Chapter 1

Discourse and health communication

Gavin Brookes and Daniel Hunt

The aim of this book is to explore some of the ways in which discourse can be studied in contexts of communication about health and illness. At first, approaching the understanding health and illness by studying communication may seem irrelevant; pain, illness and psychological distress as well as new-found vitality and physical ability can all feel like they are experienced in a primal, corporeal way that is somewhat pre-linguistic. In short, our bodies ail and heal regardless of the language we use. Alternatively, we might think that the actions that have the most profound effects upon our health are those carried out wordlessly by clinical technologies – stethoscopes, scanners, scalpels – and the chemical compounds that make up medications. Nevertheless, rendering our bodily experiences meaningful to ourselves and discussing them with friends and family members, recounting them to health professionals, organising healthcare systems, performing surgical operations, saving and improving lives, and shaping health behaviours among the public all depend upon acts of situated communication about health and illness. Put another way, they all involve health discourse.

Over the forthcoming chapters, we will encounter twelve ways of approaching health discourse that reflect a mixture of established and emerging trends in the study of health communication. Harvey and Adolphs (2011: 470) describe *health communication* as an 'all-embracing concept, which takes into account a huge and diverse range of communicative activities touching on health and healthcare, ranging from personal accounts of health and illness and encounters with medical professionals through to health policy documentation and side effects information presented on drug packaging'. Health communication thus constitutes a broad area of inquiry which takes in a wide range of texts and contexts, in addition to various modes of communication, such as speech and writing but also emerging, digital modes that increasingly mediate the practices that constitute contemporary healthcare and public health messaging. Reflecting this breadth of topics, modes and contexts, the study of health communication is a richly cross- and interdisciplinary endeavour. This book is concerned with health communication research that seeks to analyse naturally occurring discourse about health and illness and/or found in health-related contexts, rather than approaches to health communication that are theoretical in orientation or which seek to establish what constitutes effective communication in healthcare settings. This is not to say, however, that the research presented in this book and discourse studies of health communication more generally cannot be used to inform and improve professional practice (see Rolfe et al. 2015, for example).

Contrary to our unproblematic use of the word *discourse* to this point, it is fair to say that this term is somewhat vague, not least because it is used in a variety of ways – often inconsistently – both within and across disciplines. Since the 1970s, the concept of discourse has been appropriated within diverse areas of intellectual inquiry, all concerned with the analysis of language and text, such as linguistics, psychology, philosophy and cultural studies, to cite just a few examples (see Mills 1997, 2005 for an overview of conceptualisations of discourse).

Gwyn (2002) describes two broad senses in which the term *discourse* tends to be used, a micro sense and a macro sense, which provide useful starting points for beginning to understand the broad differences between the various ways in which this concept is operationalised. Discourse in the micro sense refers to the 'specific meaning of spoken or written discourse, the particular means by which individuals express themselves in language', while the macro sense broadly denotes 'a generic style of representation, that is, constrained ways of thinking and talking within a given sociocultural orbit' (Gwyn 2002: 31; see also: Candlin et al. 1999; Gee 2010: 34). The micro sense of discourse described by Gwyn is likely to be most familiar to linguists but also some social and discursive psychologists, while the macro sense arguably reflects better the approaches adopted by researchers working in disciplines like cultural and literary studies (ibid.). Yet, this distinction is also anything but binary and it is not uncommon to find analysts adopting approaches which combine elements that might be associated with opposite ends of this cline, as we will discuss shortly.

As well as disciplinary variation, the view of discourse we take can also correspond to the analytical approach that we use to analyse it. For example, the view of discourse in the macro sense described above is associated most closely with Poststructuralist or Foucauldian forms of discourse analysis, while the micro view is characteristic of conversation analysis. Yet, as noted, the micro and macro views of discourse can also be fruitfully combined, for example in approaches informed by critical discourse studies, which produce close and systematic analyses of the micro lexical and grammatical choices evident within texts but with the aim of interpreting these in relation to more macro-level phenomena like power and societal structures. The relationship between our view of discourse and analytical methods can be bi-directional; we might opt for a particular analytical approach because it suits the view of discourse that we have, or alternatively we might inherit the view of discourse we take from an analytical approach that we find appealing or which suits the needs of our research and the type of data we are focusing on. The chapters of this book reflect the diversity of the concept of discourse described above. It is most productive, therefore, for us to conceive of the micro and macro senses of discourse as broad descriptors which apply to different but not incompatible perspectives. In fact, in true poststructuralist spirit we should view them as having the potential to be combined to the benefit of our research, where such a combination fits with our objectives and is sensitive to the approaches we are synthesising.

While the approaches to discourse introduced and demonstrated by the chapters of this book differ to varying extents, they share as a starting point the understanding of health (and illness) as something that can be mediated through, and even constituted by, discourse. As Harvey (2013a: 5) points out, '[i]ndividuals' experiences of health and illness are not simply based in the biological 'realities' of their bodies, but, crucially, in the discourse they use to communicate them […]. If we take the view that language in use constitutes people's understandings of themselves and the world around them, then analysing discourse offers a means of making sense of the social experience of health.' The precise extent to which discourse does indeed constitute our embodied experiences of health and illness is open to theorisation and debate and will depend to some extent on the broader approach to discourse that we adopt. Discourse also constitutes a central activity to the practices of institutions related to health. As Candlin et

al. (1999: 323) argues that discourse provides 'ways of structuring areas of knowledge and social/institutional practices', while Sarangi (2004: 1) characterises the relationship between patients and practitioners as a 'communicative' one.

Analysis of health-related discourse can also help to shed light on major changes to social and health(care) landscapes and the ways in which macro-level processes can refract into micro-level contexts. For example, Jones (2013: 4) describes how a shift in focus in industrial societies away from communicable diseases towards preventable diseases related to lifestyle has led to a proliferation of discourses which position illness 'less as a result of external risks and more as a result of individual behaviour'. He adds that '[t]he focus of health-related discourse has moved away from the curing of illness to the maintenance of health', where 'health has become not just a matter of physical, mental and social well-being, but primarily a discursive exercise of constantly reproducing ' health ' in our daily lives as part of ongoing identity projects' (*ibid*.:4-5; see also: Lupton 1995).

A consequence of this refocusing of emphasis *away* from the eradication of disease and *towards* the maintenance of health is medicalisation, which Conrad (1992: 209) defines as the process by which 'nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders', whereby 'every moment is the potential site of a ' health decision ' , whether it has to do with where we live, what we eat, who we have sex with, or what kinds of consumer products we buy' (Jones 2013: 5). Conrad (2007) and others have argued that society has become increasingly medicalised, with more and more aspects of life coming to be viewed as medical phenomena. Support for such claims is provided by studies of discourse and health which have provided semiotic evidence of the effects of medicalisation not only at the macro-level, for example in diagnostic manuals (Crowe 2000) and pharmaceutical advertising (Harvey 2013b), but also at the micro-level, for example in interactions between nonexperts (Hunt and Brookes 2020). Writing this chapter in mid-2020, the concept of medicalisation feels sharply pertinent as many nations reorient themselves around suppressing the spread of COVID-19. In our own country, government public health campaigns have saturated public consciousness, inflecting even the most mundane decisions and social interactions with reflections on risk and responsibility.

A shift towards preventable illnesses and the medicalisation of daily life represent just two examples of broad social processes that have had profound implications for the ways we think, act and communicate in relation to health and there, of course, others; movements towards patient-centredness (Brown et al. 2006), healthcare privatisation (Brookes and Harvey 2016) and growing scepticism about central developments of modern medicine (Kata 2012) are further examples. The analysis of health discourse within and across different contexts can help us to better understand the effects, but also the very nature of, broad changes to social and health(care) landscapes and how they are refracted at the level of the individual. Precisely what the analysis of discourse is taken to reveal will depend on the topic in question, the context we are investigating, and the methodological approach and view of discourse that we adopt.

The relationship between discourse and health is a powerful one, then, but it is also highly complex. This is because the discourses surrounding health and illness are numerous and variable, often contradictory even, and so afford us with different ways in which to interpret, explain and otherwise behave in relation to their health and their bodies. As Gwyn (2002: 13) alludes, '[w]hen we open the newspapers or switch on the television or radio, we encounter an increasing variety of articles and programmes offering information, advice and warnings about every conceivable dimension of health and care of the body.' The complexity of discourses surrounding health can thus result in differing experiences and understandings of health and illness matters at an individual level. Moreover, as the current scepticism towards public vaccination against preventable diseases demonstrates, while it is the case that some discourses enjoy dominance over others within societies, individuals can engage even with these discourses in various ways, including by challenging them and drawing on alternative ways of thinking and communicating about health. Koteyko (2014: 544), for example, describes communication about health and illness as 'far more than a one-way dissemination of information', while Jones points out that,

> Our response to health-related discourse is not always predictable. Sometimes we neglect easily perceptible risks, and amplify "virtual" ones, we give credence to the opinions expressed on internet websites and ignore the assessments of experts, and we even appropriate the language of health and safety in ways that may facilitate unsafe or unhealthy behaviours. These stories show how in communicating about health and risk people draw from a wide range of different sources as diverse as biomedical discourse, television talk shows, and their own sexual fantasies. They also demonstrate that many of the most important conversations that people have around health do not occur in clinics or hospitals, but rather in other places like bedrooms and around dinner tables, and the people who most influence our health may not be our doctors, but rather our sexual partners, our friends, our family members, or our favourite television personalities'.
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> (Jones 2013: 3)

These features of discourse, that it could have the power to dramatically shape our health-related behaviours but also that it is complex and varies depending on the topics, individuals and contexts involved, that makes it eminently worthy of study for researchers interested in the social dynamics of health and illness. Health communication is, as Harvey and Koteyko (2013: 2) point out, 'essentially an inter and multi-disciplinary field that goes beyond the core disciplines of communication and medicine to include such fields and sub-disciplines as media studies, sociology, philosophy, social psychology and informatics'. Moreover, as well as spanning disciplines, interest in health communication also seems to grown since the 1980s, which has also given rise to a so-called 'communicative turn' in medical practice, wherein greater premium has been placed on the value of communication training as a means of fostering stronger therapeutic relationships between providers and their patients. Meanwhile, practices associated with 'narrative medicine' (Greenhalgh and Hurwitz 1998) in clinical settings are broadly premised on the assumption that paying attention to the discourses on which people draw to make sense of their embodied experiences can lead to greater

understanding of subjective experiences of illnesses and, in turn, lead to the development of more effective forms of treatment.

These two characteristics of the wider field of health communication – its interdisciplinarity and its emphasis on understanding the ways in which health and healthcare practice are constituted in context – are well represented in the following chapters, each of which introduces an approach to discourse that can be used to gain a better understanding of how health and illness are conceptualised and communicated. Rather than merely describing these approaches, the chapters will provide a worked demonstration of the applicability of each approach to health communication data through original research. As well as introducing different approaches to discourse, these case studies are also based on data representing a range of contemporary modes and contexts of health communication.

Some of the approaches that are introduced constitute discrete methodologies in the traditional sense, like conversation analysis, while others do not represent methodologies in the strictest sense but assemblages of theoretical concepts that can be brought to bear to shed unique light on the functions and effects of discourse, such as pragmatics and discursive psychology. Some approaches, like corpus linguistics and critical discourse studies, sit somewhere in-between, as they are both characterised, variously, as methodological approaches as well as fields of academic inquiry in their own right. Similarly, discursive ethnography is not a unitary methodology but rather, like ethnography more broadly, involves researchers combining participant observation with a range of data types and analytical techniques in order to understand the discursive practices of a particular social group or context.

Although these twelve approaches are partitioned into discrete chapters, this is ultimately a somewhat artificial separation and does not mean that they are mutually exclusive of each other in practice. Rather, in a reflection of the wider field of health communication research, the following chapters illustrate that these different approaches share a number of analytic priorities and conceptual assumptions, and that they are frequently combined together to productive effect. In some cases, these overlaps reflect historical relationships between different strands of discourse analysis. These include, for example, the influence of the writing of historian Michel Foucault on post-structuralist discourse analysis, discursive ethnography and critical discourse analysis, the turn towards cognitive linguistics in the field of stylistics, and the influence of the conversation analyst Harvey Sacks (1992) on interactional sociolinguistics and discursive psychology (Edwards 1998; cf. Wetherell 1998). Likewise, much work in critical discourse analysis and the social semiotic approach to multimodal discourse analysis illustrated in Chapter 10 is directly influenced by Halliday's systemic functional linguistics (Halliday 2014). In other cases, methods and concepts are brought together on a more *ad hoc* basis to offer complementary perspectives on the data at hand. Hence, Chapter 11 on pragmatics draws upon the line-by-line approach to analysing transcripts of interaction that characterises conversation analysis (Chapter 2), while the stylistic analysis in Chapter 13 also makes use of techniques from corpus linguistics (Chapter 6). Given the diversity of health communication as a field, we argue that these combinations should ultimately be unsurprising and that they should not be regarded as signalling inconsistencies

on the part of the researchers. On the contrary, responding to the complex communicative phenomena that characterise health discourse often necessitates the integration of different methodological perspectives. The blurredness of boundaries, then, is something that characterises much about contemporary accounts of discourse and, indeed, health communication, and is something that we have embraced in bringing this volume together.

While there are a number of overlaps between the different approaches expounded in the following chapters, then, one factor that distinguishes them is the notion of context that they employ and how extra-textual factors are drawn upon in order to comprehend the discourse at hand. On the one hand, conversation analysis (CA) has been characterised by the 'strong' position it adopts in relation to context; for the conversation analyst, 'the interaction is the context' (Stubbe et al. 2003: 355). As a consequence, CA practitioners characteristically refrain from imputing the relevance of contextual factors (the participants' ages, genders, the interactional setting, wider cultural norms, etc.) in order to explain the meaning of a particular turn of talk. Instead, the context used to understand a speaker's utterance is the preceding and subsequent turns of interaction, since it is through the ongoing organisation of talk that speakers incrementally produce and signal their meanings to each other. Likewise, it is through the uptake or particular interactional roles (e.g. questioner and answerer) and the contents of their respective turns that speakers signal their orientation to the external context of the interaction and their role within it. In this sense, context, including participants identities, is seen to be constituted *within* the course of the interaction itself rather than somehow external to it. Limiting the scope of interpretively relevant context in this way has afforded CA a meticulous focus on the speakers' utterances, allowing analysts to access the 'endogenous orientations of the participants in those events' (Schegloff 1997: 167) ostensibly untrammelled by the researcher's assumptions (though see Stokoe 2012 for a discussion of researcher inference in the related field of membership categorisation analysis).

As noted above, CA's concerted focus on the intricacies of talk in interaction has proven influential in other strands of discourse analytic research, most notably discursive psychology and interactional sociolinguistics. However, the latter of these, in particular, takes a somewhat different approach to contextualising speakers' utterances. While interactional sociolinguistic analyses place primary emphasis on the linguistic and non-linguistic cues through which speakers signal their meaning, these 'contextualisation cues' (Gumperz 1982) are seen to index meanings on the basis of often-unspoken knowledge and assumptions that participants bring to the interaction. Knowledge of the social and cultural contexts in which speakers are interacting, therefore, can allow interactional sociolinguists to further illuminate the significance and tacit meanings of speakers' utterances. Likewise, as a field of linguistic inquiry, pragmatics is fundamentally concerned with the way in which the meaning of an utterance depends upon its context of use, with relevant contextual factors including the situation in which interaction occurs, the speakers' background knowledge of each other and the world, and the preceding interaction (Cutting 2008).

In contrast to CA's notion of context as 'co-text', explaining the relationship between a text and the wider sociocultural context in which it arises is the key characteristic of more critical approaches to discourse analysis, not least critical discourse analysis (CDA) (Fairclough 1989). Along with poststructuralist discourse analysis, CDA is concerned with examining how

discourse both reflects and reproduces aspects of wider social structure, with particular focus on how this serves the vested interests of powerful institutional actors. As Meyer (2001: 15) explains, because CDA practitioners regard all discourses as rooted in historical change, they argue that discourses can only be fully apprehended by reference to their historical and cultural contexts. Consequently, Meyer continues (ibid.), it is common for such critical analyses to draw upon the explanatory power of such 'extralinguistic factors as culture, society, and ideology' in a way that is rare in the CA advocated by Schegloff (1997).

Between the two – somewhat notional – poles of CA and CDA, we find a diversity of perspectives on the analytical relationship between a text and its context. Indeed, the distinction between text and context becomes blurred in those approaches to discourse analysis that are not solely concerned with written communication and transcripts of talk. Discursive ethnography arguably resolves the issue of how much the analyst's knowledge of the context can be used to explain the data by turning the context *into* data. That is, through systematic, longitudinal observation and assessment of the research field, discursive ethnographers can situate texts within a wider network of individual histories and spatial and material practices that are also recorded as research data; 'culture' is not a contextual factor that explains the data, it is the very object of research. Relatedly, studies in multimodal discourse analysis have begun to consider, for instance, the relationship of coordination between the language of branded fitness classes and the construction materials used to make the buildings in which they take place (Machin and Ledin 2018). Finally, as is discussed in Chapter 6, corpus linguistic approaches to discourse analysis require the analyst to address unique challenges around how to contextualise linguistic features. In examining very large volumes of electronically stored language data (corpora) that are often made up of hundreds or thousands of texts, corpus linguists may struggle to account systematically for the myriad contexts of production and reception in which their data is embedded (c.f. Baker et al. 2008: 279).

The different conceptions of data and context that characterise approaches to discourse analysis constitute one factor we have tried to account for when sequencing the chapters in this book. In addition, one of the aims of this collection is to showcase approaches to discourse analysis that have had long-term uptake in health communication research as well as those which are seeing more emergent (though no less effective) use. To this end, Chapters 2-5 illustrate research in firmly established approaches to health discourse, starting with conversation analysis in Chapter 2. CA has been used extensively to examine the numerous clinical interactions that make up healthcare and to understand how numerous personal and interactional dilemmas are negotiated by patients and healthcare providers (Barnes 2019). Chapter 2 is no exception to this, as it illuminates how general practitioners and patients treat medical appointments as accountable events that needs to be legitimised and, moreover, how this legitimacy is worked out interactionally through question-answer sequences about prior treatment.

As noted above, CA's microanalytical focus been influential in other fields of discourse analysis, not least those outlined in the subsequent three chapters. Chapter 3 discusses interactional sociolinguistics, a discipline that combines the detailed analysis of talk-in-interaction with ethnographic insights that help to flesh out the ways that meanings, actions and identities are continually negotiated by participants. Interactional sociolinguistics has been

used extensively in the study of professional and institutional discourse and is employed in this chapter as part of a longitudinal study of one patient's experience of the New Zealand healthcare system as they move through multiple encounters – and clinical interventions – in primary and secondary care. Like Chapter 2, the analysis closely examines the role of question-answer sequences, demonstrating how their analysis can shed valuable light on the important healthcare issues of patient participation, shared decision making and the performance of lay expertise in during different clinical interactions.

Narrative analysis (Chapter 4) is a longstanding approach in health communication research and has been a mainstay of studies concerned with understanding the ways in which patients structure and articulate their experiences of illness. Similarly, discursive psychology (Chapter 5) has been popularly used to examine how sufferers express their views of illness while also accounting for illness behaviours and beliefs and legitimising their sense of personal identity. Although narrative analysis and discursive psychology have more commonly been used to interrogate spoken communication, in this volume both are applied to written texts produced in online environments; Chapter 4 examines collaborative narratives of genetic testing in an online support group for sufferers of chronic fatigue syndrome while Chapter 5 considers a blog by an individual who has undergone ostomy surgery. Nevertheless, both approaches pay close attention to the ways in which information is sequenced by writers, the rhetorical effects this sequencing produces, and the social actions writers perform when discussing genetic testing and life-changing surgery.

While chapters 2-3 and 4-5 illustrate the discourse analysis of clinical interactions and online patient communication respectively, Chapter 6 addresses communication between doctors outside of the clinic during focus group discussions of how best to manage depression. As well as showing how the speakers understand depression as a problematic diagnostic label and take a broad view of 'therapies' that can treat the condition, the chapter also demonstrates how methods of discourse analysis – and specifically corpus linguistics – can be applied to the sorts of interview and focus group data gathered in qualitative health research more generally.

Chapters 7-9 on poststructuralist discourse analysis, discursive ethnography and critical discourse studies, respectively, best characterise the macro understanding of discourse and discourse analysis discussed towards the beginning of this chapter. Mutually influenced by Foucault's notion of discourse as a form of socially embedded practice, each of these chapters seeks to chart the ways texts are enmeshed with wider systems of knowledge and power. In doing so, these chapters demonstrate how particular kinds of institutional knowledge are strategically employed by speakers in evaluating human papillomavirus vaccinations (Chapter 7) and in defining the identities of psychiatric patients (Chapters 8 and 9).

Thereafter, chapters 10-13 showcase fields of discourse study that have seen more embryonic use in the analysis of health communication, even while being longstanding areas of linguistic research in themselves. Chapter 10 presents a multimodal approach to discourse analysis, using a study of a dementia awareness campaign to evince the benefits of attending to the ways in which health discourse is conveyed through a combination of linguistic and non-linguistic modes of communication. Given the prominence of health promotion campaigns and their

dependence on visual and musical modes for their rhetorical effects, a multimodal approach clearly has much to offer our understanding of contemporary health communication.

While pragmatics is a prominent field of linguistic research in its own right, pragmatic studies of health communication are surprisingly scarce. Chapter 11 works to address this lacuna, using the linguistic analysis of speech acts (Austin, 1962) to illustrate how leadership is performed in the context of an emergency medicine team. Likewise, despite cognitive linguistics being a firmly established sub-discipline, there are still relatively few cognitive linguistic studies of health discourse. Cognitive linguistics is anchored around the notion that evidence of the conceptual structures of the mind can be found in language use, a premise that makes it well suited to examining people's health beliefs and reasoning. This is clearly demonstrated in Chapter 12, which charts how speakers in a focus group come to misunderstand the different ways in which infectious diseases can be transmitted and the consequences this may have for their health behaviours.

Finally, Chapter 13 focuses on stylistics, a field typically associated with the analysis of literary texts. While an approach conventionally used to analyse literature may initially seem far removed from the practice of healthcare, the chapter illustrates how the stylistic analysis of written accounts of schizophrenia has much to offer in understanding the lived experience of illness. More specifically, and in keeping with the cognitive linguistic approach introduced in Chapter 12, the stylistic analysis reveals the way in which the sufferer's particular mental world is conveyed through their repeated linguistic choices, a method of analysis that can equally be used to inform clinical practice.

Taken together, the chapters comprising this volume represent a broad coverage of current approaches to discourse analysis as well as a healthy representation of diversity in focus of contemporary health communication research. Where early studies tended to focus on spoken interaction within clinical encounters (typically those involving doctors and patients but latterly other medical professionals), contemporary research in this area is, as noted, characterised by studies addressing a variety of modes and contexts, going beyond speech and even writing, and taking in an ever widening range of clinical and non-clinical contexts. Hence the current volume covers primary care consultations and team communication in emergency care but also patient records, public health campaigns, psychiatric facilities, autobiographical writing, focus groups, blogs and online support forums.

Wide-ranging though it is, there is nevertheless a number of approaches to discourse that we have not been able to include in this book for one reason or another. Had we more space, we would like to have included chapters on, for example, Mediated Discourse Analysis (Jones 2014). There are also many contexts that constitute prominent foci in contemporary research on health and discourse but which, due to limitations on space, we have been unable to cover in this book. This includes contexts such as operating theatres, palliative care, print media and telemedicine, as well as the range of contexts involving speakers from different linguistic and/or cultural backgrounds. Likewise, we should acknowledge that the contexts that are examined in this book are mostly European and English-speaking, except for Chapter 8, which uses data gathered in Denmark, and Chapter 9, which focuses on texts collected in Poland. As such, health communication that is particular to developing countries is less clearly addressed

in this volume. However, the applicability of the approaches introduced in this volume is not restricted either to the particular languages or contexts that are addressed in each chapter's case study. This flexibility is attested by the range of the research cited in each chapter but is also clear, we hope, from their worked demonstrations given in this book. Finally, in focusing on approaches to the empirical study of discourse, the chapters of this book are likely to be more familiar and of more use to researchers and students undertaking empirical studies of discourse than those adopting a theoretical approach to understanding what constitutes effective health communication (see, for example, the handbook compiled by Thompson et al. (2011)). These considerations notwithstanding, we believe that this book represents a rich collection of studies that provide brand new insights into a range of health topics and contexts as approached from diverse but potentially complementary perspectives on discourse. We hope that readers will agree with our assessment of this book and find value and inspiration in its pages.

References

Austin, J. (1962). *How to Do Things With Words*. Oxford: Oxford University Press.

Baker, P., Gabrielatos, C., KhosraviNik, M, Krzyżanowski, M., McEnery T. and Wodak, R. (2008). 'A useful methodological synergy? Combining critical discourse analysis and corpus linguistics to examine discourses of refugees and asylum seekers in the UK press', *Discourse and Society* 19(3): 273-306.

Barnes, R. K. (2019). 'Conversation analysis of communication in medical care: Description and beyond', *Research on Language and Social Interaction, 52*(3): 300-315.

Brookes, G. and Harvey, K. (2016). Opening up the NHS to market: Using multimodal critical discourse analysis to examine the ongoing commercialisation of health care. *Journal of Language and Politics*, 15(3), 288–303.

Brown, B., Crawford, P. and Carter, R. (2006). *Evidence Based Health Communication*. Buckingham: Open University Press.

Candlin, C. N., Maley, Y., and Sutch, H. (1999) 'Industrial instability and the discourse of enterprise bargaining'. In S. Sarangi and C. Roberts (Eds.), *Talk, Work and Institutional Order: Discourse in Medical, Mediation and Management Settings*. Berlin: Mouton De Gruyter, pp. 323–349.

Conrad, P. (1992). Medicalization and social control. *Annual Review of Sociology*, 18, 209–232.

Conrad, P. (2007). *The Medicalization of Society: On the Transformation of Health Conditions into Treatable Disorders*. Baltimore: The Johns Hopkins University Press.

Crowe, M. (2000). Constructing normality: A discourse analysis of the DSM-IV. *Psychiatric and Mental Health Nursing*, 7(1), 69–77.

Cutting, J. (2008). *Pragmatics and Discourse*. London: Routledge.

Edwards, D. (1998). 'The relevant thing about her: Social identity categories in use'. In C. Antaki and S. Widdicombe (eds), *Identities in Talk*, London: Sage, pp.15-33.

Fairclough, N. (1989). *Language and Power*. London: Longman.

Gee, J.P. (2010). *An Introduction to Discourse Analysis: Theory and method* (3rd edition). London: Routledge.

Greenhalgh, T. and Hurwitz, B. (Eds.) (1998). *Narrative based medicine: dialogue and discourse in clinical practice*. London: BMJ Books.

Gumperz, J.J. (1982). *Discourse Strategies*. Cambridge: Cambridge University Press.

Gwyn, R. (2002). *Communicating Health and Illness*. London: Sage.

Halliday, M.A.K. (2014). *Introduction to Functional Grammar*. Abingdon: Routledge.

Harvey, K. (2013a). *Investigating Adolescent Health Communication: A Corpus Linguistics Approach*. London: Bloomsbury.

Harvey, K. (2013b). Medicalisation, pharmaceutical promotion and the Internet: A critical multimodal discourse analysis of hair loss websites. *Social Semiotics*, 23(5), 691–714.

Harvey, K. and Adolphs, S. (2011). 'Discourse and healthcare'. In: M. Handford and J. Gee (Eds.), *The Routledge Handbook of Discourse Analysis*. London and New York: Routledge, pp. 470–481.

Harvey, K. and Koteyko, N. (2013). *Exploring Health Communication: Language in action*. London and New York: Routledge.

Hunt, D. and Brookes, G. (2020). *Corpus, Discourse and Mental Health*. London: Bloomsbury.

Jones, R. (2013). *Health and Risk Communication: An Applied Linguistic Perspective*. London and New York: Routledge.

Jones, R. (2014). 'Health risks and mediated discourse: a case study of 'AIDS in action'.' In: H. Hamilton and W. S. Chou (Eds.), *The Routledge Handbook of Language and Health Communication*. London and New York: Routledge, pp. 109–122.

Kata, A. (2012). 'Anti-vaccine activists, Web 2.0, and the postmodern paradigm: An overview of tactics and tropes used online by the anti-vaccination movement', *Vaccine*, 30(25): 3378-3789.

Koteyko, N. (2014). 'Critical studies of health and illness discourses'. In: C. Hart and P. Cap (Eds.), *Contemporary Critical Discourse Studies*. London: Continuum, pp.545–559.

Ledin, P. and Machin, D. (2018). 'New codifications, new practices: The multimodal communication of CrossFit'. In S. Zhao, E. Djonov, A. Björkvall, and M. Boeriis (eds.), *Advancing Multimodal and Critical Discourse Studies: Interdisciplinary research inspired by Theo van Leeuwen's Social Semiotics*. New York: Routledge, pp. 147–163.

Lupton, D. (1995). *The Imperative of Health: Public Health and the Regulated Body*. London: Sage.

Meyer, M. (2001). 'Between theory, method, and politics: positioning of the approaches to CDA'. In R. Wodak and M. Meyer (eds.) *Methods of Critical Discourse Analysis*, London: Sage, pp. 14-31.

Mills, S. (2005). *Discourse* (2nd edition). London and New York: Routledge.

Rolfe, A., Atkins, S., Hawthorne, K. and Roberts, C. (2015). *The Insider's Guide to the Clinical Skills Assessment for the MRCGP*. London: Royal College of General Practitioners.

Sacks, H. (1992). *Lectures on Conversation*, vols 1 and 2 (ed. G. Jefferson). Oxford: Blackwell.

Sarangi, S. (2004). Towards a communicative mentality in medical and healthcare practice. *Communication & Medicine*, 1(1), 1–11.

Schegloff, E.A. (1997). 'Whose Text? Whose Context?', *Discourse and Society*, 8(2): 165-187.

Stokoe, E. (2012). 'Moving forward with membership categorization analysis: Methods for systematic analysis', *Discourse studies, 14*(3): 277-303.

Thompson, T. L., Parrott, R. and Nussbaum, J. (Eds.) (2011). *The Routledge Handbook of Health Communication* (2nd Edition). London and New York: Routledge.

Wetherell, M. (1998). 'Positioning and interpretative repertoires: Conversation analysis and poststructuralism in dialogue', *Discourse and Society*, 9(3): 387–412.