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'That's exactly what I will share with you today!' Negotiation for a ticket of entry to unsolicited health education talks

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ABSTRACT

Previous studies in health communication demonstrated how clients' mention of health-related problems serves as a 'ticket of entry' (ToE) in facilitating healthcare providers' advice-giving task. Based on 24 Taiwanese health education sessions in which Taiwanese college students delivered information to elderly people, this study proposes a framework analyzing discourse mechanisms and patterns of establishing ToE. Two core moves were identified: deliverers' use of perspective-checking questions via which recipients' need status for knowledge is revealed, and explicit statements that connect this need status to the upcoming information. Based on the low occurrence of ToE and its preferred collocation with a series of perspective-checking questions, we conclude that the establishment of ToE is a nuanced communication skill that warrants extensive pedagogical training.

1. Introduction

Health literacy, the general public's capacity to 'access, understand, and use health information to make informed and appropriate health-related decisions' (Ishikawa et al., 2008), is recognized as an important concept in patient education and disease management (Gold and Miner, 2002:6). However, the communication skills needed for effective health education are seldom taught or closely examined (Maguire et al., 1986; Sanson-Fisher et al., 1991; Nutbeam, 2000; Benbassat and Baumal, 2009). Although online health information has becoming a major educational resource for motivated users (Sarkar et al., 2010; van Weert et al., 2011), delivering health knowledge in face-to-face interactions is irreplaceable, especially in preventative care. In contrast to curative or palliative care, in which the goal is to improve the health status of individuals with some existing health condition, preventive care aims more at preventing not-yet-existing diseases, e.g., via community health education talks. When patients voice their complaint for existing health problems (e.g., 'I've had this headache for two days and it's killing me'), they offer doctors with a 'ticket of entry' ('ToE' hereafter) to offer advice.

The term 'ticket of entry' was originally used by Sacks (1972) in describing a discourse device used by children to ensure their entry into conversations typically dominated by adults. In medical discourse (Heritage and Sefi, 1992; Maynard, 1993; Roberts, 1996), ToE is adopted in describing discourse elements, such as patients voicing their medical needs, which ensure medical professionals' follow-up move of advice-giving is grounded and legitimate. However, in preventative care, where the target audience of health education may not have immediate medical needs, the information or advice initiated by the health providers are 'unsolicited,' and thus might be non-effective or liable to be refused (Heritage and Sefi, 1992; Maynard, 1993). Therefore, establishing a ToE is an important communication skill for health educators in preventive care.

Although many studies have examined the discursive process of advice-giving by experienced health professionals and their impacts on communication (Ten Have, 1989; Maynard, 1993; Roberts, 1996; Heritage and Sefi, 1992; Leppanen, 1998; Pilnick,

Abbreviations: LP, lay people (as in contrast to medical professional); ND, need; PCQ, Perspective checking question; ToE, Ticket of entry; ST, student.

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1999; Reid et al., 2009), there remains a knowledge gap with regard to what discursive moves are involved in establishing a ToE in health education talks in a preventive care context, where health knowledge is usually unsolicited by the general public.

This communication skill in face-to-face interaction for health education purposes is especially important when the target audience involve less-educated elderly patients, the least likely group to make use of advanced online health information or resources. Between 2011 and 2015, a language and communication course was offered in a medical school in Southern Taiwan with the goal of upgrading students' abilities in communicating medical knowledge in Taiwanese, the local dialect of the elderly population. As part of the course requirements, students were asked to give two health education talks regarding a common geriatric disease to a lay people aged 70 or older (cf. Section 3). During the semester, although no pedagogical instruction was given regarding the knowledge or practice of ToE skills, I noticed that students in 24 sessions (out of 169 sessions) developed discourse behaviors similar to ToE. While ToE is a concept well documented by sociologists or medical discourse analysts, it has not yet entered the curricula of mainstream medical education. Although the confined context (students presenting to elderly people) of these 24 sessions limits its representation of professional health talks in a spontaneous context (cf. Hanna and Fins' discussion on limitation of simulated interaction in medical education, 2006) it nevertheless offers a valuable opportunity to qualitatively study and compare the way ToE evolves under such context. Based on literature review, discourse analysis on the 24 sessions, and small-scale quantitative results from the 24 sessions, this study proposes a framework for analyzing ToE in the 24 sessions' opening stage and identifies discourse mechanisms and patterns via which ToE evolved (Sections 4 and 5). The last section concludes with the implication of how the above framework and findings can be applied into the training of health professionals' communication skills.

2. Literature review

Although information-giving activities are generally considered as more factual, non-normative, and non-personalized than advice-giving ones (Heritage and Sefi, 1992; Silverman et al., 1992), the goals of a health education talk lie between the two—to upgrade the public's health literacy by providing factual knowledge, to engage them in a way that the promoted knowledge is needed and relevant to their daily life, and finally to persuade them to make behavioral changes toward a healthier lifestyle (Falvo, 1994; Glanz et al., 2002). Among the three goals, the second is most relevant to the current study. The following literature review presents four themes that emerged from previous studies regarding effective information-giving in health communication and the establishment of ToE.

(1) Prior to the information-giving, the recipient's information needs should be assessed
(2) A problem presented by the advice-recipient is the core in establishing a ToE;
(3) The emergence of a ToE is dynamically constructed via a series of discourse moves.
(4) Without the ToE, subsequent advice is likely to be rejected or more interactional work is needed to warrant an acceptance.

The first theme is a shared communication principle that, prior to the information-giving activities, the target audience's information needs should be assessed. In their study comparing older cancer patients' versus nurses' perspectives toward the importance of 66 factors related to chemotherapy treatment, van Weert et al. (2013) found discrepancies between the two parties' expressed importance on these aspects and concluded that more attention should be paid to needs assessment to ensure high quality patient education tailored to the patients' needs. Among the various approaches to health education, the motivational interviewing approach (Miller and Rollnick, 1991; Christie and Channon, 2014) also emphasizes a person-centered method which aims to activate individuals' motivation for behavioral change toward a healthier lifestyle by guiding people to talk about their health situation and find their own solutions. In doctor-patient communication, Kurtz et al. (2005:44–48) recommend that doctors discover the extent of the patients' desire for information and relate their explanation to the patients' perspective, and provide opportunities for the patients to participate. Sarangi et al. (2004) focused on 24 counseling sessions regarding genetic risk for Huntington's Disease, and concluded that counselors' routine use of six types of reflective questions that invite clients to engage in introspective thinking can facilitate more informed and client-centered decision-making. We may conclude that all of these pre-assessment involve the information-deliverer's use of posting questions for the recipients' perspectives or needs to be understood. The following review will show that such a pre-assessment task is mainly composed of the deliverer's use of questions in soliciting the recipient's perspectives, among which a problem acknowledged or revealed by the latter forms the core of a ToE, and if this is not established then the follow-up advice-giving is liable to be rejected, i.e., themes (2), (3) and (4).

As part of a broad range of preventive care measures, health visitors (HV) in the United Kingdom are obliged by law to give routine visits to mothers with children under five, regardless of whether the visits are requested by the mothers or not. In their analysis of the emergence of advice-giving sequences between health visitor (HV) and first-time mothers in United Kingdom, Heritage and Sefi (1992) noted that a vast majority of the sequences were initiated by the HV (about 90%, p.373), and they often emerged without a clear indicator in prior turns that such advice was desired by the mothers (p.377). A typical HV initiated advice-giving sequence is composed of five steps, via which an existing problem is unearthed (in Step 2, e.g., 'I haven't bathed her yet') as a response to the HV's inquiry (in Step 1, e.g., 'and you feel you're all right bathing her?') and then a solution is topicalized (in Step 5) through a focusing inquiry (Steps 3 and 4).

Step 1: HV: initial inquiry
Step 2: M: problem-indicative response