U O W

Health Semiotics

SFL FRIDAY RESEARCH STUDENT MASTERCLASS S1 2020

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OF WOLLONGONG
AUSTRALIA

To begin – who are we?

- Find someone you don't know and introduce yourself!
- Next we will go around the whole group – please tell us something important about your given name – what it means, where it comes from, why you're called that, who you're named after, etc.
- Please also tell us what your research is on.

What do you want to get out of this course?

?

My aims for this course

HEALTH SEMIOTICS

- profile work on the role of meaning making in health and healthcare that draws on a Systemic Functional Linguistic approach

- to critically reflect on the potential for SFL to make a substantial contribution to the field of medicine and healthcare (and maybe more broadly to improving our health), and obstacles which might block such work

- to critically reflect on the potential for health as a field of enquiry to test SFL's theoretical and descriptive tools

Learning outcomes

HEALTH SEMIOTICS

On successful completion of this course students will be able to:

- critically discuss how variation in language/semiosis influences the quality of health care and health status
- evaluate the contribution of SFL and 'fellow traveller' approaches to describing this variation and going on to address significant barriers to quality health care and good health
- use existing and/or new skills in semiotic analysis to examine a health issue
- identify the kinds of pressures that studying health discourse throws back onto SFL's theoretical and descriptive tools
- extend and refine their interpretation of SFL as a theory and body of work.

Course format

HEALTH SEMIOTICS

- 2-3pm Weeks 1, 2, 3, 5, 9, 11: lecture
- 2-3pm Weeks 4, 6, 8, 10, 12: student-led discussion of readings
- 3-4pm: Text analysis and discussion

Course wiki

ALISONROTHAMOORE.COM

- Readings and other material are here.
- More material coming.
- Check regularly.
- Any problems – email me at alisonrothamoore@uow.edu.au

Assessment

HEALTH SEMIOTICS

1. Your student-led reading discussions (not graded)

- do in pairs (?)
- choose one from a list of articles provided
- find a second paper of interest (a starter list of journals will be provided.

2. Essay minimum 2000 words + analysis to be marked by your supervisor (graded) and also handed in to me. Due Friday 5th June (Wk 14).

- text analysis required
- may be supplemented with corpus or another secondary analysis
- essay instructions available by Week 7

How to make the most of this course

- Please read any articles set down as ‘must read’ before the lecture
- Read actively, annotate, respond to articles, and ask questions
- Evaluate the articles we read, don’t just absorb them (more later)
- Reflect on your personal experience as a health consumer, carer, practitioner …
- Reflect on how health issues are represented in discourses around you
- Reflect on cultural/linguistic variation in how health discourses are structured
- Reflect on differences between other registers you have studied and the domain(s) you are studying in this course
- Engage with each other and with me through in-class discussions, emails, etc.
- Participate in discussions
- Keep coming!
- Let me know if things are too fast, too slow, unclear, burning issues we must address.

U O W

Health Semiotics Week 1

Health, health care, and health discourse: What can the fields of health and social semiotics offer each other?

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OUTLINE FOR TODAY

- What is ‘health semiotics’?
- Where does this field fit in SFL landscape & history?
- What kind of a context is ‘health’ and how can we use SFL principles to think about this?
    - everyday construals of health
    - core healthcare context: doctor patient interaction (started this)
- What clarifications are health and social semiotics likely to bring each other? (We started thinking about this but didn’t get to it as a specific section)

Main sources: Halliday 1999 on pain, Hasan 1985 on text structure, Harvey and Koteyko 2012 Ch1 on practitioner-patient relationship, Moore 2019 on language and medicine

1. What is ‘health semiotics’?

HEALTH SEMIOTICS

WHAT IS IT?

"Health semiotics, an emerging concept, studies healthcare activities from a semiotic angle. It focuses on the use of information for communication and action in health domain…" (sic)

Kecheng Liu, in forward to Michell et al. (2014) *Handbook of Research on Patient Safety and Quality Care through Health*, Hershey, US: Medical Information Science Reference p. xx.

HEALTH SEMIOTICS

IS IT REALLY AN EMERGING CONCEPT?

"Semiotics – referring in earliest usage to medical concerns with the sensible indications of changes in the condition of the human body – constituted one of the three branches of Greek medicine"

Thomas Sebeok (2001) Signs: An introduction to semiotics, 2nd edition. U Toronto Press, p. 47.

HEALTH SEMIOTICS

SEBEOK GOES ON… (2001:47-49

"…Symptomology, or *semeiology* (Sebeok 1973b), eventually developed into a branch of [modern] medicine with a specialised … preoccupation with diagnostics.

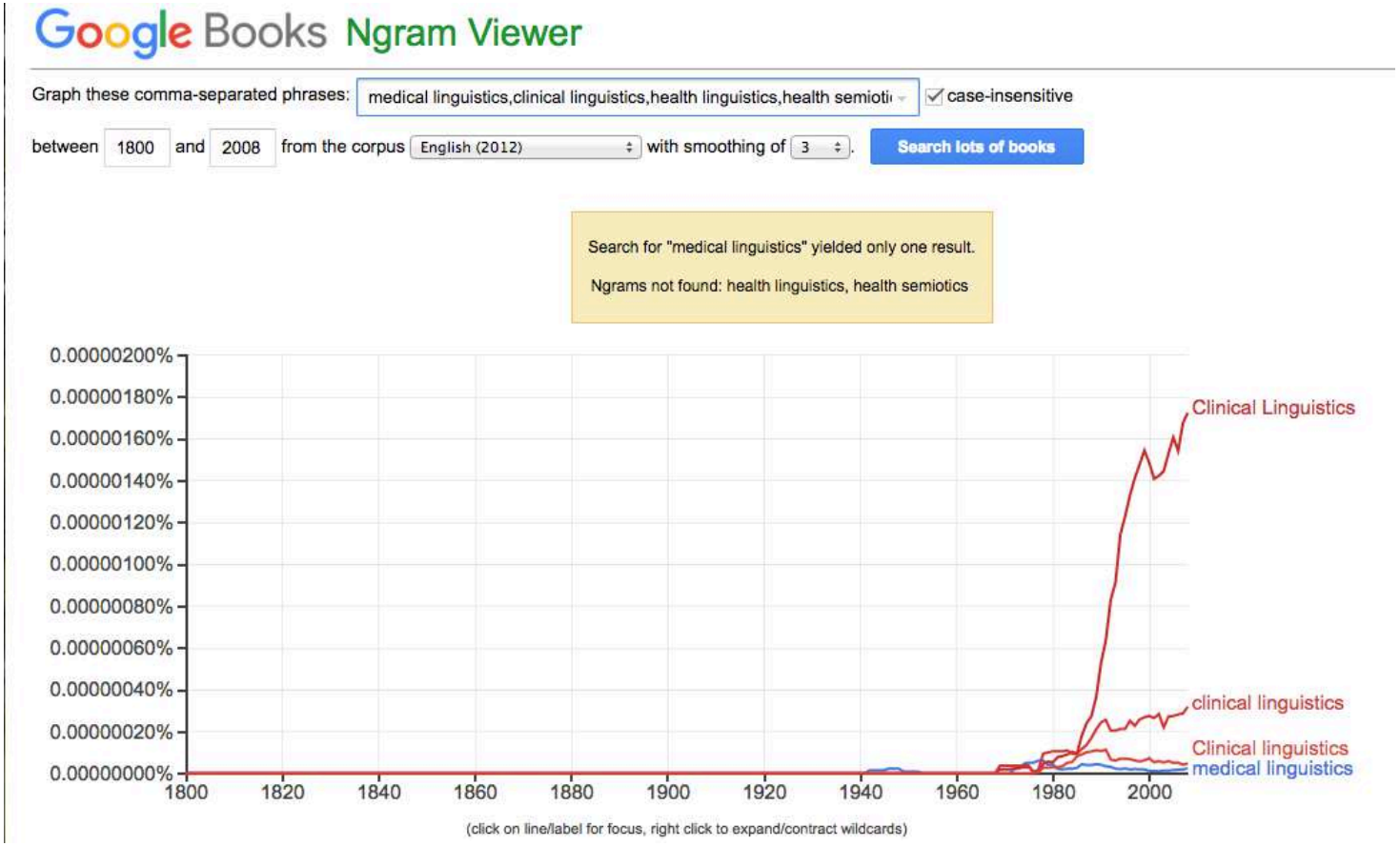
…the distinguished work of Michel Foucault [e.g. Birth of the Clinic 1963] … was … remarkably anticipated by Kleinpaul, in 1888, who paid homage to Hippocrates as the father of 'Semiotik' in having traced this nexus out in its Saussurean pre-figurements…

Like all signs, symptoms may figure in both paradigmatic systems and syntagmatic chains…"

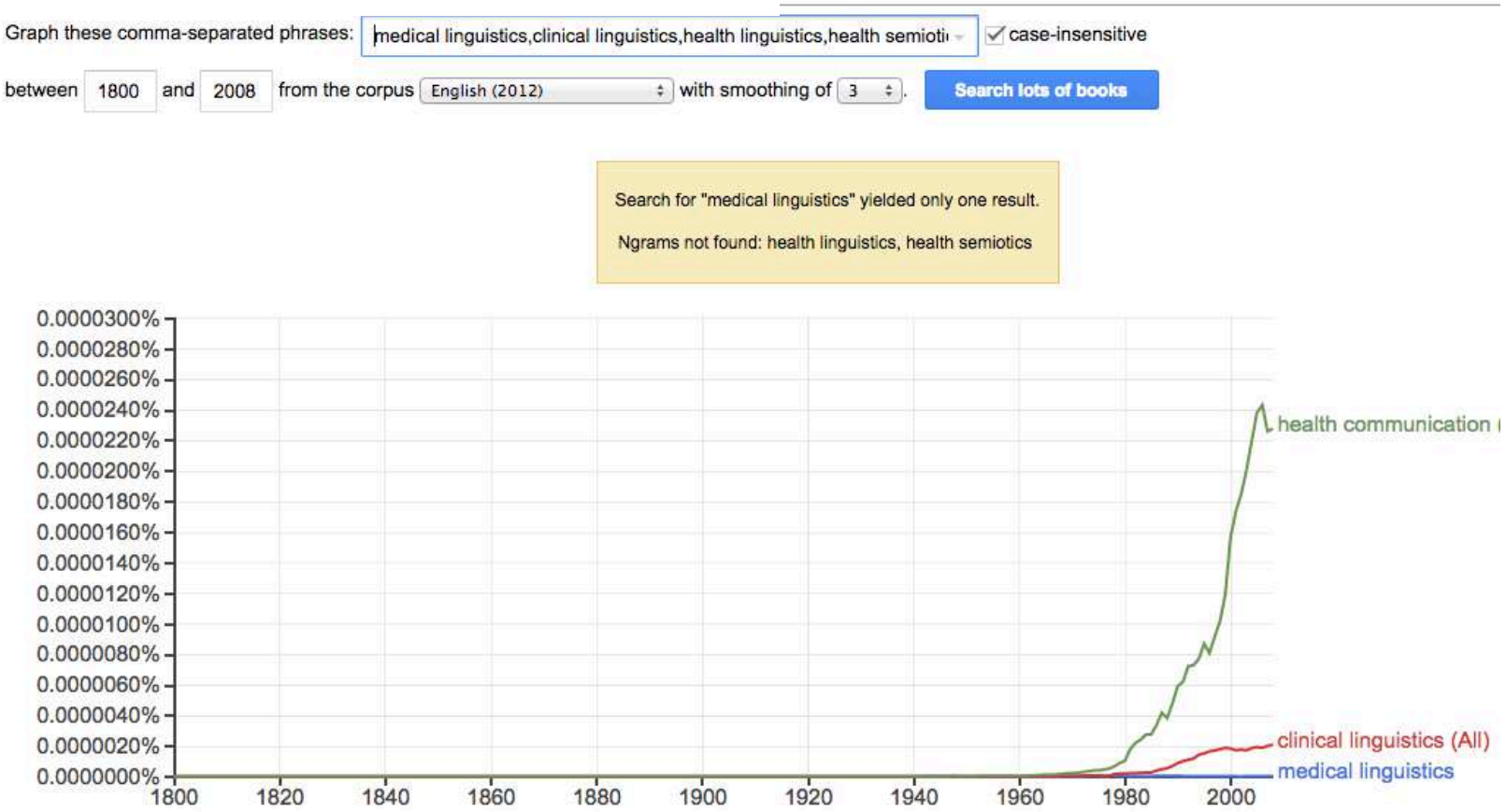
See also Kappagoda (2004) writing on the Plague of Athens.

Medical linguistics, clinical linguistics, health linguistics, health semiotics

WHAT'S IN A NAME?



Medical linguistics, clinical linguistics, health linguistics, health semiotics **and health communication?**



SO, WHAT IS "HEALTH SEMIOTICS" ?

FOR THIS COURSE

The application of social semiotics, including SFL-inspired approaches to studying language and intersemiosis, to the critical study of health domains and health concerns.

(working definition for now)

WHAT IS "HEALTH" ?

FOR THIS COURSE

Health is a very contested concept. We will postpone this question for now but come back to it through the course.

2. Where does health semiotics fit in SFL landscape and history?

IN SFL we have seen:

- a steady stream of healthcare work
- includes heavy hitters (e.g., Halliday, Martin, Slade, Eggins, Matthiessen, Butt, Thompson, v Leeuwen, Fine, Iedema…)
- but health linguistics/semiotics not a prominent subfield of SFL

causes/symptoms:

- co-ordination between researchers
- little metadiscourse on SFL medical discourse
- theory/application cycle
- Field, Tenor, and Mode relations between disciplines in health semiotics

✓ opportunities for SFL

Intervention Points

NEED TO CONSIDER WHERE WE CAN BEST 'INTERVENE'

- the physical or conceptual places within a biological or institutional system where pressure can be applied to disrupt existing function and promote change (after Reinsborough & Canning, 2010).

Your turn:

If you were the richest person in Australia and could put as much money as you liked wherever you liked in order to improve the health of Australians, where would you spend it?

Health is dependant on our genes, our lifestyles, environment and health care

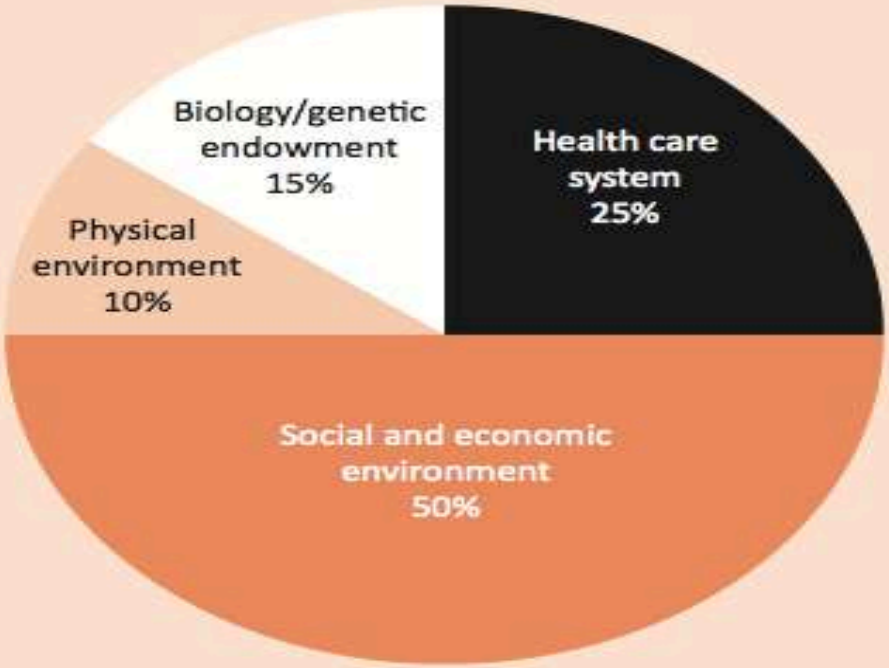
From: The King''s Fund: Ideas that change health

Website

Source: Dahlgren, G. and Whitehead, M. (1993) Tackling inequalities in health: what can we learn from what has been tried?

Health care is only 25% of what determines health

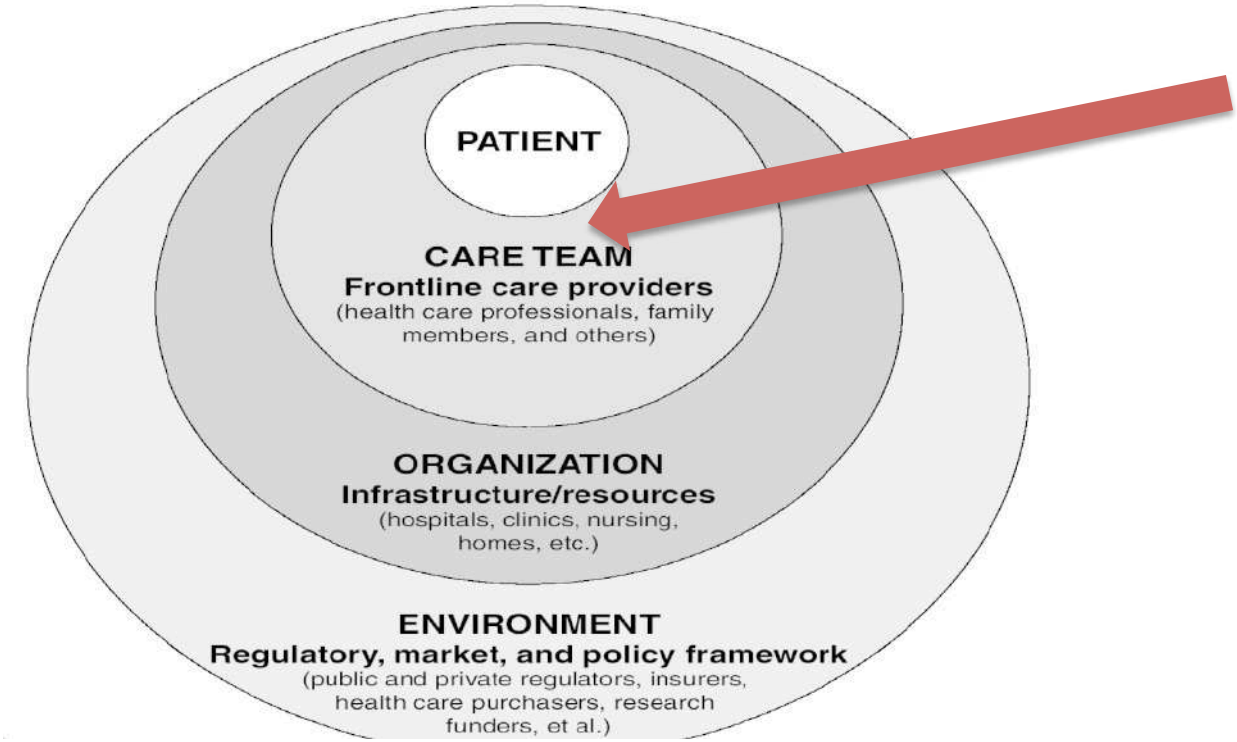
Figure 1 Estimated impact of determinants on health status of the population



Source: Canadian Institute for Advanced Research, Health Canada, Population and Public Health Branch AB/NWT 2002

Which points of intervention addressed with SFL

NEED TO CONSIDER WHERE WE CAN BEST 'INTERVENE'



INTERVENTION POINTS

1. Everyday construal of health experience
2. Clinician-patient interface (inc mental health)
3. Mediating the c-p interface including medical education, training and research, interpreting…
4. Healthcare as system & institution
5. Culture shaping illness, treatment, prevention

Outline of topics

HEALTH SEMIOTICS

Week 1 – Health, health care, and health discourse: What can the fields of health and social semiotics offer each other?

Week 2 – Patients talking to clinicians: focusing on doctors and patients enacting and negotiating role relationships

Week 3 – Patients talking to clinicians part 2: Guest lecture from Dr Neda Karimi - https://www.researchgate.net/profile/Neda_Karimi. Experiential issues - transitivity concordance

Week 4 – Broadening the clinical setting: other clinicians, families

Week 5 – Broadening the clinical setting part 2: interaction in mental health contexts

Week 6 – Mediating clinical interaction: healthcare interpreting and medical education

Week 7 – NO CLASS 10 APRIL

Recess – NO CLASS 17 APRIL

Outline of topics

HEALTH SEMIOTICS

Week 8 – Mediating clinical interaction part 2: written & online information

Week 9 – Mediating clinical interaction part 3: decision aids and social media

Week 10 – Mediating clinical interaction part 4: interaction within surgical / other hospital teams

Week 11 – Institution- and system-wide issues: cultures of risk and safety in the organisational and built environment

Week 12 – Health beyond the health system: cultural, legal, and economic drivers of health and contested notions of health

Week 13 – Q&A

Note: This 'core' to 'outer context' way of organising the material means that we will also be moving (roughly) from spoken to written mode and on to image, proxemics, architecture and institutional and cultural formations.

3. What kind of a context is ‘health’ and how can we use SFL principles to think about this?

A. EVERYDAY CONSTRUAL
OF HEALTH

- Halliday (1998) ‘The grammar of pain’
- uses first 20-million-word COBUILD corpus, a short text, and paradigms of typical spoken expressions

Read and discuss …

- What is Halliday's aim in this paper?
- What is his main finding?
- According to Halliday, which was more likely in English '*I have a headache'* or '*My head aches/is aching/hurts"*?
- Why?
- Does this seem to be peculiar to English or a wider pattern?
- Would you say there is a 'congruent' way of talking about pain in English? Why/why not?

(SOME) ANSWERS

- pain is **multiply categorized**:
  - quality (*sore* tummy)
  - thing (*tummyache*),
  - kinds of process (my tummy *aches*, *hurts*, *is giving* me trouble, etc.) (2005 [1998]: 306).
- more likely to hear '*I have a headache'* than '*My head aches/is aching/hurts*.
- French, Russian, Chinese show similar pattern
- presenting the self (I/me) as Theme construes whole person as 'setting out point'
- Greek (Lascaratu 2002, 2007), Japanese (Hori 2006), German (Overlach 2008) and Italian (Bacchini 2012) replicate studies.

A. EVERYDAY CONSTRUAL
OF HEALTH

- Jordens cancer illness narratives (2002, Jordens et al. 2001)
- complexity and its significance
- after Martin and Plum (1997) narrative types
- argues – contra Frank (1995) that patients with the greatest life disruption have the most complex and, in some ways, the most tightly organised – rather than chaotic – narratives.
- cf Henderson-Brooks (2006), Butt et al (2010) on complexity in psychotherapeutic discourse

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- 10 minute break

Fleischman (1999:7)

“Language, as Freud reminds us, is never innocent. As a linguist I am particularly attuned to the metamessages and psychological substrate of the expressions we use—for the most part unconsciously—to talk about our health and its disorders. What first prompted my interest in referring expressions for states of ill health was a remark made to me several years ago, when I was still asymptomatic, by someone who had heard that I was not well. "I'm sorry to hear you're sick" the person said. Albeit well intentioned, the phrase struck me as odd. For in the event, I looked fine, I felt fine, I was going about my business as usual. I wasn't sick. My place was still within the community of the well. I just had a bad disease.”

Your turn: Discuss in pairs

1. How would you describe the difference in English between:
   being sick
   being ill
   having a disease

2. Are there other expressions that you think belong to the same set of choices and what determines when you would use them?

Your turn: Look at the texts on next slide and consider whether lexis is the most important difference between the two passages

Interviewer: ARE YOU CURRENTLY TAKING ANTIVIRAL MEDICINE FOR HIV?

MARTIN A: Um the regiment of taking drugs at a certain time before meals, after meals, um to me it is just like asking a lot. It is like saying well, you have to look at the clock to remind you that you are sick and you've got HIV ... and then look at the clock two or three hours later and tell yourself you've got HIV and take another pill.

Interviewer: ARE YOU ON ANY SORT OF MEDICAL REGIME RIGHT NOW FOR HIV?

MARTIN B: Um, yeah, I'm on my own little vitamin trip. I take between 12-15,000 milligrams a day of vitamin C powder and I'm also on a garlic tonic which is probably bumps me up to between 20-30,000 milligrams of vitamin C a day and I've been on that now for quite a few years. Um as well as uh I take Echinacea and I take 4-5 multi vitamins in the morning and I take B complex in the evenings.

From Race et al. (1997: 5), discussed in Moore 2004.

Your turn again!: Discuss in pairs

Is there a medical register? Is there a health register? If so how do we characterise it and compare it with other registers?

HEALTHCARE & REGISTER

- SFL's primary tool for characterising the co-variation of meaning and context is the concept of register. Healthcare is an area where detailed register description is needed.

HALLIDAY'S APPROACH TO REGISTER

QUESTION:

- We may want to think about whether we want to use register as count noun or a mass noun. Does it matter?

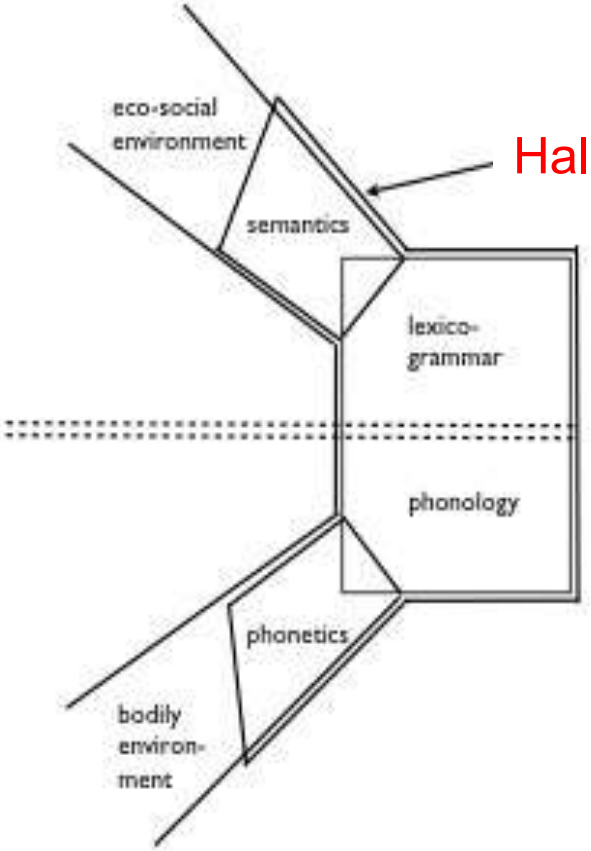
- Yes it matters because it indexes a tension between *registers* as discrete and *register* as continuous variation

- Halliday's own definitions of register varied but in his most explicit statements he favoured 'continuous multi-dimensional variation' (Moore 2020)

- There appears to have been a drop-off in work taking the continuous multidimensional angle as its primary focus, with some limiting effects

Halliday (2003:13)

REGISTER IS LOCATED:



Halliday's 'register'

Figure 1: Language in relation to its bodily and eco-social environment (Reproduced from Halliday, 2003: 13)

Halliday's idea of register has always been one of continuous variation

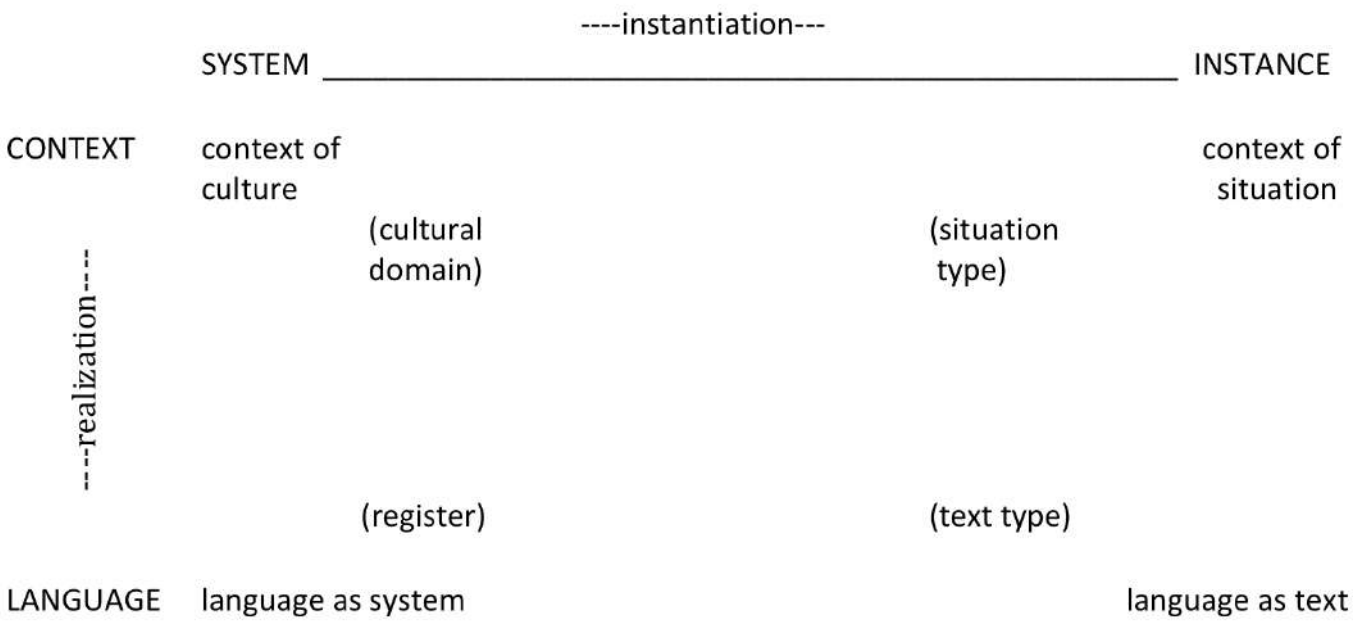
Halliday (1985:38)

A REGISTER IS:

> "a semantic concept. It can be defined as a configuration of meanings that are typically associated with a particular situational configuration of field, mode and tenor. But since it is a configuration of meanings, a register must also, of course, include the expressions, the lexico-grammatical and phonological features, that typically accompany or realize these meanings"

Register (after Halliday 1999:8)

LOCATED STRATALLY AND INSTANTIALLY



Note differences from Martin's model (see Martin 1992, Tann 2017)

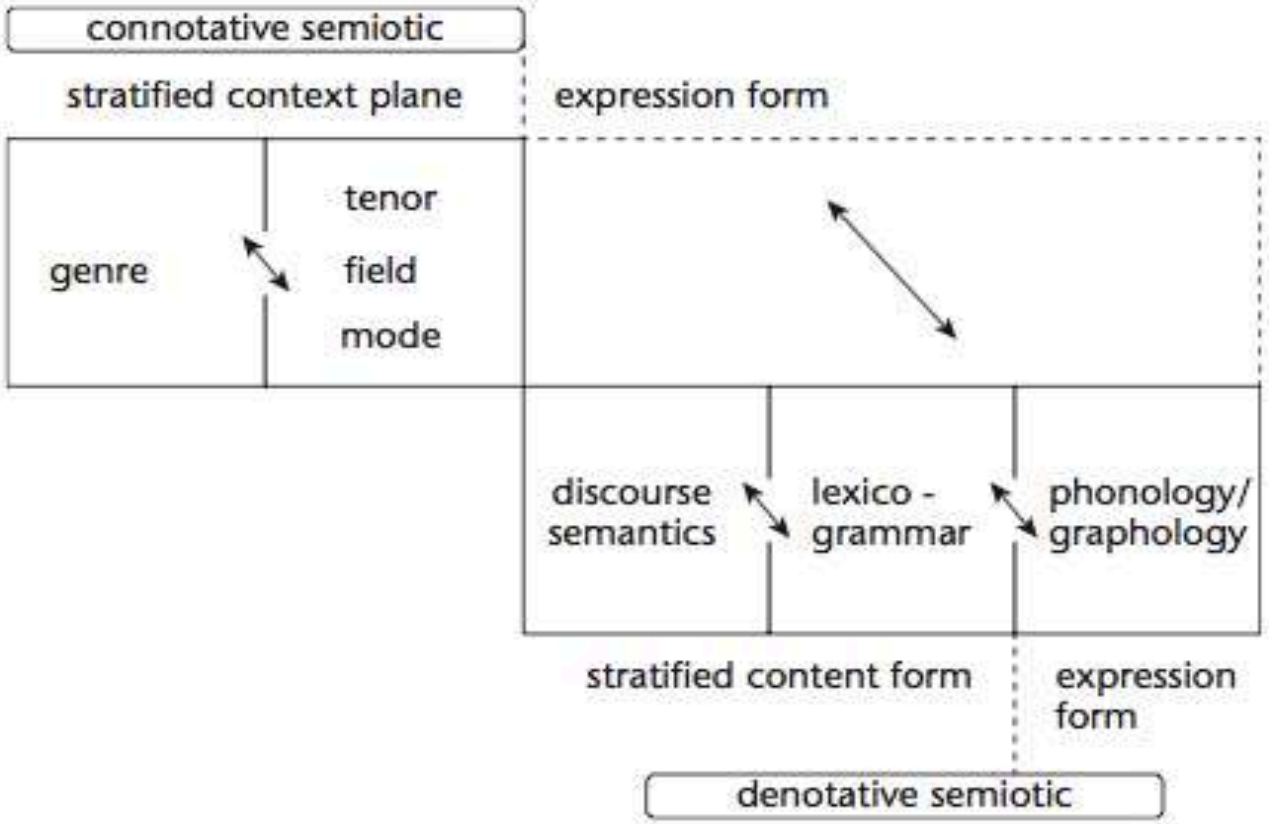


Figure 27.1 Stratified model of context and language

Source: Martin (1997)

Tann

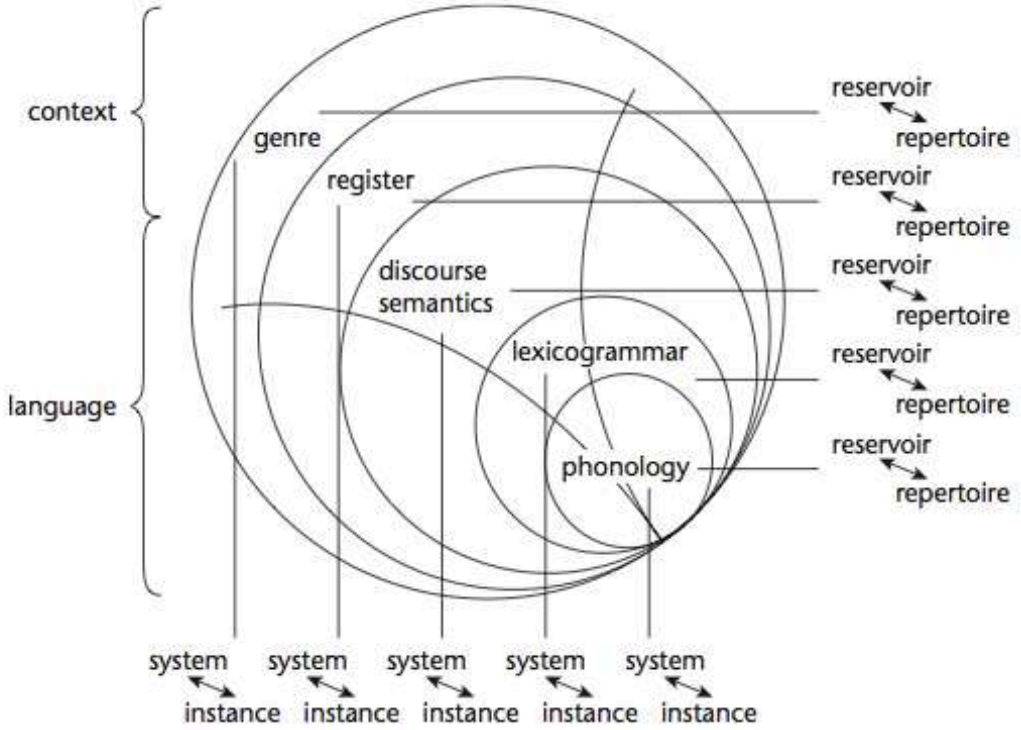


Figure 27.2 Stratification, instantiation and individuation in the Sydney architecture

Halliday's views have arguably been consistent

REGISTER IS

1 a construct belonging within the semantic stratum;
2 a multifunctional, multidimensional construct that cannot be reduced to a single feature or cline such as 'degree of formality' or 'degree of spoken/writtenness';
3 a construct that is responsive to settings in field, tenor and mode;
4 a primary category that is centrally involved in motivating systems of grammatical distinction and handling indeterminacy – not an 'add on' to the architecture of the theory; and
5 a concept that is capable of detailed (and contested, disparate) application, not only a flag to fly over the notion of variation.

But Halliday's views are not invariable

REGISTER IS

1. a variety of language, *corresponding* to a variety of situation (1985)
2. a configuration of meanings *that are typically associated* with a particular situational configuration of field, mode and tenor (1985)
3. the configuration of semantic resources that *the member of a culture* typically associates with a situation type (1978)

Caution against reifying register

> What we recognize as “a register” is a clustering of features ... that can be observed to co-occur in a regular fashion: a local resetting of the global probabilities of the system... Like a dialect, a register comes to exist only because the great majority of possible feature combinations never occur at all; there are huge disjunctions, empty regions in a language's variable space. (Halliday 2003[1997]: 255)

Not a change in view

- Registers are defined by formal (linguistic) not situational properties:

"if two samples of language activity from what, on non-linguistic grounds, could be considered different situation-types show no differences in grammar or lexis, they are assigned to one and the same register: for the purpose of the description of the language there is only one situation type here, not two". (Halliday, et al. 2007[1964])

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Illustrating some of the issues for text analysis

TEXT 1 (Hasan 1985:54, slightly adapted)

A: Can I have ten oranges and a kilo of bananas please?

B: Yes, anything else?

A: No thanks.

B: That'll be dollar forty.

A: Two dollars. [Hands over $2 in cash]

B: Sixty, eighty, two dollars. Thank you.

Illustrating some of the issues for text analysis

TEXT 1 (Hasan 1985:54, slightly adapted)

How does Hasan describe the Contextual Configuration of Text 1 (p. 59)

CC { Field:
Tenor:
Mode:

Context: Field, Tenor, Mode

FIELD

TENOR

i agentive roles: vendor & customer (not interchangeable)

ii status: hierarchic +

iii social distance: +++

iv influence: none apparent

MODE

Context: Field, Tenor, Mode

FIELD

TENOR

MODE

i role of lang: ancillary

ii type of interaction: dialogic

iii medium: spoken, not scripted but fairly routine

iv chanel: phonic

v rhetorical thrust: co-operative exchange

vi shopping transaction

Context: Field, Tenor, Mode

FIELD

i experiential domain: economic transaction

ii short term goal: purchase retail goods(perishable food; counter service)

iii long term goal: keep good customers etc?

TENOR

i agentive roles: vendor & customer (not interchangeable)

ii status: hierarchic +

iii social distance: +++

iv influence: none

MODE

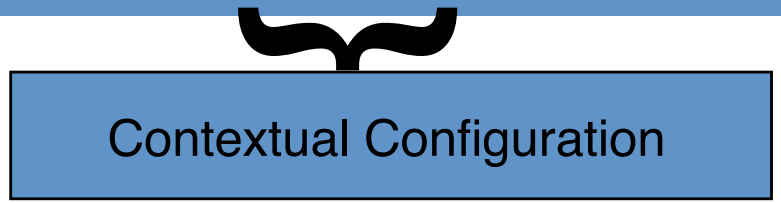
i ancillary

ii dialogic

iii spoken, not scripted but fairly routine

iv phonic

v co-operative exchange



Context: Field, Tenor, Mode for Text 4

FIELD social activity	TENOR social roles	MODE language role
*context of care: medical	*agents doctor/patient	* constitutes activity
*decide treatment	*hierarchic?	* channel phonic
*control virus	*social distance low	* medium spoken
*maximise P health	WHY?	* process sharing ++
	* appraisal from both	* evaluation

Illustrating some of the issues for text analysis

TEXT 1 (Hasan 1985:54, slightly adapted)

Table 1: Contextual Configuration of Text 1 (after Hasan 1985: 59)

CC {

Field:	Economic transaction: purchase of retail goods: perishable food ...
Tenor:	Agents of transaction: hierarchic: customer superordinate and vendor subordinate; social distance: near-maximum ...
Mode:	Language role: ancillary; channel: phonic; medium: spoken with visual contact ...

Your turn: Discuss in pairs

Are you happy with this type of characterisation? What might be its limits?

HASAN: NOT JUST INDIVIDUAL (L-G) PATTERNS (1973)

- It has been too readily assumed that the easiest and most valid form of describing the linguistic characteristics of registers is to state the frequency or likelihood of individual patterns or of their combinations. I would suggest that it might be advantageous to specify the characteristics of given registers by reference to some high-level semantic component. (1973, p.273)

Illustrating some of the issues

TEXT 2 (After Hasan 1985:54, adapted a bit more)

A: Good morning Mrs Reid.

B: Good morning Bob.Can I please have a couple of boxes of those raspberries you've got on special? But can I please have some on the ones just behind you there, not the ones out the front that have been in the sun?

A: Yeah, sure - is that all today?

B: Yes thanks.

A: Five dollars thanks.

B: Thanks. [Hands over 10 dollars]

A: Thanks. And five dollars change. See ya later.

B: Thanks. Bye.

Illustrating some of the issues

TEXT 3 (After Hasan 1985:54, adapted out of the shop)

A: Hello Bob.

B: Good morning Mrs Reid.

A: Can I have a prescription for Ritonavir and another one for Bactrim please?

B: Yes, anything else?

A: No thanks.

B: That'll be a hundred and forty dollars.

A: Two hundred dollars.

B: Sixty, eighty, two hundred dollars. Thank you.

Summary

Starting from the point that semiotics arguably began within medicine, we noted that the partnership hasn't continued in the way we might have expected. Compared to fields such as education and media, the health/linguistics/health semiotics partnership is relatively underdeveloped (and spacious!) We made the following observations (among others):

- research on communication in health needs to be meaning based not just word-based
- there is a need for mutual alignment around 'ways of saying' = even something as simple as there are limits to the idea of a recognisable 'medical register' e.g. 'standing up' could be 'behavioural process' or habitual material process (as per Halliday's example in 'The grammar of pain')
- There are limits to the idea of a recognisable 'medical register' – going beyond the stereotypical (more next week)
- Halliday and Hasan's tradition of relating context to meaning to wording (and other 'expression planes' in other modes) may hold promise for enriching our understanding here.

Summary (continued)

- there is a need for both static and dynamic (phase based) models of health interactions
- the value of corpus work in health semiotics – even some great insights e.g. those of Fleischman (social linguist, but not SFL) could be tested against the 'typical actual' (Firth) practices in specific settings and their valeur for different participants/ speech communities.
- it seems possible to 'contribute to the practical alleviation and management of pain' by analysing the grammar (and other layers of meaning) – a form of 'logotherapy'
- we need some kind of map of the territory for doing this – where we 'are' when doing any form of text analysis – more in coming weeks
- the capacity for SFL to contribute to improving health (not just healthcare) might rely on it taking an expanded view of its object of study, not just interaction between clinicians and patients though by no means has the last word been said on clinical interaction. It is heartening to see so many students interested in the social determinants of health!

U O W

- Next week:

  Topic: Patients talking to clinicians
  Read Week 2 Readings – get from wiki
  Look at list of readings and journals for student-led discussions – we will select in Week 2 and start in Week 4

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