to verify a theory.

Conversation analysis

Conversation analysis (CA) is one among many approaches for the study of spoken discourse. (See Schiffrin and Titsch *et al.* for introductions to the wide and complex variety of methods referred to as 'discourse analysis'; 22-23.) CA, like several other approaches to the study of face-to-face interaction, requires recorded interactions as the form of data for analysis. Unlike ethnographic and grounded theory approaches, however, which can be based on field observations and interviews, CA is predicated on capturing naturally occurring interactions in real time. This technical requirement, which initially was just a way to 'keep a grip' on the social world (24, p.235), is nonetheless grounded in the philosophical and sociological traditions that undergird this particular form of discourse analysis (24-25).

In contrast to other methods outlined in this chapter, researchers using a CA approach are not engaged in describing contexts or in deriving concepts and theories through inductive coding; nor is conversation analysis a critical approach, though it can be used to uncover members' orientations to dominant ideologies. Unlike most other approaches to the study of

discourse, which treat context as an external phenomenon, CA treats context as something shaped through participant talk and action (26–28). This concern with participant agency is a central tenet of this qualitative approach and is, therefore, highly useful for discerning patient and clinician perspectives as evidenced through their embodied actions.

Through close transcription of recorded materials (29–30) the conversation analyst attends to the details of verbal and non-verbal behaviour to see how the participants create meanings. It is thus possible to observe what themes or roles the participants make relevant (or not) and how they accomplish that work through face-to-face interaction. This allows researchers to closely view and describe the visible processes of ‘coming to an understanding’ (in Kafka’s terms).

It is clear from conversation analytic studies in oncology settings that health practitioners risk meeting with resistance from their clients when there is a failure to properly justify the advice or recommendation (31–32). Indeed, the final formulation of a treatment recommendation can be accounted for by the conversational actions of both participants, including the shaping that occurs when patients subtly resist an initial formulation (33). In other words, recommendations are not unidirectional forms of communication. Additionally, patients’ poor understanding of the risks and benefits of cancer treatment (34–35) has been explained by an examination of the inherently equivocal nature of those recommendations (2). An unavoidable tension persists between oncologists’ presentation of recommendations and their avoidance of guarantees. Moreover, it has been suggested that oncologists’ talk about clinical trials is shaped in such a way that it may contribute to differing rates of enrolment (36).

Also important for oncology and palliative care is Maynard’s work (37) on bad news delivery. This line of research has demonstrated how acceptance of, or resistance to, bad news is interactionally achieved. When practitioners are able to draw out a client’s point of view and can find ways to incorporate that into the news delivery, there can be a smoother transition to acceptance of bad news. Maynard thus recommends eliciting the patient’s perspective before delivering news. By connecting bad news to what patients have already expressed to the practitioner about what they know and believe, medical news will be in relation to that, rather than simply being dropped into the conversation as a confusing surprise. Maynard also highlights how news itself is neutral, perhaps a key point for clinicians to remember. The valence of news as ‘good’ or ‘bad’ is dependent on the participant’s reception of it. While we assume, for example, that a prognosis with a short horizon is bad news, if a patient has been preparing for death, it may be a relief to know that the end will arrive soon.

Ethnography of communication

In contrast to conversation analysis, which comprises a micro-analytic stance toward interaction and which focuses on recorded face-to-face communication, ethnography of communication takes a wider view. Similar to a traditional ethnographic approach, the aim is to describe and explain values, actions, and norms within broader structures of cultural knowledge and behaviour. The focus is more concentrated, however, on language practices: what is said, where it is said, by whom, in what manner, through what channel, for what goals, and according to which norms (38, pp.52–71). Findings are based on field observations and interviews, collection of artifacts (e.g. documents), and similar to grounded theory, a process of tracking back and forth in a ‘dialectic interplay’ between description, analysis, and development of theoretical explanations (23). This method generates a wide angle view of settings, but keeps a spotlight on speech events, taking into account observable activities as well as participants’ accounts of their behaviours.

Fisher (39) uses this framework to explain differing rates of treatment of cervical dysplasia in two separate clinics. The differences, which could not be easily explained on medical or

socio-demographic grounds, are discerned qualitatively by highlighting strategic uses of language that may represent the physicians' attitudes toward different patients.

Postmodernism

Postmodernist and critical modernist scholarship, like other interpretive approaches, emphasizes the discursive or social construction of reality. Data-collection techniques, such as examination of texts, participant observation, and interviews, are shared with other qualitative approaches. However, in postmodern scholarship, the underlying assumption is that there is no single, observable truth. Although pain and illness certainly exist as biological realities, they are understood as socioculturally experienced. In other words, a patient's experience of disease is shaped as much by belief systems and cultural norms as by physical reality. As reviewed and evaluated in Lupton (40), the value of postmodern and critical modernist approaches for understanding healthcare is their insistence on examining paradoxes and problems. Variant truths are highlighted and can, therefore, be compared and contrasted. The emancipatory impulse in critical modernist scholarship allows for exposure of inequalities as well as the possibility for negotiation and change (41, p.14).

Postmodernist and critical modernist research primarily uses the analytic tools of literary criticism (e.g. discernment of metaphor, tropes, and themes). For example, the military and sports metaphors that predominate in Western medicine (41-43), along with a belief in the individual will for overcoming adversity, clearly shapes the practice of informing patients. The dominant ideology is for patients to 'fight' their disease (44); however, some research suggests that doctors were still not fully and clearly disclosing cancer diagnoses (45). This raises a paradox: the ideology of the individual's ability to overcome adversity through their own effort is at odds with a choice to shield patients from discouraging news that might somehow constrict their ability to fight. On the flip side of the metaphor that indicates 'fighting' for life, is that cancer patients may experience being at war with themselves, which has implications for the patient's sense of rationality (46, p.27).

As spotlighted in postmodern and critical research, contradictory ideologies and explorations of metaphor provide points of departure for thinking about the ways in which attitudes, behaviours, and even the experience of pain and illness, are communicatively shaped. Through thematic and rhetorical analysis of textual, observational, and interview data, scholars in the postmodern and critical modernist traditions examine the cultural and personal paradoxes forming webs of meaning within which patients and clinicians strive to make sense of health and illness.

Ethical issues in field-based qualitative research

Because much of the qualitative research in medical settings relies upon observations, interviews, and recordings of interaction, studies can be intrusive and lengthy. And, since there is an ongoing and interactive relationship between the researcher and the setting's participants, issues of rapport, confidentiality, and consent can be particularly delicate matters. Thus, the ethical challenges faced in field-based studies can be unique in that they are emergent and unpredictable. Some have even argued that covert research of difficult to reach populations (e.g. the homeless) should be allowed without the constraints of informed consent and voluntary participation (47-49). This position is untenable in the healthcare context, where the biomedical and social overlap seamlessly.

Fine (50) argues that ethnographers are socialized to accept an idea of themselves as empathetic, honest, and accurate; however, the necessities of maintaining good relations for ongoing field observations actually may entail everything from minor interpersonal deceptions to highly

suspect and intentional shaping of events. In other words, as Lindlof and Taylor (15) argue, the danger for the field observer or interviewer is in 'assuming that attainment [of ethical ideals] is easy' (p.140). Punch (51) acknowledges the inevitability of deception at some minor level, but exhorts the researcher to continually monitor and reflect upon his/her practices. Seeing documents or overhearing conversations that might otherwise have been guarded by participants, presents ethical challenges that are bound to occur in busy, public domains. These gray areas (52) can be particularly sensitive in medical settings where, perhaps naively, staff believe they are doing a good job of protecting patient confidentiality.

The sensitive nature of medical settings also raises the critical question of the incorporation of follow-up with participants who may have been observed or interviewed at vulnerable moments. Polit and Hungler (53) address this dilemma in the context of how parents cope with a child's terminal illness. Since such a study would require a potentially painful probing of parents' emotional states, the researcher must consider not only whether the benefit of such knowledge would assist in the design of effective strategies for helping parents, but also what the long-term result of making such demands on parents would be. Once the child has died, what is the researcher's responsibility to the parents? Protection of subjects must, therefore, be broadly construed and considered integral to follow-up as well as to implementation.

An additional complexity of field research in medical settings is that social and medical settings are permeable; people who were not expected, and, therefore, were not part of a consent process, can enter a scene. Thus, the ability to easily obtain informed consent is undermined (54). In envisioning projects, researchers should consider the possibility of such contingencies and plan accordingly. Post hoc consent may be possible, but is often untenable. Furthermore, some locations are considered public (e.g. corridors) and would be exempt from consent procedures, while others (e.g. patient rooms) may be considered private. For those collecting audio- or video-recorded data, an additional consent form is warranted that outlines possible uses of the recorded data beyond research team meetings (e.g. for use in classrooms, at conferences, in electronic journals). Participants should initial those uses to which they consent; this would constitute full and open disclosure concerning the use of recordings. Clearly, the complexities of attaining informed consent are many, and must be balanced against the potential social and scientific benefits to be gained.

Finally, though not an ethical issue at first glance, researchers must 'consider the possible consequences of their culturally ascribed identities for the ethics and politics of conducting research' (15, pp.141-2). The physical characteristics, social attributes, and degree of insider knowledge are among the 'ambiguous gifts' that fieldworkers can carry unwittingly into a scene and which will therefore 'establish axes of difference and similarity' with other participants (15, pp.141-2). Again, the researcher's reflection and monitoring of these dimensions both in planning and implementation are necessary for considering the ethical challenges of field-based studies.

For those interested in healthcare communication research in cyberspace, Jones (55) lays out ethical issues that are relevant for that medium where what is considered public, private, and deceptive becomes even more challenging for research.

Validity and reliability

Scholars differ in their opinions of whether or not reliability and validity are relevant concepts for qualitative research. From a social constructionist perspective, the argument is that the transient and contingent nature of human interaction renders any concern for reliability irrelevant. Validity is probably more relevant, since a particular interaction or event may be accurately analysed, but rare enough that it would be hard to find another just like it for comparison. Although the process

of collecting instances and comparing them provides for a grounded claim about a particular action or behaviour, it is also the case that 'one' is a number and that analysis of a particular case holds value (56) and can be built upon for developing further insights.

However, Silverman (57) warns that if qualitative researchers are not mindful of issues of reliability and validity then they are at risk of engaging in the romanticism of nineteenth-century thinkers and chroniclers. In that tradition, observers may have selected data for its dramatic or exotic qualities, or because it fit an idealized pre-conception of the culture being studied. Therefore, Silverman suggests formulating hypotheses and testing assumptions through triangulation and checking for participant validation.

Conclusion

Misunderstandings, whatever their root-cause, can haunt patients and practitioners as they strive to make sense of a complicated interpersonal world within the medical organization. The value of qualitative and interpretive methods for studying medical communication resides precisely in the ability of the researcher to discern practices and beliefs that may give rise to misunderstandings. These participant orientations and behaviours are not necessarily available at a conscious level and may only be available through systematic observation and interpretive analysis. In addition to gathering patient and clinician narratives about their experiences and beliefs (through interviews and focus groups), a great deal can be learned from systematic observation and recording of actual interactions (ethnographic and conversation analytic approaches), which can capture details of the dynamic, transactional nature of (mis)understanding. Greater attention to theory development that is grounded in inductive analysis and interpretive procedures (such as grounded theory) can bring to light the inter-dependent relationship of practitioner and patient in terms of the larger social context. Critical and postmodernist approaches help to uncover paradoxes and power dynamics that can bring to the surface the webs of social and cultural meaning in which we manoeuvre with little awareness.

To better understand patient-clinician communication is to better understand the ongoing, situated processes that constitute communication. How are recommendations made, how is advice given and received, how do both parties participate in the construction of the medical moment? These kinds of questions imply understanding of the communication process, not just its outcomes. By definition a process is a series of activities, but in human terms, these activities rarely have discreet, discernable boundaries. Qualitative methods lend themselves especially well to understanding this fluid, socially constructed process of communication.

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