Communication accommodation between healthcare providers at a private hospital in England:

How does identity talk?

Eloise S. Penman

Master's Thesis

Intercultural Communication

Department of Communication

University of Jyväskylä

JYVÄSKYLÄN YLIOPISTO

Tiedekunta – Faculty Faculty of Humanities	Laitos – Department Department of Communication
Tekijä – Author Eloise Sorcha Penman	
Työn nimi – Title Communication accommodation between healthcare providers at a private hospital in England: How does identity talk?	
Oppiaine - Subject Intercultural Communication	Työn laji - Level Master's Thesis
Aika – Month and year August 2015	Sivumäärä – Number of pages 103

Tiivistelmä – Abstract

A healthcare environment consists of a number of people who perform different roles, and at differing levels of seniority on the workplace hierarchy. How these people communicate with each other is based on many individual factors, including language, culture, ethnicity, and in what way they perceive their own and others' seniority. These factors can complicate communication, and lead to communication that is ineffective and/or failed.

This thesis used the Communication Accommodation Theory to explain how verbal communication between healthcare providers is achieved, and Social Identity Theory to explain why communication is achieved in a particular way.

Through analysis of one-on-one interviews with a cross-section of healthcare providers at a private hospital in England this study aimed to research the role of social identity in communication between healthcare providers.

Comprehension and open communication were found to be the ultimate aim of most communicative interactions between healthcare providers, irrespective of professional function or rank. It is believed this study has implications for the awareness of the way in which healthcare providers communicate with each other, and could increase the efficacy of such communication and the quality of healthcare received by patients.

Asiasanat – Keywords

communication accommodation, social identity, healthcare, health outcomes

Säilytyspaikka – Depository

University of Jyväskylä

Muita tietoja – Additional information

ACKNOWLEDGMENTS

Though it is my name on the front of this thesis, a great number of people have contributed to its completion. I am deeply grateful to all who have helped me finish both this thesis, and master's degree.

My supervisor Professor Stephen Croucher has given me the confidence to believe in myself when exploring ideas on my own. He has been immensely patient with my need for reassurance throughout the process of completing this thesis, and master's. Such skills are invaluable, and I am extremely grateful to Stephen for everything he has taught me in this past year.

The participants in this study were extremely helpful and friendly, and it is a shame that I cannot name names as I would like. In particular, I must express great gratitude to two ladies who gave up a large amount of their time to show me round the hospital, organize interviews, and make me feel comfortable.

My fiancé Heikki has tolerated my homesickness, distinct lack of talent for the Finnish language, and cheered me on enthusiastically throughout this thesis, and master's. Kiitos, rakas.

Finally, my parents David and Helen have supported me through everything, not least of which is this thesis. They have taught me determination, patience, and the immeasurable benefits of hard-work. Thank you, Mum and Dad, for never giving up on me.

CONTENTS

INTRODUCTION

This study was conducted at a private hospital in England and aimed to explore the perceptions of doctors, nurses, and administration staff of their communication with each other by using the Communication Accommodation Theory as a basis for analysis. The focus was primarily on discovering perceptions of ways in which this communication is achieved, and factors perceived to influence this communication. The aim was also to discover the opinions held among healthcare providers about the effect their communication with colleagues has on patient treatment.

Communication, both verbal and nonverbal, is informed by social identity. Social identity is, in turn, influenced by many factors, which include perceived salience of group identity to an individual, perceived reputation of that social group to an individual, as well as language, culture, power distance, and ethnicity. Because of the link between communication and social identity, the former is unique to each individual. This study aimed to research the perceived function of social identity, and its influencers, in communication between healthcare providers in the hope of raising awareness among individuals of the ways in which they communicate with colleagues and, possibly, ways in which this communication could be improved.

Respect towards the professional ability of colleagues of different professional capacities has also been linked to the efficacy of intergroup communication in a healthcare setting (Kreps & Thornton, 1992). This study sought to research the perceptions of power distance between colleagues and the effects this is believed to have on patient health outcomes.

Communication between healthcare providers is of paramount importance to patient health outcomes because of the implications this has on information transfer. Partly caused by the fragmentation of hospitals into different departments, poor interdepartmental

communication can lead to possible omission of important patient health information during patient handoffs to other colleagues (Darves, 2010; Frellick, 2011; Maguire, 2014; Shepard, 2012). The main motivation of this study, therefore, was to increase awareness of the importance of open, effective communication with colleagues, arguably considered by certain healthcare providers to be "too uncomfortable to delve into" (Garelick & Fagin, 2004b, p. 225). As such, this study could contribute to better health outcomes and a great quality of care in this particular hospital environment.

This study consists of five parts, the first of which is the introduction. The second part is the theoretical framework in which the theories guiding this research, Communication Accommodation Theory and Social Identity Theory, are outlined, and key concepts introduced and explained. A short summary of this section is given before the third part of the study; health communication. In this section the theoretical framework of the study is narrowed to an application to healthcare settings. The significance of communication to healthcare outcomes, as well as the influencing factors of some communication, are further expanded upon in this section. A brief conclusion of this section is given before the fourth part of the study; proposed method. Research questions, data collection method, and method of data analysis are defined in the proposed method section. The fifth and final part of this study is a list of references used to inform this research.

HEALTH COMMUNICATION

INTRODUCTION TO HEALTH COMMUNICATION

Health communication has been defined as 'any type of human communication whose content is concerned with health' (Rogers, 1996, p. 15). Berry (2007) asserted human communication consists of verbal and non-verbal aspects, and communication is constant; "Even saying or doing nothing conveys a message" (Berry, 2007, p. 1). Whilst the latter is a

rather polemic statement it serves to demonstrate the all-encompassing nature of health communication.

Health communication is indeed a wide field as exemplified in the approach of health communication case study books. Ray (2005), for example, approached the concept of health communication from numerous angles such as social identity, age, and culture. Pagano's (2010) approach mirrors that of Ray (2005), further supporting the assertion of health communication as a vast field.

Because of the great scope of health communication many scholars have chosen to define the concept in broad terms. Kreps and Thornton (1992), for example, defined health communication as "the way we seek, process and share health information" (p. 2). This is an important interpretation of the concept as it highlights communication as a two-way process between multiple different actors; health communication is not only that between doctors and patients, but also between healthcare providers, other patients, and family and friends. As such, the term "healthcare provider" is used to address the fact that multiple actors exist within the sphere of healthcare.

Health communication as being comprised of various actors is also noted by Rice (2001) who argued health communication involved "patients with health care providers, physicians with other health care providers and technicians and insurers, patients with patients and significant others […]" (p. 19). Schiavo (2014) also maintained the presence of numerous actors in health communication and observed the focus of the term on supporting individuals, healthcare providers, and the wider community to make or maintain positive health behaviours with the ultimate aim to improve health outcomes.

SIGNIFICANCE TO HEALTH OUTCOMES

Health communication, though broad in scope, has been shown by scholars to have huge implications for health outcomes. Ong, De Haes, Hoos, and Lammes (1995) termed

communication “the main ingredient in medical care” (p. 903), a statement supported by Manojlovich et al. (2015), who argued “poor communication” was the main reason for “preventable adverse events in hospitals” (p. 61). R. E. Rowe, Garcia, Macfarlane, and Davidson (2001) maintained the link between communication and medical tragedy, arguing “poor communication may contribute to a small proportion of stillbirths and infant deaths” (p. 23). Nevertheless, R. E. Rowe et al. (2001) emphasized what they perceived to be an absence of additional studies on communication and medical tragedy, and warned against making inferences based on their research.

It is worth noting “poor communication” (Manojlovich et al. 2015, p. 61) has been the term given by many researchers to refer to ineffective (Berry, 2007; R. E. Rowe et al., 2001; Watson & Gallois, 1998, 1999) or “unsatisfying” (Bashour et al., 2013; Watson & Gallois, 1998, 1999) communication. Van Dulman and Van Weert (2001) argued such communication consisted of “ignoring nonverbal signs” (p. 486).

Whilst the latter comment is the subject of another literature review, the nonverbal aspects of medical practitioner and patient communication have been arguably neglected by health communication researchers. D’Agostino and Bylund (2013) argued as such in their quantitative analysis of the effect of communication training and gender on nonverbal accommodation behaviour (p. 563).

Communication between doctor and patient has been argued to have a great effect on patient compliance with medical advice and, as such, has a negative effect on health outcomes. Ley (as cited in Ogden, 2008, p. 157) claimed patient compliance with medical advice is predicted by how satisfied the patient was with the consultation, how well the patient understood advice given, and how well the patient remembered this advice. Indeed, patient recall of information is extremely poor according to Kessels (2003), who asserted the percentage of medical information given by healthcare providers that is remembered by

patients could be as little as only 20%. Rice (2001), who also acknowledged the link between communication and patient compliance, purported physicians provide "difficult-to-understand explanations" (p. 20), which could provide some explanation for the poor recall statistics offered by Kessels (2003). Rice (2001) also wrote patients believe their doctors lack good listening skills and this, in addition to difficult explanations, contributed to patients avoiding going to see healthcare providers.

It could, therefore, be argued communication between healthcare provider and patient is paramount to patient willingness to seek medical advice in the future. Kreps and Thornton (1992) supported this assertion, stating "human communication performs an important role in the delivery of healthcare and the promotion of health" (p. vii).

Health promotion can take place in many spheres, the most public of which is through public health campaigns. Corcoran (2011) believed such campaigns are a vital part of public health interventions, and the communication of such campaign played an important part in achieving the goals of the campaign. Holtgrave, Tinsley, and Kay (1995) noted the possibility for divergent conclusions to be drawn about the usefulness of condoms based on the different ways in which the same information is presented, thereby highlighting the influential effect of communication in health campaigns to subsequent health behaviours.

A key component of the communication of health campaigns that has been noted by scholars is the audience to whom the campaign is directed; "The campaign images, messages, components and methods must be carefully selected for a specific audience in order to be effective" (Hoy et al., 2003, p. 4). Maibach and Parrott (1995) argued the most effective communication strategies in health campaigns were those that identified both the audience and the opinions and needs of that audience regarding the health issue in question.

Such campaigns are increasingly communicated to their audience through internet-based platforms - a method which has been purported as a way through which to access many

people who might otherwise not seek medical advice (Abroms & Lefabvre, 2009; Rice, 2001). Nevertheless, internet-based health communication is not necessarily superior to face-to-face meetings with a doctor or other healthcare providers as information can be inaccurate, misunderstood, or, as it has been termed by one scholar "outright quackery" (Rice, 2001, p. 21). Whilst this thesis focuses primarily on face-to-face interactions between healthcare providers and patients it is beneficial to be aware of some of the various other ways in which health is communicated.

Whilst health communication does indeed focus on improving health outcomes and increasing patient knowledge of health and willingness to seek medical advice, it may in fact cause the opposite if certain terminology is used. It is argued language such as "the disabled person" or "the autistic child" (Improving Health Communication By Putting People First, 2015, para. 7) is believed to emphasize the disability, and not the person, and could lead to the patient not seeking help because of the stigma such language perpetuates. Language and health communication will be discussed in more detail later in this thesis.

The negative outcomes of health communication highlight certain specifications communication must have in order for it be both successfully executed and successfully comprehended. The nature of communication resulting in positive consequences for health has already been demonstrated as being effective (Kreps and Thornton, 1992; Ong, De Haes, Hoos, & Lammes, 1995; Rice, 2001; Schiavo, 2014), designed with the audience in mind (Hoy et al., 2003; Maibach & Parrott, 1995), and devoid of stigmatizing terminology (Improving Health Communication By Putting People First, 2015).

However, Rice (2001) asserted communication must also be "timely" (p. 19) in order to lead to favourable health outcomes. Crane (1997) supported this statement, arguing "prioritization of information is important" (p. 4). In their case study approach to bad news delivery Thompson and Gillotti (2005) argued healthcare providers must be tactful when

informing a family of the death of a loved one, for example by not asking for permission to donate the organs of the loved one at the same time as telling the family their loved one has passed.

Furthermore, Thompson and Gillotti (2005) highlighted the value of not assuming all patients understand medical terminology and to allow the patients to guide the sophistication of language in a conversation; "it was best to communicate bad news slowly and in nonmedical terms, giving limited information at first but with planned follow-up" (Thompson & Gillotti, 2005, p. 17). However, Crane (1997) asserted limited information given to patients leads to a tendency for patients not to comply with medical directives. Kreps and Thornton (1992) also contradicted Thompson and Gillotti (2005), arguing making assumptions about the patient's ability to comprehend their illness and treatment could have negative implications for health outcomes. The issue of patient-focused communication will also be discussed in more detail later in this thesis.

SIGNIFICANCE TO HEALTHCARE PROVIDERS & HOSPITALS

Apart from having implications for patient health, health communication can also influence the efficacy of teams of health providers. Kreps and Thornton (1992) alleged communication is vital for the success of healthcare teams; "health care professionals depend on their abilities to communicate effectively with their colleagues […] to perform their health care responsibilities competently" (Kreps & Thornton, 1992, p. 2). Fagin and Garelick (2004a) argued the relationship between doctors and nurses, though highly important, is still characterized by a disparity of power and lack of respect of doctors towards nurses. In order to improve such a relationship and, by extension, the efficacy and harmony of the workplace, Fagin and Garelick (2004a) advocated improving communication between doctors and nurses through being more respectful and sensitive towards the nurses; "When delegating, do not presume that nurses are there to carry out menial tasks or that they are less busy than you are"

(Fagin & Garelick, 2004a, p. 284). The influence of professional hierarchy on communication between healthcare providers will be expanded upon later in this thesis.

Communication can not only impact team effectiveness, but it can incur negative consequences if it falls below expectations. Reid (as cited in Fallowfield and Jenkins, 1999, p. 1593) asserted the majority of malpractice complaints brought against healthcare providers in the UK are a result of poor communication between healthcare provider and patient, rather than actual clinical negligence or malpractice. Levinson (1994) also noted dissatisfaction with healthcare providers' communication as the cause of patient litigation.

Ryll (2015) noted litigation lawsuits as contributing to lasting negative psychological effects in healthcare providers accused of clinical malpractice. Sanbar and Firestone (2015) also noted these effects, writing malpractice lawsuits "may be extremely traumatic to the accused physician" (p. 9). Loss of reputation and earnings are cited as some of the factors contributing to the mental and physical suffering caused by litigation (Quinn, 1998).

Ryll (2015) also noted the long-term professional effects of a malpractice lawsuit, regardless of the outcome; "every time a nurse applies for a new job, renews his or her license, or purchases malpractice insurance, his or her malpractice stain appears on his or her record" (p. 37). The cost of medical indemnity insurance for the individual can also rise when legal claims are brought against the medical profession in the UK (Lind, 2013). As such, not only do individuals accused in medicolegal cases suffer, but so can their colleagues in the profession.

Litigation can involve either bringing a case against a single individual, or implicating an entire hospital in a lawsuit (Ryll, 2015). In the UK whether the individual healthcare provider, hospital, or both are implicated in medicolegal proceedings depends on where a patient received medical treatment, be it in an NHS or privately-run facility (Goldberg, 2012). Regardless of this difference, it is evident hospitals may also be liable to suffer the financial

and reputational losses than accompany litigation proceedings (Berlin, 2006; Nakamura & Yamashita, 2015).

Scholars have also noted "defensive medicine" tactics as another negative effect of litigation for hospitals. (Kessler & McClellan, 2002; Smith et al., 2014). Defensive medicine, defined as "precautionary treatment with minimal expected medical benefit administered out of fear of legal liability" (Kessler & McClellan, 2002, p. 175), has been demonstrated to negatively affect hospital efficiency (Smith et al., 2014), and is believed by some to increase the cost of healthcare (Hermer & Brody, 2010).

The heavy consequences accompanying litigation have been remarked as contributing to lowered physician job satisfaction which, in turn, could lead to negative patient health outcomes (Zuger, 2004). E. S. Williams and Skinner (2003) also noted the link between physician job dissatisfaction and poor, or absent, patient compliance with medical advice; "[physician] unhappiness has serious consequences for physicians and patients" (p. 136).

Evidence demonstrates, therefore, communication is not only of paramount importance to positive patient health outcomes, satisfaction of the patient with interactions with healthcare providers, and patient compliance with medical advice, but also for the continued harmony and health of the workplace environment for healthcare providers.

COMMUNICATION TRAINING

Many factors affecting communication in a healthcare setting have already been outlined, such as patient-centred communication, stigmatizing language, good workplace relationships between healthcare providers, and fear of litigation. There are indeed many more factors affecting communication in medical interactions, which supports the assertion of B. Brown, Crawford, and Carter (2006) that there exists "a wide range of social, cultural, political and economic factors" (p. 1) affecting health communication. However, arguably the

influence the most widely commented upon is communication training, both for healthcare providers and patients.

OF HEALTHCARE PROVIDERS

It is arguably easy to assume the centrality of communication to successful health outcomes means healthcare providers are good communicators. In their case study Thompson and Gillotti (2005) demonstrated the difficulty faced by healthcare providers in remaining a composed and an effective communicator when delivering bad news; "It can't be easy to tell someone they have cancer" (Thompson & Gillotti, p. 17)**.** Healthcare provider communication training is, therefore, a salient issue in health communication, with many scholars noting the need for healthcare providers to take a less clinical and more emotionally-sensitive approach to patient treatment (Fallowfield & Jenkins, 2004; Jensen et al., 2011; Makoul & Schofield, 1999; Ulene, 2009).

Ulene (2009) asserted "communication skills are glossed over in medical school and residency training, and most physicians are never taught how to deliver bad news" (para. 9). This assertion is supported by a statement from the Audit Commission (1993) that hospital staff "easily lose all sense of […] what patients need to know" (p. 12). Despite the noted need for improved healthcare provider communication, communication is an arguably neglected area of the medical profession (Rotthoff et al., 2011).

Communication training of healthcare providers is perceived as having a positive effect on the efficacy and success of communication. For example, in their study on communication training for gynaecologists Van Dulmen and Van Weert (2001) noted a communication training course "positively influences gynaecologist and patient behaviours" (p. 490). Healthcare provider communication training leading to more effective communication has also been noted as having the potential to improve patient satisfaction with interactions with healthcare providers (Bashour et al., 2013; Stein, Frankel, & Krupat,

2005), as well as to decrease the risk of healthcare provider "stress, lack of job satisfaction and emotional burnout" (Fallowfield & Jenkins, 1999, p. 1592).

The benefits of communication training not only focus on the effect of this training on the patient, but also on the healthcare provider themselves. Buckman (1984) asserted such training could help physicians to cope better with the process of delivering bad news to patients, as well as confronting the personal fears of the physician "it is much easier to defend the illusion of invulnerability by keeping at a distance from the patient and avoiding the discovery that patients are often very similar to us" (p. 1599). Fallowfield, Lipkin, and Hall (1998) also noted the positive effect of communication training on physicians' confidence in their professional abilities. Stein, Frankel, and Krupat (2005) argued communication skills courses could result in improved physician confidence in dealing with "difficult patients" (p. 5) which could, in turn, lead to lowered frustration of healthcare providers in the workplace.

Communication training for healthcare providers can come in many forms. Rice (2001), for example, has approached communication training from the point of view of internet-based information designed to improve communication between healthcare providers and patients. Fotheringham, Owies, Leslie, and Owen (2000) also focused on the benefits of computer-mediated healthcare communication training, lauding such a method of training for "expanding the range and flexibility of intervention and teaching options available in preventive medicine and the health sciences" (p. 113).

Other scholars (Carvalho et al., 2011; Jensen et al., 2011; Makoul & Schofield, 1999; Rotthoff et al., 2011; Stein, Frankel, & Krupat, 2005; Van Dulmen & Van Weert, 2001) have chosen to focus on face-to-face training programmes implemented during medical school or as part of continued professional development of already-qualified healthcare providers. One such face-to-face training programme noted in particular by scholars is the Four Habits Model (Jensen et al., 2011; Stein, Frankel, & Krupat, 2005). This is described as "a tool that can be

used by health care practitioners to improve the medical interview" (Margolis, 2013, para. 1). This tool follows four stages, which move from a creation of rapport with the patient, discovering the perspective of the patient on their health concerns and care, showing empathy, and giving a diagnosis and creating a treatment plan based on information gained during the medical consultation (Frankel & Stein, 1999).

Despite the usefulness purported by scholars (Frankel & Stein, 1999; Jensen et al., 2011; Stein, Frankel, & Krupat, 2005) of the Four Habits Model, some academics have argued healthcare provider communication training methods still require improvement. For example, Rotthoff et al. (2011) argued communication training programmes for healthcare providers suffer from a lack of "supply and demand" (p. 174) because of the inability of existing communication training tools to assess the need for further training for individual healthcare providers. Furthermore, Berkhof, Van Rijssen, Schellart, Anema, and Van der Beek (2011) argued communication training programmes needed to be more accurately documented by researchers if they are to be improved upon in the future.

Perhaps unsurprisingly, much of healthcare communication training literature has focused primarily on improving communication between healthcare provider and patient, and tends to neglect the need also for improved interpersonal skills with colleagues. Nevertheless, this is not to say scholars have entirely ignored this need. For example, McConnell, Butow, and Tattersall (1999) argued in particular the written communication skills of certain doctors needed improvement in order to avoid misunderstanding, confusion, or omission of important patient health information when writing to their colleagues. Makoul and Schofield (1999) also noted the need for an improvement of written communication skills of healthcare providers, as well as communication with colleagues conducted over the phone. The effect of patient health documentation on communication with colleagues will be discussed in greater detail later in this thesis.

COMMUNICATION ACCOMMODATION IN HEALTHCARE

In this section of this thesis CAT will be applied to relationships between healthcare providers with patients, and healthcare providers with other healthcare providers. Though there are many factors present in these different social groups that influence the use of approximation strategies those of particular interest are; perceived power distance, economics, language knowledge, culture, and gender. These factors will first be outlined to demonstrate their salience to the different professional relationships within healthcare, and then later applied to these relationships using CAT.

Arguably, there exists a greater focus in healthcare communication research on medical practitioner and patient communication, rather than communication between healthcare provider and colleagues. CAT, whilst it does not offer an answer to the question of how best to communicate in a healthcare setting, does have the potential to increase awareness of communication and could potentially lead to behaviours that promote better patient health and more effective workplace communication.

SOCIAL IDENTITY

Social identity is constructed by communication; “Through talk, doctors and patients express who they are, what they expect of each other, and what kind of relationship they have’’ (Roter & Hall, 1993, p. 5). More specifically social identity is constructed though approximation strategies as defined by CAT. CAT has been termed applicable “to any intercultural or intergroup situation where the differences between people are apparent and significant” (Griffin, 2012, p. 403). In a healthcare setting there are undeniable intergroup interactions, and not just those between healthcare providers and patients; there also exists a distinction between different healthcare provider, which can also arguably be broadly characterized as consisting of doctors, nurses, and administration staff. Hajek, Villagran, and

Wittenberg-Lyles (2007) argued an intergroup approach to healthcare relationships is important "given the salience of group identity in such encounters" (p. 294).

However, these differences in role and social group present potential challenges to communication due to possible intergroup tensions and assumptions. Hewett, Watson, and Gallois (2015) acknowledged this possibility, arguing "health care providers are required to cooperate and collaborate for patient care, but they belong to different subgroups, such as departments and specialties, with which they identify more strongly than their profession" (p. 71).

Problems arising from social group membership dichotomy between healthcare providers and patients have also been noted by scholars. Hajek et al. (2007) asserted "many patients are likely to perceive—and hence communicate with—physicians in terms of their social category membership and unique roles rather react to them than as idiosyncratic individuals" (p. 296). As such, Hajek et al. (2007) purported intergroup boundaries hindered communication between healthcare providers and patients.

Evidently, social identity is a salient issue to a healthcare setting due to the multiple different groups of people within such an environment. Social identity itself is influenced by many factors, the first of which will be discussed is power distance.

POWER DISTANCE

Power distance maintains and influences social group membership. Power distance has been argued as being felt more keenly in certain environments than in others; "Physicians working in hospitals will perceive the communication [with colleagues] as more influenced by competitiveness and the hierarchical social structure than will non-hospital physicians" (Akre, Falkum, Hoftvedt, & Aaslund, 1997, p. 521). Akre et al. (1997) also argued hospital specialists perceive this power distance more keenly than colleagues in public or family medicine.

Power distance has been defined as resulting from "force, material resources and knowledge" (Toffler, as cited in Goodyear-Smith & Buetow, 2001, p. 449). In healthcare the traditional model is power lies with the treating physician; "patient's preferences were generally not elicited, and were over-ridden if they conflicted with the physician's convictions about appropriate care" (Ludwig & Burke, 2014, para. 3).

However, certain scholars have argued this role has changed and patients consider themselves to be the holders of power, rather than their healthcare providers; "over the past few decades, the patient has 'come of age' through recognition that ultimately, power rests with patients" (Goodyear-Smith & Buetow, 2001, p. 451). Indeed, the nature of private hospitals as being paid for by the patient could also maintain the idea it is the patient with whom the most power lies. Economics, therefore, is a salient issue linked to power distance and will be discussed in the next section of this thesis.

ECONOMICS

Roter and Hall (1993) argued being a patient has become more consumerist in nature and healthcare more competitive. Indeed, the private hospital chosen for this study is one of four other private hospitals within a 10 mile radius that offers similar services. Treatment at a private hospital is paid for by patients who can afford it. Communication between healthcare providers and patients could, therefore, be improved by the increased salience of patient satisfaction to the success of the private hospital. Economics, therefore, is clearly a motivator for healthcare providers at private hospitals to offer the best service possible in order to tip the balance of competition in their favour.

However, some scholars have argued private medicine undermines the "physician-patient fiduciary relationship" (Aggarwal, M. Rowe, & Sernyak, 2010, p. 1145) because of the monetary incentive. Gray (1991) argued patients have become less of a priority to healthcare providers due to the salience of economics to hospital treatment; "physicians have

become increasingly accountable to organizations that have their own agendas and economic interested and to which the physicians' income is tied" (Gray, 1991, p. 4).

Time constraints have also been mentioned as salient to the economics of a hospital and to the communication between social groups of a hospital. Pagano (2010) stated; "I have heard [health] providers often state that they have no time for more conversation with patients. […] I am acutely aware of the current time constraints placed on a wide variety of healthcare contexts." (p. x). Time constraints are frequently noted in conjunction with poor handovers between hospital healthcare providers. This influence may be less evident in a private hospital due to the importance placed on time efficiency. Nevertheless, it is undeniable that economics is also an important factor to consider when researching communication in a hospital environment.

LANGUAGE KNOWLEDGE

Barriers to effective communication in healthcare are not just created by power distance and economics. Language difficulties have also been noted as posing a challenge to the efficacy and quality of healthcare consultations. Seijo, Gomez, and Freidenberg (1991) observed how patients who did not speak the same language as their doctor tended to ask fewer questions about their health issues and, as such, could be assumed to know less about their health concerns than their bilingual compatriots. On the other, healthcare providers' knowledge of another language has the potential to increase positive patient health outcomes (Enriquez et al., 2008).

Language barriers between work colleagues have also been noted as causing challenges to the working environment. Gasiorek and Van de Poel (2012) noted whilst foreign-language healthcare providers might perceive their communication with their colleagues to be efficient this is not always the case; "colleagues reported a number of concerns including difficulty with small talk, nonverbal communication, and observance of

(related) local cultural norms" (p. 368). Gasiorek and Van de Poel (2012) argued language and culture training for these foreign-language colleagues could aid communication with colleagues. Language has been closely linked with culture (Boroditsky, 2010; Emma, 2010; Holliday, 2009), which is also a highly salient issue to healthcare communication.

CULTURE

Culture in healthcare has been approached from the point of view of behavioural norms (Gasiorek & Van de Poel, 2012), as a synonym for ethnicity by some scholars (Cooper-Patrick et al., 1999), and as "norms, values, basic assumptions, and shared meanings" (Hemmelgarn, Glisson, & Dukes, 2001, p. 95). The wide scope occupied by the term "culture" in healthcare literature arguably complicates giving a concrete definition of the term. Nevertheless, it emphasizes the importance of individual interpretation of the concept within healthcare.

It has been noted cultural differences between patient and healthcare provider can negatively affect communication between these parties, in part, due to a possible lack of understanding by physicians of "patients' […] cultural disease models or attributions of symptoms" (Cooper-Patrick et al., 1999, p. 588). Indeed, culture has been observed to cause "considerable differences and difficulties in communication between doctors and patients" (Schouten & Meeuwesen, 2006, p. 28).

Gasiorek and Van de Poel (2012) also noted the communicative problems caused by cultural disparity between colleagues. However, whilst it may be the case communication with colleagues is also affected by individual culture, it has also been argued organizational culture can be an extremely powerful force over employees (Chatman & Cha, 2003). Therefore, it could be argued communication between colleagues is less affected by individual culture than communication between healthcare providers and patients as organizational culture dominates individual culture (Harris, 1994).

Healthcare culture has also been linked to gender. For example, Akre et al. (1997) noted medicine has "traditionally been a male culture with masculine images and values such as autonomy, control, and curing at its core (p. 520). As such, gender is also considered an important consideration in relational dynamics within healthcare.

GENDER

Bertakis (2009) termed gender "one of the many factors that impact doctor-patient interaction" (p. 356). Female healthcare providers have been observed to spend more time with patients (Bertakis, 2009), and "were more likely to report empathic behaviour" (Nicolai & Demmel, 2007, p. 200). Empathic behaviour has been termed "a specific element of effective communication" (Nicolai & Demmel, 2007, p. 200) and has been reported to "explain partially the observed higher patient satisfaction scores for female physicians" (Bertakis, Helms, Callahan, Azari, & Robbins, 1995, p. 407).

Moberg and Kramer (2015) argued gender differences can negatively affect communication between colleagues in a healthcare environment, arguing "expectations of the behaviours of female doctors […] can mean that colleagues on occasion are less cooperative" (p. 190). Gorter, Bleeker, and Freeman (2006) noted the influential effect of gender on communication between colleagues in a healthcare setting, suggesting awareness among certain members of the medical profession of the influential effect of gender on communication is not high enough, and measures must be taken in order to correct this.

COMMUNICATION BETWEEN HEALTHCARE PROVIDERS AND PATIENTS

CAT asserts healthcare providers and patients are different social groups and, as such, are expected to have different communicative tendencies. Evidence shows the communicative tendencies of these different groups sometimes follow expectations about power, economics, and language, among other factors, but sometimes diverge from these expectations. The author considers the most effective way to illustrate social identity in healthcare to be

outlining the CAT-related literature on some of the influencing factors of social identity. It is also important to note the author considers maintenance and divergence to be two separate, though closely linked approximation strategies

Communication accommodation theory asserts healthcare providers, as the imparters of knowledge and resources should theoretically maintain their speech and not converge to that of the patients, for example by using technical terms to demonstrate their role and divergence from the patient (S. C. Baker et al., 2011). Patients should, therefore, converge to their healthcare provider. For example, D'Agostino and Bylund (2013) observed communication between doctor and patient is "influenced strongly by the norms attached to their respective roles." (p. 564).

Healthcare provider-centred communication implies patient convergence to health providers. However, this can have negative implications both for patients and healthcare providers. Hajek et al. (2007) noted "if patients experience little accommodation from their physicians, their willingness to assist these professionals in meeting both parties' goals may be compromised" (p. 294). Frederikson and Bull (1995) also noted the negative effect of power distance, asserting patients can be reluctant to share health information and concerns, even when directly questioned by the physician to do so. Frederikson and Bull (1995) cited "belief that it was not their place to [voice concerns]" (p. 52) as a contributing factor to patient convergence to healthcare provider communication.

However, S C. Baker et al. (2011) argued power distance does not always manifest itself in divergence or under-accommodation, but can also present in over-acommodation or stereotyping; "doctors may over-accommodate to their stereotypes of patients (e.g., as people who have difficulty making decisions, living their lives, or accepting their illness)" (p. 380). Patients are also susceptible to making assumptions about their healthcare providers as "very expert and powerful […] and may follow recommendations without overt question" (S. C.

Baker et al., 2011, p. 380). Hehl and MacDonald (2014) observed the phenomenon of stereotyping in their examination of communication between patients with osteoporosis and their medical practitioners during ambulance visits. They noted doctors assumed patients had revealed all pain information when they ceased talking about their pain, and that patients did not reveal certain pain information because they deemed it unnecessary for their doctor.

Despite studies presenting communication problems between healthcare providers and patients, other studies show another, more positive side to healthcare provider and patient interactions. For example, Van Dillen, Hiddink, Koelen and Van Woerkum (2005) observed a positive ability among certain doctors of being able to adjust their communication style; "family doctors behave like chameleons, by adapting their style to the specific circumstances" (p. 47). Hajek , Villagran, and Wittenberg-Lyles (2007) also demonstrated the positive effect of healthcare provider convergence to patient communication on patient compliance with medical advice, demonstrating the use of approximation strategies by healthcare providers is not always dominated by power distance.

Indeed, the roles of healthcare provider and patients are not quite so clearly cut for many reasons. One of these reasons is the realization in the medical community of the importance of patient-centred communication. As such, physicians, nurses, and administration staff should converge to the speech and behavioural patterns of their patients in order to maximize communication efficacy and quality. Economics is a motivating factor for this convergence, particularly in a private hospital where patients are directly paying for treatment.

Language is one way in which convergence to patient communication patterns is demonstrated. Jain and Kreiger (2011) asserted convergence to patients is a method employed by a number of healthcare providers in order to control and reduce potential obstacles caused by language barriers between the two groups. Despite the usefulness of convergence to patient

communication, healthcare providers still use medical terminology, which is often not understood by patients. DeLue (2009) noted the tendency for such a disparity between physician and patient vocabulary knowledge to go unnoticed by physicians "what we as physicians believe is inherently evident is not always so obvious to our patients" (para. 3). As such, scholars have advocated "stringent use of an unambiguous vocabulary of medical terms shared by doctors and patients" (Tring & Hayes-Allen, 1973, p. 53). This could be considered another form of patient-centred communication, or healthcare provider convergence to patient communication.

Lack of understanding between healthcare providers and patients can also be caused by a cultural dichotomy between the two parties. Schouten and Meeuwesen (2006) asserted ethnicity and culture are one and the same concept, and argued white healthcare providers tend to demonstrate greater empathy with white patients than with those from an ethnic minority, and that interactions with patients from ethnic minorities tended to feature more healthcare provider-centred communication than in interactions with white patients; "patients had few opportunities to initiate a topic; the doctor determined the conversational direction and often patients acted politely, which health care practitioners were seldom aware of" (Shouten & Meeuwesen, 2006, p. 25). Evidently, the white healthcare provider deemed his culture (herein understood to be synonymous with race) more powerful than that of his patient, and chose a dominating communicative style, therein not accommodating to his patient.

Healthcare provider gender has also been demonstrated to influence choice of communication style, with female healthcare providers choosing patient-centred communication styles more often than male healthcare providers (Jefferson, Bloor, & Spilsbury, 2015). Janssen and Lagro-Janssen (2012) also asserted healthcare provider gender is often a factor in patient choice of physician, due to the stereotype by patients female

physicians tend towards a more patient-centred style of communication. Therein lies evident for the assertion of CAT convergence to one's own communicative style is more desirable than divergence from one's communicative style.

COMMUNICATION BETWEEN HEALTHCARE PROVIDERS

Communication between healthcare providers is also subject to the same influencing factors as between healthcare providers and patients. However, as far as the author has been able to find at the writing of this thesis there exists a relative lack of studies on healthcare provider communication. As such, what will be presented herein is a theoretical summary of CAT in healthcare, with supporting studies where available.

Power distance, as defined earlier by Goodyear-Smith & Buetow (2001), is created not only by professional role hierarchy, but also by knowledge. That is, the individual with the most knowledgeable has the greatest amount of power in communicative interactions. Yukl (2013) defined this as "information power", which involves "both the access to vital information and control over its distribution to others" (p. 195). Apker, Propp, and Zabava Ford (2005) argued though nurses used to be lower down the professional hierarchy due to assumptions about professional knowledge and expertise, various factors, including a change in role expectations, have contributed to greater workplace equality for healthcare providers, part of which has been involving nurses more and greater sharing of information. Therefore, not passing information on, or ineffectively documenting patient health information for one's colleagues, constitutes divergent communication, and an assertion of one's social identity (Akhunbay-Fudge et al., 2014; Darves, 2010; Frellick, 2011; Maguire, 2014; Shepard, 2012).

As earlier stated, Hecht et al. (2008) asserted a desire for comprehension dominates the desire to assert social identity. As such, many factors affecting healthcare provider communication should, in theory, be governed by a desire to achieve maximum efficiency and comprehension, as patient health outcomes, and hospital reputation, depend on these.

In particular, a private hospital relies on the effectiveness, and quality of its treatment of patients achieved, in part, by departments that function well together. As such, CAT asserts the focus of interdepartmental and inter-colleague communication should be on comprehension, rather than on demonstrating one's individual social identity, professional status etc. However, this is not always so, particularly in terms of language comprehension.

Language should also be clear, concise, and understood, in order to deliver healthcare to a high standard. However, a study conducted by Hewett, Watson, and Gallois (2015) found healthcare providers maintained communication style in written communication with colleagues; "doctors maintained terms and concepts local to their specialty, even though they knew that the charts would be read by outgroup as well as ingroup members" (p. 79). Evidently, although the aim of communication should be comprehension, using specialism-specific terminology demonstrates an attempt to assert one's identity.

The disruptive influence of cultural factors should also, according to theory, be at a minimum in an environment where comprehension is of paramount importance. Indeed, workplace culture can be extremely influential on the behaviour of employees, demonstrated in particular by the main language used by the employees (Louhiala-Salminen, Charles, & Kankaanranta, 2005). As such, choice of approximation strategies could be governed not by individual culture, but by that of the organization which, arguably, could result in greater communicative efficacy and a more harmonious workplace.

This same workplace culture-focus arguably extends to gender and the assumption gender has a minimal, if non-existent, effect on communication in a professional workplace. However, scholars have demonstrated gender can and does indeed influence how healthcare providers communicate with each other. Jefferson, Bloor, and Spilsbury (2015) asserted "nurses and other colleagues tend to demonstrate less cooperation with female consultants"

(p. 184), and reported medicine as a "gendered culture" (p. 187) with a bias towards male healthcare providers.

CONCLUSION

How social identity presents itself in a healthcare context is a contentious issue because of the highly individual concept of social identity. Though social identity can be influenced by certain factors, such as power distance, economics, language, culture, and gender, the effect of these factors in practice has been shown to not be quite as clear cut. Furthermore, in an environment dependent on comprehension among all parties for successful outcomes, the onus on comprehension is paramount. Therefore, approximation strategies should, in theory, be chosen on the basis of their usefulness in achieving this comprehension. However this has been shown to not always be the case.

The dichotomy between theory and practice has governed the choice of research questions and hypotheses presented in the next section of this thesis. It is important to remember the influencing factors of social identity and the choice of approximation strategies are not limited to those presented in this thesis; there exist a wide number of different causes for the choice to present one's social identity in such a way. This choice will be further discussed in the limitations section of this thesis.

THEORETICAL FRAMEWORK

INTRODUCTION TO COMMUNICATION ACCOMMODATION THEORY

Communication Accommodation Theory (CAT) was developed from Giles' 1973 Speech Accommodation Theory (SAT). The latter theory was influenced by Giles' interpretation of Labov's (1966) work *The Social Stratification of English in New York City.* Therein, Labov (1966) outlined his 1962 study of individuals' use of English in New York.

Labov (1966) argued the linguistic differences he observed during his study were the result of perceived formality or informality of the situation, as well as "attention to speech" (Giles & Coupland, 1991, p. 62) Labov himself wrote "all of the contexts for defining casual speech contributed equally to the identification of casual vs. careful speech" (p. 86).

However, it was Giles' (1991) belief such differences could be somewhat interpreted as the result of "interpersonal accommodation processes" (Giles & Coupland, 1991, p. 62). It was the research in Montreal, Canada in 1976 into convergence and divergence of speech of bilingual participants that finally led to the construction of the theory of Speech Accommodation. By 1987 various revisions of SAT contributed to the renaming of this theory to "communication accommodation".

At its core, CAT centres both on verbal and nonverbal aspects of communication. One of the most widely noted features of this theory is its focus on convergence and divergence. These are termed "approximation strategies" with the aim of either reduction or accentuation of differences between interactants.

Much of the early research into this theory focused on bilingualism of co-existing groups of different ethnicities (Griffin, 2012). The theory has since been applied to a multitude of contexts, from law enforcement (Giles et al., 2006; Kwon, 2012), and health communication (S. C. Baker, Gallois, Driedger, & Santesso, 2011; Hehl & McDonald, 2014; Watson & Gallois, 1999), to intergenerational situations (Griffin, 2012; A. Williams & Garrett, 2008).

MOTIVATIONS FOR APPROXIMATION STRATEGIES

According to Hellinger and Pauwels (2007) CAT was "an attempt to conceptualise language attitudes and the behaviour associated with them" (p. 610). Griffin (2012) noted the main issues with which SAT, and later CAT, were concerned were the motivations behind the

use of approximation strategies, how these were perceived by the receiver and whether or not the process of using approximation strategies was a conscious one.

Various motivations for approximation strategies have been suggested by researchers. Gallois et al. (1995) believed approximation strategies resulted from the desire to "gain social approval […] show distinctiveness" and to "achieve clearer […] communication" (p. 117). Giles and Soliz (2015b) asserted uncertainty reduction, among other factors, informed the choice of approximation strategy. Whilst these are predominately positive approaches to the foci of the theory, it is not one held by all; Berry (2007) chose to define "accommodation" as often resulting "in one or other person just giving in to another" (p. 119).

Nevertheless, there is an undeniable consensus among researchers of the existence of approximation strategies. For example, Garrett (2011) wrote the "basic notions" of CAT were those of convergence and divergence (p. 105). He also claimed the idea of maintenance as neither converging nor diverging (p. 106). Interestingly, the process of maintenance was suggested by Bourhis (as cited in Gallois et al., 1995, p. 117) to be another form of divergence, whereas Griffin (2012) purported this to be a form of under-accommodation. A. Williams (1999) asserted divergence, maintenance and under- and over-accommodation were all different strategies.

The disagreement among scholars of definitions of terms constitutes a degree of complexity to CAT. Giles (2008a) confronted this complexity, minimizing the importance of a consensus of definitions between disciplines and emphasizing the theory as a process (p. 162). This process is demonstrated by the causal relationship between convergence and intergroup harmony noted by Sachdev and Giles (2007).

Sachdev and Giles (2007) wrote "mutual language convergence could be used as a strategy to promote ethnic harmony" (p. 355). This idea of intergroup harmony is also noted by the results of the 1976 experiment of Simard, Taylor, and Giles. This experiment

demonstrated how language convergence was perceived differently when respondents knew the motivations for a speaker's choice of language. This, therefore, demonstrates an addition to the assertion of Sachdev and Giles (2007) that convergence was perceived positively only under certain conditions (Garrett, 2011). The arbitrary nature of how convergence is perceived will be further discussed in the next section of this literature review.

Convergence has been demonstrated to have a negative side, further supporting the assertion of Sachdev and Giles (2007). Over-accommodation, or "excessive convergence" are terms used to refer to times when convergence is not received positively and is considered unnecessary (Griffin, 2012; Hecht, Jackson, & Pitts, 2008; A. Williams, 1999). Hecht et al. (2008) referred to this as the "accommodative dilemma" (p. 28). Under-accommodation was purported as continuing in one's original communication style, despite the communication style of the other (Griffin, 2012).

CONSCIOUSNESS AND PERCEPTIONS OF APPROXIMATION STRATEGIES

Approximation strategies are the subject of controversy because of the inability to demonstrate consciousness to their invocation. A. Williams (1999) termed this "communication awareness" which she believed constituted "a component of miscommunication" (p. 156). As previously mentioned, interpretation of CAT-specific vocabulary has been the subject of great discord between researchers. Nevertheless, the link between awareness and miscommunication is an interesting one.

A. Williams (1999) also argued a "self-report" revealed a one-sided perception of communication behaviour and did not explain what really occurred during an interaction (p. 157). Once again, individual perception of a behaviour rather than real-life phenomena has been demonstrated as problematic to CAT-centred analysis. However, A. Williams (1999) argued individual perceptions of accommodative behaviours were, nevertheless, of merit to CAT researchers as this was linked to harmony or discord of inter-group relations. Garrett

(2011) noted the negative perception on the part of the receiving group of a communication shift, thereby demonstrating the possibility of mutual awareness of accommodative behaviour, but clashing conclusions about the use thereof.

Awareness and perception have played a role in the discussion among researchers about subjective and objective accommodation. Sachdev and Giles (2007) described the contrast between the motivation a speaker is perceived to have in converging and the real motivation of the speaker. Garrett (2011) stated accommodative behaviours were the result of "how we believe or perceive others to be shifting and this may be quite different from the objective view" (p. 111). Griffin (2012) supported this claim, asserting "what's […] important is not how the communicator converged or diverged, but how the other perceived the communicator's behaviour" (p. 401). Platt and Weber (as cited in Garrett, 2011, p. 111) also believed conclusions could not be easily drawn about the motivation for accommodative behaviours as this was individual to each person; "we cannot always be confident that judgements based on subjective impressions will lead to appropriate outcomes" (Garrett, 2011, p. 111).

The difficulty in recognizing subjective and objective accommodation motivation has also been linked to communication efficacy. Hecht et al. (2008) observed the ability of converging or nonconverging speech to either delay or quicken comprehension between peoples of different groups, further arguing "lack of shared conversational rules" as contributing to delayed, or failed, inter-group communication (p. 27). This links back to the idea of culture informing one's use of approximation strategies (Garrett, 2011; Giles & Coupland, as cited in Hecht et al., 2008, p. 28; Griffin, 2012). By describing the 1984 experiment of Platt and Weber, Garrett (2011) concluded difficulties in interactions between native-speakers and non-native speakers were the result of "mismatches" between the aim of an appropriation strategy and the strategy itself (p. 111).

Hecht et al. (2008) concluded desire for comprehension dominated the desire to maintain one's social identity. Sachdev and Giles (2007) noted this occurrence through the example of a suggested interaction between a bilingual western professor and Chinese student. They believed whilst the professor may evaluate the student positively if the student converged to the professor's English, the student may feel "deprived of his social identity" (Sachdev & Giles, 2007, p. 357).

CAT & SIT

The motivations for accommodative strategies have been linked to social identity. Abrams and Murachver (2008) described accommodative strategies as a way to achieve either "intragroup convergence" or "intergroup divergence" (p. 56). Hecht et al. (2008) also maintained the link between CAT and SIT, arguing CAT explained how social identity is achieved. Garrett (2011) termed accent manipulation, a form of these strategies, a "valued tactic for asserting cultural identity" (p. 108). Furthermore, Giles and Coupland (as cited in Hecht et al., 2008, p. 27) claimed nonconvergence was a useful tool for the assertion of ethnic and national group membership.

Griffin (2012) maintained the link between CAT and SIT and noted initial orientation as the predictor for a person's tendency to maintain either identity as an individual or identity as a member of a particular group. Initial orientation was purported as consisting of various cultural influences, past interaction with a group, stereotypes, group norms and group dependence as prominent components of initial orientation (Griffin, 2012). These are important factors to remember when analysing maintenance of or convergence from in-group expectations.

SIT has been defined as "social psychological analysis of the role of self-conception in group membership, group processes, and intergroup relations" (Hogg, 2006, p. 111). Stets and Burke (2000) outlined the theory as a way in which the self clarifies itself in relation to other

social groups. The link between SIT and CAT is exemplified in the study of Tong, Hong, Lee, and Chiu (1999) on language and Hong-Kong vs. Chinese identity; "Those who claimed to be primarily Hongkongers would evaluate the Hong Kong speaker more favourably when the speaker maintained Cantonese [the language of the in-group] than when he or she converged to Putonghua" (p. 285).

Bourhis (as cited in Chakrani 2015, p. 18) also noted the positive appraisal of an in-group member who maintained his dialect despite being confronted with an out-group member who outranked him. In-group members can also be the subject of censure when they fail to observe standards of in-group communication. Dorjee, Giles, and Barker (2011) observed an in-group setting of diasporic Tibetans in India where members were evaluated negatively as "arrogant and pompous" (p. 354) for using a communication style that diverged from communication expectations of that context.

Hargie's (2014) study on approximation strategy choice between Protestant and Catholics in Northern Ireland further demonstrates the salience of group identity to communication accommodation. Hargie (2014) argued greater instances of convergence were noted in interactions between in-group members, and more instances of discourse management were observed in interactions between in-group and out-group members. Hargie (2014) also noted choice of conversational topic was heavily influenced by whether the other is a member of the in-group or the out-group.

Attitudes towards another person have been demonstrated to be heavily influenced by feelings towards his/her group membership. Hecht et al. (2008) stated "immediate and past experiences [of an out-group]" influenced perception of the use of approximation strategies" (p. 28). Chakrani (2015) conducted a study on the attitudes towards different Arabic dialects. In this study, a Moroccan Arabic speaker chose to assert his identity by maintaining his dialect instead of converging to the dialects of his two interlocutors. He was negatively

evaluated by one interlocutor but positively evaluated by the other. Chakrani (2015) asserted this difference in reaction was caused by opinions on the prestige of Moroccan Arabic. However, it could also be suggested the interlocutor who reacted negatively did so because the Moroccan Arabic speaker violated the former's expectations by not diverging from his dialect. Therefore, it is evident expectations exist not only for in-group members, but also for out-group members.

RELEVANCE TO ORGANIZATIONS

Social identity in an organization is often analysed in literature from the point of view of diversity management. Diversity management is a term employed to refer to the importance of awareness and effective management of different groups in an organization, which Kossek and Lobel (as cited in Bassett-Jones, 2005, p. 169) argued could include different genders, religions, races, nationalities, and languages. The term arguably assumes it is not possible for people to negotiate their different social identities themselves, as so must be managed in order to avoid problems in the organization.

One such effort to manage the many different social identities in an organization is outlined in the study of Tange and Lauring (2009) on the implementation of a corporate language. It was argued a corporate language policy led to less "information transfer" (p. 228) between employees because of the the exclusion of non-Danish speakers (the out-group) from social interactions in the workplace. Herein it is evident organizational policies can make social identity a salient part of the workplace and, quite possibly, be detrimental to the functioning of the organization.

Furthermore, Mael and Ashworth (as cited in Stuart, 2002, p. 28) argued "the more employees identify with an organization, the more likely they are to show a supportive attitude toward it". Many organizations encourage personal affiliation with the organization among their employees, for example through organizational structure and encouraging

employees to own shares in the company, or through terminology, by calling employees "partners", as is the policy at the British department store chain John Lewis. The latter is particularly salient to communication accommodation, as it demonstrates one way in which communication is employed to encourage a feeling of "in-group" membership. The statements of these scholars and evidence in society further illustrate how feeling part of the "in-group" leads to positive outcomes.

RELEVANCE TO POWER DISTANCE

Social identity and communication have been previously demonstrated as having an effect on organizational policy and on relationships with one's colleagues. The use of approximation strategies in the workplace is an important method for asserting one's position in the professional hierarchy. Giles (2008a) noted the role of convergence in reinforcing social position; "accommodative acts are often a function of the social power a target-other is perceived to possess" (p. 163). This idea of perceived power of the other was seen in the 1975 accent experiment of Bourhis, Giles, and Lambert (as cited in Garrett, 2011, p. 107). This experiment revealed results that showed the respondent was perceived to be more intelligent when he converged to the RP speech of the interviewer, than when he did not, and maintained his social identity as a Welshman and responded in his local dialect. Whilst Garett (2011) did not approach this from the point of view of power distance, it could be argued that by converging to the speech of his interviewer, the Welshman was concealing his identity and conceding power to the interviewer.

The Welshman could, arguably, have been converging to the speech of his interviewer because he perceived this as the more positive social group. The effect of the desire to be held in greater social esteem on language was also observed by Chakrani (2015) who noted the convergence of Upper Egyptian Arabic speakers to the better-respected Cairene Arabic. Garrett (2011) outlined positive social group membership as the ultimate goal of

approximation strategies. He purported membership with a different group as another solution to regain this positive social group membership if it were lost. Giles (2008a) supported this idea and asserted people were more likely to converge to those whom they believed could be of social benefit to them. Maintaining this belief Giles and Soliz (2015b) asserted individuals from social groups held in less esteem by others would sometimes converge to a dialect held in greater esteem in order to "gain favour and/or establish credibility with others" (p. 162). Whilst Giles and Soliz (2015b) argued individuals from less well-respected groups would sometimes not accommodate to the more powerful they argued this inevitably came at a cost to one's pride or reputation in the eyes of the other.

However, Ross and Shortreed (as cited in Giles and Soliz, 2015b, p. 165) argued strong links between social identity and communication can result in the efforts of outgroup members to converge to in-group members as being considered offensive to the latter. Therefore, it is important to note is not always so that accommodation to the other yields positive results. The same is true for divergence not always yielding negative results (Giles & Soliz, 2015b).

RELEVANCE TO BICULTURALISM

So far the link between communication accommodation and social identity has been examined from the point of view of belonging to a single group. The concept of biculturalism demonstrates a degree of complexity to this conceptualization. Benet-Martínez, Leu, Lee, and Morris (2002) approached biculturalism as a person who has "multiple cultural and racial backgrounds, travel[s] overseas extensively, live[s] in ethnically diverse environments, or live[s] in more than one country" (p. 493).

The effect of exposure to multiple cultures has been shown to frequently result in identity and communication difficulties (Benet-Martínez et al., 2002; Tadmor & Tetlock, 2006; Toomey, Dorjee, & Ting-Toomey, 2013). These difficulties have been described by

Ting-Toomey et al. (2013) as "unique sets of […] challenges when communicating with others due to conflicting feelings of identity" (p. 113).

Resolution of conflicting cultural identities is a highly individual process and has been purported as relative to how well the individual perceives his/her two cultures to be compatible with each other (Benet-Martínez et al., 2002). Tadmor and Tetlock (2006) agreed with this conclusion, asserting "The choice of acculturation strategy will depend on the combination of internal and external accountability pressures faced by the individual" (p. 165). These assertions demonstrate a great deal of complexity to resolving identity issues, and how reaching a conclusion as to which approximation strategy to use is much more complicated a process than it may seem.

Nevertheless, it has been suggested negotiating two cultural identities may not be as complicated as certain scholars have suggested. The aforementioned statement by Hecht et al. (2008) about desire for comprehension dominating the desire to maintain social identity is particularly salient to those who claim two cultures as their own. The statement suggests cultural and/or individual identity becomes irrelevant when confronted with communication difficulties, and achieving comprehension becomes paramount. However, it must be noted the question of when culture (and, therefore, cultural identity) is relevant is disputed among scholars. Piller (2012), for example, asserted "who makes culture relevant to whom, how, in which context and for which purposes?" (p. 12). Piller's (2012) statement casts some doubt over whether or not comprehension does indeed dominate one's social and cultural identity in all occasions.

Biculturalism, for all of these potential challenges, is praised by some scholars for its benefits. For example, Feliciano (2001) asserted bicultural youths tended to enjoy greater academic success than single-culture youths, whilst Enriquez et al. (2008) purported bicultural healthcare providers could improve healthcare outcomes for HIV-positive Hispanic

adults. Biculturalism is, however, different for every person and subject to individual perceptions of one's own identity and, as such, it is considered unwise to make generalizations about the concept.

Nevertheless biculturalism is a particularly useful concept to demonstrate the inextricable link between social identity and communication. Attitudes towards one's own social group and towards others informs how one communicates with both groups. One's own identity as an individual, and not as a member of a particular group, has also been outlined as influential to how one communicates.

IMPLICATIONS FOR COMMUNICATION ACCOMMODATION

The link between social identity and communication accommodation is a highly important link to remember when conducting CAT-related research. The dependence of the use of approximation strategies on social identity, a very personal concept, could present challenges to CAT researchers, as could the issue of consciousness of one's identity and communication. Ability to communicate is another important point, and will be briefly discussed in this section.

Awareness of one's own identity and of one's communicative tendencies is a polemic subject. Heretofore, we have made assumptions about awareness of one's group identity and how this influences communication. For example, the approach taken towards managing bicultural identities implied one is aware of both identities and can choose which identity to call upon when necessary. Hünerberg and Geile (2012) argued awareness of language was one of the major ways to "realize communication" (p. 215). Littlewood (2011) also supported the claim language awareness is an important factor in how one communicates. Therefore, CAT researchers must not assume their perception of an approximation strategy and the identity of the study participant is that which was intended by the participant.

Furthermore, it may be the participant is aware of how he communicates yet is unwilling to reveal certain information about himself because of the unfavourable light his in which his motivations would place him. For example, Arana (2013, para. 2) noted the reluctance of some undergraduate students to reveal negative impressions about a person who use a double negative in speech. Arana (2013) was of the opinion "judgments about speech are judgments about the speakers themselves" (para. 2). Hall and LaFrance (2012) demonstrated Arana's (2013) point by showing how use of homophobic language by heterosexual men often led to negative judgements about the heterosexual men.

Another important aspect of the use of approximation strategies and social identity is the assumption made heretofore about the ability of the person using these strategies. We have assumed physical and mental competence on the part of communicators. McArdle (2001) outlined what she perceived as a widespread prevalence of communication impairments and wrote "Many people with communication impairment, however, have disabilities that do not have any physical signs" (p. 95). This is another vital consideration to take into account when conducting CAT research as communication or speech impairment may influence how social identity is communicated, how the participant perceives his communication, and the motivations for using approximation strategies.

LINKS WITH OTHER THEORIES

SIT is not the only theory to which CAT has been linked. Ethnolinguistic Identity theory (ELIT) is also an important theory to remember in regard to CAT. Hecht et al. (2008) even termed ELIT a "natural progression" from CAT (p. 28), whilst Harwood, Giles, and Palomares (2008b) also supported this connection. Whilst ELIT will not be discussed herein, it is worth noting the remark by researchers that ELIT can also inform approximation strategies; "the language of the highest vitality group is the one that predominates [bilingual

interpersonal interactions]" (Clément, S. C. Baker, & MacIntyre, as cited in Hecht et al., 2008, p. 29).

CAT has also been linked to many other theories, such as Anxiety Uncertainty Management Theory (Gallois et al., 1995). Uncertainty Reduction Theory (Griffin, 2012), Communication Theory of Identity (Hecht et al., 2008), and Cultural Contracts Theory (Hecht et al., 2008). Such connections demonstrate the consistency of CAT with other communication and identity theories, and constitute a strength of the theory. This is important to remember in the next section where researcher criticism on the strengths and weaknesses of CAT will be examined.

CRITICISM OF CAT

Miller (2002) outlined Kuhn's criteria with which to judge the quality of a theory. Though Miller approached these criteria from the point of view of post-positivist analysis, these criteria could be applied to any theory, regardless of the scholastic perspective of the researcher. These criteria purported a theory must be accurate (and, consequently, testable), consistent with itself and other widely accepted theories, have a broad scope, be simple and be of heuristic value to researchers. It is disputable whether or not CAT meets all of these criteria.

INCONSISTENT TERMINOLOGY

Even in its very early stages, CAT was termed "very complex" (Gallois & Giles, as cited in Griffin, 2012, p. 404). The root of this complexity was purported as the inconsistency in structure and definition of terminology associated with CAT (Gallois, Ogay, & Giles, as cited in Griffin, 2012, p. 404). Whilst Giles and Coupland (1991) did attempt to define key terms, using various tables and illustrations, these debatably added further complication. Gallois et al. (1995) outlined further extensive analysis of the issues related to CAT, arguably fuelling criticism of the complexity of CAT.

Such negative evaluation is one also acknowledged by Burgoon, Dillman, and Stern (1993) who argued CAT-definitions were "embraced under the umbrella of conversational adaptation patterns" (p. 311), suggesting such conglomeration of terms was not possible and did not fully cover the complexities of conversation. Burgoon et al. (1993) supported this assertion, also critiquing the lack of set definitions and the inability of convergence and divergence to fully explain the myriad of processes at play during conversation; "conflicting and ambiguous definitions of […] concepts, along with inadequate differentiation from other patterns […] have hindered theoretical and empirical progress" (p. 295). Giles and Soliz (2015b) also admitted the lack of a how, what, when and why of accommodative strategies is a problem that still remains unsolved in CAT literature.

UNCLEAR ASPECTS OF CAT

Another noted criticism of CAT is that of a failure to distinguish between long- and short-term accommodation. In 1995 Gallois et al. stated CAT was single-interaction-focused, and asserted "CAT has not explicitly theorized a distinction between long-term and short-term accommodation" (p. 128). Danescu-Niculescu-Mizil, Gamon, and Dumais (2011), though they asserted a definition of long- and short-term accommodation as as that which is not "instant, occurring from one conversational turn to another" (p. 747), nevertheless argued there is, with a few exceptions, a lack of empirical evidence for the existence of long-term accommodation.

Other scholars have also argued for the existence of long-term accommodation, further supporting the need for CAT to reflect this. Hecht et al. (2008) cited a previously published assertion from 1993 on the effect of communication on identity; "identity is formed, maintained, and modified in a communicative processes" (p. 31). Identity management and maintenance are, arguably, long-term processes, thereby demonstrating the possibility to apply CAT to a long-term process as well as single, short-term interactions. Garrett (2011)

also noted this application, stating CAT had addressed "longer term" issues (p. 119). Nevertheless, the need for a revision of CAT to directly reflect such a distinction has not yet been fulfilled.

DIFFICULTY TESTING CAT

Though CAT has been said to offer a "flexible approach to generating and analysing data" (Pitts & Harwood, 2015, p. 90), such an unfocused methodology to analysing the theory arguably complicates the theory. Undeniably, much of early CAT research analysis has taken the form of quantitative analysis, though more recent studies have included qualitative analysis (Gasiorek, Giles, & Soliz, 2015a).

One question in testing CAT is raised by the study of Danescu-Niculescu-Mizil et al. (2011) in which a quantitative analysis approach to analysis of CAT data was taken and the conversational corpus of Ritter, Cherry, and Dolan (2010) adapted to construct a separate conversational dataset to analyses Twitter-based conversations. Danescu-Niculescu-Mizil et al. (2011) noted the difficulty in analysing accommodative behaviours in online Twitter interactions due to the limit of messages to 140 characters; "it is not a clear a priori whether accommodation is robust enough to occur given the constraints of this new environment" (p. 745). This is an interesting observation and raises the question of how detailed an interaction has to be in order to contain evidence of accommodative behaviour. DiVerniero (2013) also acknowledged this problem with CAT, and suggested analysing each interaction individually before generalizing any findings.

Giles also acknowledged other drawbacks of CAT. Gallois and Giles (as cited in Griffin, 2012, p. 404) admitted the complexity of CAT rendered it nearly impossible to simultaneously analyse all of the theory's features. Nevertheless, they rejected the idea this represented the theory to be false. Instead, they recommended CAT researchers develop "mini-theories" to suit their needs, but to remain aware of the original theory (Gallois &

Giles, as cited in Griffin, 2012, p. 404). Indeed, further complications arise if researchers are recommended to develop "mini-theories" (Gallois & Giles, as cited in Griffin, 2012, p. 404). Whilst this is a valid suggestion to simplify the vastness of CAT, it could be argued the theory is no longer that of CAT if researchers adapt it.

ASSUMPTIONS OF CAT

CAT assumes both rationality on the part of communicators, and assumes they are consciously aware of their communicative behaviours. The assumption of rationality of communication participants has also been the subject of criticism by researchers. West and Turner (2004) termed this assumption the "possible dark side of communication" (para. 3). CAT has already been demonstrated herein to play a role in intergroup interactions, which can sometimes lead to conflict when adaptive behaviours are interpreted differently by participants. West and Turner's (2004) observations show how CAT does indeed assume both parties are equally able to rationally analyse behaviour and come to rational conclusions. Nevertheless, it could be argued rationality is not empirically testable and is, therefore, outside the scope of CAT.

Another such important criticism is that of the consciousness or unconsciousness of the use of accommodative behaviours. This also constitutes a vagueness of CAT and, as such, is the subject of criticism. Giles (2008a) termed this a "thorny issue" of the theory, recommending researchers expand this area of CAT (p. 170). Giles and Soliz (2015b) maintained this opinion still 7 years later, demonstrating this as an area of future research to scholars. This problem could conceivably be linked to the problem of empirically analysing rationality. It raises the question whether or not it is possible, in any way, for the consciousness or unconsciousness of accommodative behaviour to be confirmed without relying on the perception of the person using the behaviour, or from one's own perspective?

The neuroscience of free will is not an insignificant topic among philosophers and medical researchers and is too extensive to outline herein.

Despite these numerous weaknesses of CAT as demonstrated by researchers, it is worth remembering the guidelines, which have been followed to construct this overview of criticism are only guidelines. Griffin (2012) also offered his own criteria for analysing CAT, and came to a positive conclusion of the theory; "Falsifiable it is not" (p. 404). Furthermore, a degree of flexibility in the strictness with which one analyses CAT should be encouraged. The widespread variety of sources using CAT as a form of analysis are testament to the great heuristic value of the theory and, indeed, to the resourcefulness of many researchers. CAT is, undoubtedly, a complicated and multi-faceted theory. Nevertheless, whilst it may not be possible to simultaneously test all aspects of the theory, CAT has been demonstrated to be in accord with various theories such as SIT and ELIT and has, arguably, been applied to great effect to many different areas of research.

CONCLUSION

CAT has been demonstrated to be a multifaceted theory with a degree of complexity and weakness. It has yet to be developed to cover a number of drawbacks, debatably the most important of which are the issues with CAT-related terminology, and the difficulty in testing the theory.

Nevertheless, CAT has been linked to a number of other communication theories and applied to many different disciplines, which could support its strength as a communication theory. It is particularly important to remember the link between social identity and the use of approximation strategies, as this has a practical application for a number of different situations. Whilst this literature review by no means covers the vast literature on the topic the important social, professional and psychological motivations for the use of approximation strategies have been outlined.

METHODOLOGY

RESEARCH QUESTIONS & HYPOTHESES

The research questions and hypotheses presented herein are believed to be most salient to this study, and to the overall aim of this study to provide useful, influential data for use in a healthcare environment.

RQ1: What are the approximation strategies adopted by healthcare providers to communicate with each other?

A study of the use of approximation strategies in a private healthcare setting could be useful to increase the awareness of the importance of how one communicates and, quite possibly, increase the efficacy of such communication and the quality of healthcare received by patients (Hecht, Jackson & Pitts, 2008; Manojlovich et al., 2015).

RQ2: What effect do healthcare providers perceive their identity to have on their communication with each other?

Identity and how one communicates are strongly linked (Garrett, 2011; Hajek, Abrams & Murachver, 2008; Hecht et al., 2008). As such, the hierarchical structure of the hospital environment is predicted to inform the communicative strategies of healthcare staff. Discovering how these are exemplified in a healthcare setting could be highly useful in positively affecting the efficacy of communication among healthcare providers.

RQ3: What effect do healthcare providers perceive their communication with other staff members to have on the treatment of patients?

Ineffective communication with patients can have an adverse effect on the health of patients (Darves, 2010; Frellick, 2011; Maguire, 2014; Manojlovich et al., 2015; R. E. Rowe, Garcia, Macfarlane & Davidson, 2001; Shepard, 2012). This study aims to examine the perceived effect of healthcare providers' communication with each other on the effectiveness of patient treatment.

DATA COLLECTION

Data collection took place over two weeks in May-June 2015 at a private hospital in England. The hospital in which research was conducted will henceforth be referred to as PH.

4.2.1 SAMPLING & PARTICIPANT RECRUITMENT

Purposive sampling is the method of sampling chosen for this thesis. Mack, Woodsong, MacQueen, Guest, and Namey (2005) noted purposive sampling is frequently used when working on the basis of predetermined criteria, which could include "socio-demographic characteristics, or may relate to specific experiences, behaviours, roles, etc." (Mack et al., 2005, p. 5). The criteria for sampling were doctors, nurses, and administration staff working in a private hospital in England. Such a choice of sample was considered necessary to demonstrate the diversity of professional responsibilities at PH and research how social identity is constructed and acted upon within this hospital.

Sample size, however, was determined by a pre-arranged volunteer system due to the fact that data collection took place in the hospital. The decision to gather data at the place of work of study participants was, in part, due to ease of data collection this allows, but also to ensure interview questions remain in-context. Mack et al. (2005) wrote "sample sizes […] depend on the resources and time available, as well as the study's objectives" (p. 5). Indeed, the resources of this study are such that sample size was pre-determined by number of people willing to be interviewed.

METHOD

Data collection took the form of semi-structured interviews with doctors, nurses, and administration staff. Interviews were recorded with the consent of the study participants. The length of interviews ranged from five to twenty minutes. Occasionally the researcher was required to expand upon questions in order to fully explore certain concepts that presented themselves during interviews.

It was decided due to the nature of the study, researching communication with colleagues, that focus groups would not be the most effective method of data collection, and that study participants would feel at greater ease talking of this subject in a private one-on-one setting with the researcher. As such, semi-structured interviews were considered the best form of data collection. This was due in part to the greater privacy this allows, as it has been argued semi-structured interviews, rather than structured interviews, give greater opportunity for study participants to freely express opinions on matters (Croucher & Cronn-Mills, 2014). Another reason for choosing semi-structured interviews were the time-constraints on the part of study participants, meaning it was only possible to meet once with participants. Croucher and Cronn-Mills (2014) wrote "semi-structured interviews are typically used when […] interviewers only have one chance to meet with a particular participant" (p. 159).

STUDY SITE

The reasons for choosing to conduct research at a private hospital are two-fold. The first reason was the reputation of private healthcare as being quicker, of better quality, and offering more services than NHS care (Cook, 2014; Evans, 2015; Henderson, 2011; Polechonski & Farmer, 2013; "Private vs. NHS: Would you go private if you needed medical treatment?", n.d.; "What is it really like to stay in a private hospital?", 2012). It is expected the reputation of PH is afforded to it, in part, because it is a private facility, and this influences communication of healthcare providers with each other. This indeed presents an interesting facet to this study. The NHS and private healthcare divide will be discussed in greater detail in the next subsection of this study.

The second reason for choosing this particular private hospital is of a practical nature; personal connections with this hospital have led to greater ease of access than at a different hospital. This will be briefly discussed in greater detail later in this thesis. Furthermore, the geographical location of this hospital meant the flexible approach needed towards conducting

interviews with time-constrained study participants was possible, and the study site could be easily and quickly reached when the researcher was informed participants were available for interview.

NHS VS PRIVATE HEALTHCARE

Healthcare in England operates on a two-tiered system; the National Health Service (NHS), and private healthcare. These two systems enjoy vastly different reputations which are expected to play a role in healthcare providers' communication with each other at the hospital where study research will take place.

The NHS has been criticized in recent years for suffering from funding cuts which have been argued to impede the efficacy and speed of patient treatment (Dakers, 2015; "The mounting challenges facing Britain's NHS: Fulminating against bureaucrats and the private sector does not help", 2015). Private healthcare, on the other hand, is paid for by the patient and is purported to be much quicker than NHS care (Citizens Advice, n.d.).

A limited choice of patient treatment has also contributed to the tangible different in reputation of the NHS and private healthcare in England. For example, choice of where to be treated is not offered in the NHS for maternity, cancer, mental health, and emergency services (NHS Choices, 2015). Certain people, such as prisoners and military personnel, cannot choose where to be treated under NHS care (NHS Choices, 2015). Arguably, the only specification for accessing private healthcare is if a person has the means to pay for it.

Apart from limited choice of geographical facility imposed by NHS directives, there is a limited choice of services offered under the NHS. For example, laser eye surgery is only covered by the NHS if it is for a condition which, if left untreated, would lead to loss of sight (NHS Choices, 2014). Certain other procedures, such as specialist surgery for sports-related injuries, are not covered by the NHS (Do you need private medical insurance?, n.d.). It has

been argued many procedures not offered by the NHS can be obtained through the private sector (Citizens Advice, n.d.).

Staff resignations within the NHS have also been highly publicized ("A&E consultants: Why we left the NHS to work abroad", 2013; McGurran, 2006), which have arguably contributed to the assertion 53% of the British population prefer private healthcare Polechonski & Farmer, 2013). Evans (2015) also asserted 10.6% of the British population would pay for private medical insurance if they could afford it.

However, the line between the NHS and private healthcare has been said to be "blurring" (Private vs. NHS Funding and Treatment options, n.d., para. 8). Private Patient Units (PPUs), privately-run medical wards in NHS hospitals, arguably lessen the distinction between NHS and private healthcare resources (Competition and Markets Authority, 2012; Pemberton, 2014). As such, the reputation of PH may not play as clear a role in the perception of healthcare providers' communication with each other as anticipated.

ACCESS TO STUDY SITE

As previously stated, personal connections, as well as the geographical location of PH guided the decision to conduct research at this particular hospital. Ease of access is also the reason why a comparative study with a nearby NHS hospital was not conducted.

However, it was nevertheless still necessary, as per British law, to obtain an enhanced Disclosure and Barring Service check (DBS) in order to conduct research at PH. This is a form of background and criminal record check necessary if a person in the UK wishes to work with children, in healthcare, or wishes to foster or adopt a child. Certain personal documents, such as a valid passport, and driving license must be presented and a small fee (£44 at the time of this study) is charged for this check. Due to the possible long waiting time for such a check to be conducted this check was organized roughly three months in advance of conducting research.

PARTICIPANTS

Participants in this study were people who worked either full-time or part-time at PH. In order to classify participants whose professional role did not obviously fall into one of the three categories (doctor, nurse, or administration staff), classification was done based on the greatest similarity of the profession to another. For example, the work of healthcare assistants was decided to be most similar to that of the nurses in PH, and so these participants fell under the umbrella term of "nursing staff".

This study comprised of 30 interviews; 10 participants from each of the three professional categories. 11 interviews with male participants were conducted, and 19 with female participants. The reason for the relative gender disparity between participants was due in part to a gender divide in certain professions (nurses and administration staff tended to be female, whilst doctors tended to be male), and also due to being unable to interview those people who disproved the rule for gender-dominated professions.

It was decided after 30 interviews that data saturation had been reached. Data saturation in qualitative research is notorious for having no standard test by which to prove such saturation has been reached (Bowen, 2008; Kerr, Nixon, & Wild, 2010, p. 271). Many researchers have, therefore, created their own criteria by which to judge whether or not data saturation has been reached. Mead (as cited in Morse, 1995, p. 147), humorously defined data saturation as the "boredom that occurred when investigators had "heard it all"". However, other researchers take a more professional approach, defining data saturation as "when the researcher gathers data to the point of diminishing returns, when nothing new is being added" (Bowen, 2008, p. 140).

As such, the decision to cease conducting interviews was based on analysis of transcripts as data was being gathered showing that no new answers were being given, and no new information being presented. It became apparent after a number of interviews answers

were consistent across the three different groups (doctors, nurses, and administration staff), and it was felt further interviews would not add anything to the study.

DATA ANALYSIS

For this study a qualitative approach to data analysis was chosen for various reasons, the first of which is that much of early CAT research analysis has taken the form of quantitative analysis (Gasiorek, Giles, & Soliz, 2015a). This study aims to expand the ever-growing number of CAT-related qualitative studies.

The second reason for this choice of data analysis method was to take advantage of the opportunities presented by qualitative analysis for greater interpretation of data. For example, Barbour (2008) argued qualitative methods added another dimension to data analysis by offering the opportunity to access "embedded processes" (p. 13) of people's everyday lives. Barbour (2008) also noted the advantage of qualitative methods over quantitative methods for being able to "make visible and unpick the mechanisms which link particular variables, by looking at the explanations, or accounts, provided by those involved" (p. 12).

However, qualitative methods are arguably ridiculed by certain members of the medical community. For example, Malterud (2001) purported qualitative methods are "regarded with scepticism by the medical community, accused of its subjective nature and the absence of facts" (p. 483). This assertion is also supported by Popay and G. Williams (1998) who argued although qualitative methods are increasing used in healthcare research there are still many people in this field refusing to accept such methods as legitimate methods of analysis.

Qualitative methods have also been criticised due to researchers' approach to these methods. Malterud (2001), for example, argued researchers choosing qualitative methods must give greater detail about how the method was conducted; "Declaring that qualitative analysis was done, or stating that categories emerged when the material had been read by one

or more persons, is not sufficient to explain how and why patterns were noticed" (p. 486). Marshall (1996) also purported a tendency of researchers to invent "new and complex terms which cloud fundamental issues" (p. 522) as a reason for better documentation of qualitative techniques. If correctly documented Malterud (2001) argued qualitative methods constituted a "promising approach to broader understanding of clinical realities" (p. 487).

Pope, Van Royen, and R. Baker (2002) also argued for the need of qualitative methods in healthcare, asserting "the concept of quality in health care is multidimensional and complex and some of the questions we want to ask about the quality of care or services may not be amenable to quantitative measurement" (p. 148). Barbour (2008) also noted this same need in her summary of Fairhurst and Huby (p. 13) in which it was concluded GPs needed to qualitatively evaluate quantitative data before they were persuaded to alter their professional practices. As such, though qualitative methods may not be as well regarded in the medical sphere, they are arguably still necessary to this sphere.

As such, it is argued using a qualitative research method to analysis of interviews with healthcare providers could lead to a greater understanding of the intricate workings of hospital workplace relationships and, quite possibly, to a better healthcare environment for all concerned. It is also hoped this study could contribute to improving the reputation of qualitative research methods in the medical community.

THEMATIC ANALYSIS

Thematic analysis (Owen, 1984) is the method used to analyse data collected from interviews. Thematic analysis is a method used to analyse how a relationship is interpreted through communication, and was conceptualized by Owen (1984) as "unimposed lay conceptions of actual communication episodes in current relationships" (p. 274). Braun and Clarke (2006) have termed thematic analysis "a method for identifying, analysing and reporting patterns (themes) within data" (p. 79), whilst Guest, MacQueen, and Namey (2012)

called thematic analysis "the most useful [method] in capturing the complexities of meaning within a textual data set" (p. 11).

Indeed, the main aspect which researchers of thematic analysis have been concerned is the focus of the method on interpretation of data. Namey, Guest, Thairu, and Johnson (2008) purported thematic analysis as a more sophisticated form of data analysis that "moves beyond counting explicit words or phrases and focuses on identifying and describing both implicit and explicit ideas" (p. 138). The importance, rather than quantifiable nature of a theme, is purported as the focal point of thematic analysis (Braun & Clarke, 2006). Such interpretive flexibility was noted by Alhojailan (2012), who asserted "thematic analysis is considered the most appropriate for any study that seeks to discover using interpretations" (p. 10). This, arguably, renders the method highly adaptable for a research topic based on how healthcare providers interpret and act on individual social identity.

However, Braun and Clarke (2006), though they also praised thematic analysis for its flexibility, nevertheless acknowledged the lack of concrete definition of how such analysis is performed, and what they perceived as a frequent failure on the part of researchers to adequately document how themes were chosen. Namey et al. (2008) also noted reliability as a weakness of thematic analysis, though they asserted "monitoring and improving intercoder agreement" (p. 138) as a method to circumvent the possibility of falling prey to this limitation.

Despite the assertion of Braun and Clarke (2006) of a lack of guidelines on how to conduct thematic analysis, Owen's (1984) proposal of "recurrence, repetition, and forcefulness" (p. 275) as methods of theme detection is arguably a solid basis from where to start. Guest, MacQueen, and Namey (2012) asserted a theme is "a unit of meaning that is observed […] in the data by a reader of the text" (p. 50). As such, the assertions of Owen (1984), and Guest, MacQueen, and Namey (2012) arguably demonstrate a sensible approach

to thematic analysis; a theme is a meaning interpreted by an individual, and is one which is forcefully repeated.

RESEARCH FINDINGS & INTERPRETATION

In this study there were three major emerging themes affecting communication; power, private hospital advantages, and comprehension. Below is a visual representation of themes and subthemes used when coding the interview transcripts.

Figure 1. Themes for coding

Power	**Private hospital advantages**	**Comprehension**
↓	↓	↓
Between doctors and nurses	Time	Language/accent
Between ranks of the same professional group	Smaller surroundings	Hearing
		Medical specialty

These themes were guided, in part, by theory, and also previous studies relating to healthcare communication. However, this study was open to emergent themes. Although a concept did present itself during data analysis, it was decided this did not meet Owen's (1984) criteria to be termed a theme. The theme of power answers research questions one and two; "what are the approximation strategies adopted by healthcare providers to communicate with each other?", and "what effect do healthcare providers perceive their identity to have on their communication with each other?" The theme of private hospital advantage answers research question three ("what effect do healthcare providers perceive their communication with other staff members to have on the treatment of patients?"), whilst the theme of comprehension further answers research question one. Themes will be briefly outlined and quotes given in

order to illustrate further the findings of this study. Not all participants who gave responses indicating such themes will be quoted, but will, nevertheless, be acknowledged.

For the purpose of citing study participants certain abbreviations have been used. "I" stands for "interviewer". There was only one interviewer for this study; the author of this thesis. The letters "D", "N", and "A" stand for "doctor", "nurse", or "administration staff", along with a number from one to ten, assigned arbitrarily to participants in order to systematize participant groups.

POWER

Power can be defined in a multitude of different ways, including as leadership, influence, or authority. The way in which power in an organization is structured can be usefully demonstrated by an organizational hierarchy. Hierarchy structure (n.d.) conceptualized a traditional hospital hierarchy as a linear structure wherein the Chairman occupies the position of highest authority, followed by various senior administrators. Doctors, in order of seniority, assume the next highest positions, followed by nurses, also from highest to lowest seniority. The professions considered most junior occupy the base of the hierarchy, and consist of professions such as medical assistants, and clerical staff. A hierarchy has been praised for the ability to "establish internal control [and] allow[ing] employees on different levels to identify the chain of command" (Saint-Leger, n.d., para. 1). As such, hierarchy directly informs communication by demonstrating to whom one must report based on to whom one is junior or senior.

Participants in this study discussed power in regard to legitimate power afforded to them by expectations of their professional role within the hospital. There was a tendency among doctors to acknowledge the perceived seniority of their position in the hospital in relation to their communication with colleagues; eight of the ten doctors interviewed perceived their position as senior within the hospital, and believed this affects their

communication with colleagues, either because of the colleagues' attitude to their position, or their own. Doctor 1, for example, verbalized the potential for his position to be seen as superior in answer to the question "what effect do you perceive your position as a doctor has on your communication with colleagues?"

> D1: My peers, in other words, other consultants, perceive me largely as an equal, although I am aware that nurses and other members of the staff, both administration and support staff view me as a superior, but that doesn't mean that I should treat them in any way, or speak to them, as an inferior.

The assertion of Doctor 1 not only demonstrates the interpretation of "colleague" as a person of the same profession and rank, but also the potential for perceived seniority to negatively affect the communication of the person occupying that senior position. Doctor 2 also perceived their position as senior and the importance of not speaking in a condescending way to others. Indeed, a noticeable result of doctors' approach to their position was a focus on attempting to minimize the potential disruption caused by what they believed to be others' perception of their position. Doctor 3, for example, asserted doctors as leaders, and argued a quality of a leader is effective communication, achieved by open lines of communication with colleagues;

> D3: We need to let them [colleagues] ask questions, communicate with me. We need to encourage open communication and talking to each other.

Doctor 3 presented an interesting approach to the traditional model of leadership in

PH, demonstrating although doctors can be seen as senior this, for the sake of effective communication between colleagues, must not be seen as supremacy over colleagues. Instead, there should be a flat enough power dynamic in order to allow others working in PH to question the doctor. The suggestion of Doctor 3 was such open lines of communication are still encumbered by a perceived power difference between doctors and other professions within PH. Doctor 6 also commented on the disabling effect of communication informed by traditional hierarchy models;

> D6: […] colleagues in general- there is a huge difference between the perception of my status- If I talk to junior nursing staff you get the impression that they feel a little bit in awe, and that can be really hard. […] As colleagues in other disciplines become more confident and as they get to know you the balance changes completely.

Doctor 6 felt the hierarchical setting delayed communication between colleagues, and a less hierarchical setting allowed for an easier, more pleasant working environment that was more conducive to effective, quality patient care. Indeed, the existence of a traditional hierarchy within PH was emphasized by other doctors. Doctor 7, for example, asserted;

> D7: […] I think the way that people will listen to you is increased the more senior you are, so you tend to be afforded a greater length of time to speak and people will be quiet when you speak if you're more senior. […] There's a strong feeling that those kind of ideas are disappearing over time, that there's less […] concern about hierarchy and rank and that we have a slightly more horizontal structure, but in actual fact when you see how people respond and give you space to talk, I have more space to talk compared to when I was a registrar […]

Doctor 7 offered an interesting approach to the attempts purported by other doctors to minimize the power distance between them and other colleagues. Doctor 8 also argued for the existence of a power dynamic that affects "conversation" within PH between senior and junior doctors, whilst Doctor 9 asserted this power as existing in the expectations of doctors;

> D9: Well, special moments such as in an emergency situation I would need to show I'm in control of the situation to other doctors and with nurses. I would keep a certain tone of control.

Indeed, the results of this study clearly show doctors at PH believe their position within the hospital to be senior, and that this had the potential to result in a lack of convergence to the communicative style of others, and for other professions in PH to converge to the communicative style of the doctors. The potential for physician-focused communication through convergence is demonstrated in multiple ways. Firstly, by acknowledgements the professional status of a doctor could lead to speaking to another as though they were "inferior" (Doctor 1), or "condescending" (Doctor 2) speech. Secondly, by repeated testimony of various doctors a traditional hierarchy model informs communication between doctors and other professions within PH, suggesting physician-focused communication between different professions in PH.

Despite the concerns of the majority of doctors interviewed communication with other professions in PH could be negatively affected by the perceived seniority of the doctors, the responses of the nursing and administration staff suggest these concerns were unwarranted; the majority of the nursing and administration staff interviewed did not believe communication with doctors is affected by a traditional hierarchy model. For example, only

two of the ten nurses and three of the ten administration staff interviewed believed they would change their speech to converge to that of a doctor. The ways in which these members of the nursing and administration staff would achieve this convergence was by matching their accent to that of the doctor. For example, Nurse 2 described changing their accent to make it less colloquial and regionally-centred depending on the status of the person to whom they were talking. Administration Staff 2 also noted an effect of the status of a doctor on their communication;

> A2: I think I probably just pronounce my words properly […] slow down, and speak clearly […]

Administration Staff 3 asserted their communication would be "posher" when talking with a doctor. Indeed, a pattern of believing one made one's speech clearer and more elegant when speaking with doctors was noted among the study participants who believed they changed their communication style when interacting with a doctor. Nevertheless, these participants were few. The majority of nursing and administration staff did not note a change in their communication with doctors, demonstrating a perceived flatter power dynamic between staff members at PH.

The effect of perceived seniority on communication within the nursing profession also proved to be minimal, with only only three of the ten nurses interviewed asserted their alleged seniority would affect their communication with more junior staff. Nurse 1, for example, characterized their seniority in the following way;

N1: Obviously the type of communication you have would be different depending on whether you were talking to another staff nurse or maybe a healthcare assistant. With a healthcare assistant I think it might be more about instruction […]

Indeed, the focus on teaching more junior members of staff was a noted effect of subjective seniority among nursing staff. Nurse 10, for example, asserted;

N10: […] when we get new ones in I end up showing them, teaching them.

This teaching-focus of communication was also one noted by a more junior member of the nursing staff, who asserted;

N2: I think they like to teach me, so I think it's more of a parental kind of response, because they want to teach me how to do things.

Nevertheless, such an effect of one's perception of professional rank was not commented upon by the majority of the nursing staff interviewed. Nurse 5, for example, although arguing their seniority within PH, argued this had not effect either on their communication with others, or others' communication with them;

N5: It doesn't really matter if I've got a blue dress on or a green dress on because we just work together.

Indeed, six of the ten nurses interviewed used the word "team" in relation to their position in the hospital, suggesting a flatter power dynamic. For example, Nurse 8 asserted;

> N8: I try not to show that I've got a higher position than my colleagues. We try and be equal because we work as a team, all together. There's no point showing your [status].

Indeed, an important part of team communication was revealed to be building a rapport with others, thereby suggesting communication that uses less divergent communicative styles. For example, Nurse 1, for example, asserted convergent communication to achieve a rapport with others;

> N1: […] definitely I think you do sort of mirror somebody's speech pattern to kind of have a bit of a rapport […]

Nurse 5 also argued a part of being a team involves a convergent communication style;

> N5: […] when you've worked with someone for quite a while, you don't realize, you build this rapport up, and you don't actually notice it yourself. But, you've all got your own little language, and after a period of time you adapt it to one another […]

This flatter approach to the hierarchy of PH was also demonstrated in the assertions of the administration staff interviewed. Seven of the ten administration staff interviewed asserted their relationship with colleagues was either unaffected by the professional role of both parties, or that a team spirit minimized the potential power distance between colleagues. Administration Staff 5, for example, asserted;

A5: We're all here, we're all doing the same job, there's no hierarchy.

Administration Staff 5 attributed this equality to the importance of effective information transfer between colleagues, meaning less power can be asserted through knowledge;

A5: […] communication is really important because if we don't talk to people, we don't know what's going on, and they don't know what's going on. It's so important that we get communication right […]

Effective communication is characterized by Administration Staff 5 as open communication with colleagues; an opinion shared by Administration Staff 6, who asserted ineffective communication could lead to things being missed. Indeed, the communicative concerns of the majority of administration staff revolved around maximising the effectiveness of communication with colleagues; Seven of the ten administration staff interviewed commented on the importance of open communication with colleagues due to the specifications of an administrative role within a hospital. On this point, Administration Staff 7 commented;

A7: […] communication is key because we're a part of the whole hospital's operations, so we play a certain part within the larger role […]

The findings of this study indicate across distinct groups of professions in PH there is an emphasis on minimizing the potentially disruptive effects of a traditional hierarchy model.

Despite doctors being concerned with the possible negative effects of their perceived position in the hospital on communication with colleagues, the responses provided by nursing and administration staff confirm the success of all in achieving a slightly flatter hierarchy within PH.

However, to a degree such a result could have been caused by individual understanding of the word "colleague". The interview questions, which can be found in appendices 1 of this thesis, used the word "colleague" in order to ascertain another dimension to the potential power distance within PH. "Colleague" is a vague term allowing for a number of interpretations, such as "teammate", or "equal". Whilst these can, indeed, be taken simply at face value, there could also be the suggestion made those one does not consider to be colleagues are those to whom one is either senior or junior and, therefore, demonstrates another facet to the workplace power dynamic. Findings indicate four doctors understood the word "colleague" as those people performing the same professional function, compared to only two nursing and two administration staff. Responses indicating such an interpretation of the word "colleague" took the form of a directly stated difference, such as Doctor 9;

> D9: I would say I kind of accentuate my speech patterns but not for colleagues or nurses.

Doctor 9 talked of nursing staff separately to their colleagues, thereby demonstrating a clear disassociation between the group classed as colleagues, and that classed as nursing staff. Nurse 4 categorizes colleagues in a similar way;

> N4: I'm always very clear with whoever I'm speaking to; colleagues, doctors, anaesthesiologists.

Administration Staff 3 was even clearer about their perceived distinction of colleague and others;

> A3: […] I probably would be more relaxed if one of my colleagues phoned up, but if it was a patient or a consultant I probably would speak "posher […]

Despite the potential for "colleague" to be interpreted as those of the same professional function, most participants in the study interpreted the word as a conglomerate of all the different professions with which they worked in PH. Statements demonstrating a perception of workplace equality indicated such an interpretation of the word "colleague", such as Nurse 5, who maintained;

> N5: I'm quite used to talking to management, colleagues of the same level of me.

Herein, Nurse 5 acknowledged the possibility for colleagues to also be those of a different professional level, as did this direct statement on the definition of "colleague" from Doctor 8;

> D8: I think the word colleague is a bit broad because you have so many people that you count as colleagues.

Although results indicated "colleague" was understood by the majority of study participants as staff members in other professions, and of different professional rankings and

status, there was the potential for this to indicate another level to the power dynamic of PH. As this potential has been discussed in this theme, it was considered unnecessary to reiterate in other themes the understanding of the majority of the word “colleague” as including all members of staff working in PH. However, the vagueness of the term “colleague” will be further discussed in the limitations section of this thesis.

PRIVATE HOSPITAL ADVANTAGES

The second theme noted in analysis of interview transcripts has been termed “private hospital advantage”. This theme not only demonstrates the advantage of a private hospital to communication between colleagues at PH, but also illuminates the importance various staff members at PH place on communication with each other to the treatment of patients.

The theoretical distinction between private hospitals in the UK and the NHS has already been explained in this thesis. Distinguishing factors of the private healthcare sector from the NHS were a reported increase in time for patient care in the private sector (Citizens Advice, n.d.). In this study both an increase in time, and smaller surroundings were noted factors of PH contributing to better communication between all researched groups at the hospital, suggested to consist of more convergent communication styles. More than half of all participants interviewed noted more time, and a smaller work community as contributing to improved, more effective communication between colleagues at PH.

17 of the 30 study participants agreed PH, as a small private hospital, offers professionals more time to communicate with each other, resulting in a friendlier working environment, and greater benefits to patient care than in an NHS hospital. Of these 17 study participants there were five nurses, five doctors, and seven administration staff. Administration Staff 5 commented colleagues would interact more with each other more in PH than in an NHS hospital, as PH is a friendlier environment. Doctor 1 supported this assertion, arguing PH as;

D1: calmer […] more pleasant, and therefore it is very much easier to stop and have a chat with colleagues.

An environment conducive to communication with one's colleagues was a noted theme among study participants. Doctor 5 asserted communication is "more satisfactory" in PH because of the additional time to communicate with one's colleagues. Indeed, this satisfaction could be attributed to greater time PH allows for more pleasant, less rushed interactions. Doctor 4 supported such an assertion, and termed working at PH a "better experience".

A number of study participants attributed the friendlier, more communicative environment at PH to the size of the hospital. For example, Nurse 3 asserted the size of the hospital allowed for better quality communication;

N3: […] there aren't many branches it [communication] could go through, it's […] a smaller community […] it's better.

This opinion was shared by a number of study participants, including Nurse 8, who asserted PH is a friendlier "more intimate" environment because departments are smaller. The small size of department was suggested by Administration Staff 3 to be conducive to keeping everyone "on board and up-to-date". Administration Staff 7 argued;

A7: I think because we're a small unit and it's easier to communicate, I mean, we're all fairly accessible, so compared perhaps to a larger unit where it's going to be a lot more difficult to speak in person to somebody, than it would be here.

Indeed, being able to communicate with one's colleagues was noted as particularly important for transferring patients, or being able to get professional advice from a colleague. This was particularly noticeable among doctors and nursing staff, the majority (8 doctors, 9 nurses) of which noted communication with colleagues as key to patient care. Doctor 4, for example, argued communication with one's colleagues was particularly important when dealing with "difficult patients", as advice was more easily obtainable in a smaller, more pleasant environment. It was argued greater information transfer between hospital professionals happens in PH because of its small surroundings and friendly environment.

The testimony of the majority of study participants indicating more pleasant surroundings and more time to communicate with colleagues suggests a greater rapport between colleagues at PH. Rapport is built through mutual understanding, which can be achieved through a common communication style. Therefore, it is suggested less divergent communication styles are used in PH, and more convergent styles are utilized, in order to maximise colleague-to-colleague communication.

Study participants who asserted communication was no different at PH than at an NHS hospital argued various points of view; some attributed a lack of difference to an overarching focus on professionalism, whilst others argued communication with colleagues was an individual, personality-based concept For example, Doctor 6 believed communication with colleagues was dependent not on the environment, but on individual personalities, terming poor communication between colleagues the result of a "clash of personalities", therein suggesting divergent communication styles. Doctor 7 confirmed the individual nature of communication, as did Doctor 9, who argued for a professional-focus to one's work;

D9: At the end of the day it's about working with people, looking after the sick.

Doctor 2 advocated not letting personal grievances with colleagues getting in the way of one's work, regardless of whether or not the hospital is a private one, thereby acknowledging a change in communication styles could occur if the workplace were not governed by professionalism. Other study participants noted how working in a private hospital did not affect the expectations of employees regarding communication, but may affect those of patients;

> N9: I wouldn't say that [communicating in a private hospital] changes much because at the end of the day your colleagues are your colleagues; they're the ones you're working with. I suppose […] patients expect more from private, but colleagues don't. I don't think there is much difference between NHS and private; I think that's exactly the same.

Administration Staff 8 also noted the higher expectations from outside the hospital regarding communication;

> A8: I don't think it [communication] necessarily changes because you're working in a private hospital. […] I think that you're just more aware that the expectations of a private hospital are maybe that much higher and you're aware that you have to meet those expectations.

COMPREHENSION

Comprehension has been noted as dominating social identity maintenance (Hecht et al., 2008). Comprehension was acknowledged by study participants not only from the point of view of English language comprehension, but also accent, and content comprehension. The

latter pertains to comprehension of the content of a verbal interaction, irrespective of the native language or accent of either parties.

17 of the 30 study participants noted they would change their communication style to that of a colleague for reasons related to comprehension; Nine study participants attributed their perceived communication style change for general comprehension purposes. Responses indicating a change for hearing, or brevity purposes were included in this category. Seven study participants (including one who also perceived changing their communication style if a colleague was of a different speciality) noted changing their communication style either because they themselves were not native English speakers, or because another colleague was not. Two study participants (including one whose perceived communication style change was due to language) believed thy changed their communication style if a colleague was of a different specialty.

Of these 17 participants seven were doctors, four were nurses, and six were administration staff. Doctors tended to note a communication change for more specific reasons, such as because they, or another, were not native speakers of English, or because a colleague was of a different specialty. Nursing and administration staff noted changing their communication style to achieve general comprehension, such as through speaking louder, slower, or more concisely.

The majority of study participants who noted a change in their communication style did so to maximise comprehension in general. Of these study participants three were nurses, five were administration staff, and only one was a doctor. This could suggest a degree of unawareness among doctors of other issues affecting comprehension. Nurse 8 believed foregoing traditional niceties maximized comprehension in a time-constrained situation;

N8: For me it's short and sweet, and "please" afterwards [laughs]. Because that way you're sure they get the message […]

The response of Nurse 8 illustrates the importance of conveying information clearly, rather than being overly concerned with politeness. Interestingly, a seemingly brusque approach to communication was noticed also by Nurse 1 and Nurse 4, who argued straight-forwardness are key to comprehension and, by extension, the effective running of the workplace. This is particularly well-illustrated by the following quote from Nurse 4;

N4: I'm not a sort -of "faffing around" kind of person. I'm always very clear with whoever I'm speaking to […] You know, for me, if I've got a question I need answering, which is usually what my job entails, sort of saying like, "do you want to do this patient?", or "do you not want to do this patient?".

Administration Staff 8 argued they would change their communication style only when conveying certain detail;

A8: I'm conveying business data which requires more detail, more explanation, so I think I would change my speech pattern- slow down, and convey that detail.

This quote demonstrates the very flexible nature of a communication change; not only is such a change done to maximize information comprehension, but it is done only with certain types of information.

Hearing issues were another reason noted for a general communication change. For example, Administration Staff 7 acknowledged the hearing abilities of a colleague would influence their communication style;

A7: Yes, if I'm dealing with a colleague […] who I know has got […] hearing difficulties, then I would adapt my conversation accordingly, so perhaps I might have to speak slower, or raise my voice. So, yes, I would adapt my communication.

Herein, the primacy of comprehension is clearly demonstrated; there is no doubt comprehension of a colleague comes first over however the individual might like to communicate. This same primacy is noted by those for whom native language influences communication style. Doctor 2 and Doctor 3, for example, asserted changing their accent in order to be better understood by colleagues, even though their native accent is more natural for them;

D2: If I speak [in my native accent] they [colleagues] might not understand me.

D3: Sometimes. I'd say "if you don't understand my accent, please let me know".

Perhaps one of the most interesting findings was that of adapting one's communication to a colleague in a different specialty. Doctor 1, for example, asserted the following;

D1: Particularly when they're [colleagues] in the same specialty as me I can use the standard language I would use knowing that they should understand it. If they're in a different specialty, sometimes I would have to explain some terminology, because it wouldn't necessarily be familiar to them.

Herein, Doctor 1 acknowledged the possibility of terminology not automatically transferring across medical specialties. Doctor 1 expanded upon this in later communication, for which they have given permission to publicize in this thesis. Doctor 1 explained the term "OA" in gynaecology refers to "occiput anterior" which is the position of the fetus in relation to the mother's pelvis. However, in rheumatology "OA" refers to "osteoarthritis", a disease of the joints. Therein, adapting communication to other specialties is not necessarily an assertion of power through knowledge over other colleagues, but in fact can be a very sensible decision to maximise comprehension. Therefore, the following quote from Doctor 4 is interpreted as pertaining to comprehension, rather than power distance;

> D4: I suppose occasionally you do change your speech pattern for nurses to explain things that might be slightly complicated.

Changing communication for comprehension reasons with colleagues was noted by 17 study participants. Overall, however, 22 participants noted changing their communication for this reason; the five additional participants asserted adapting their communication in order to aid the patients' comprehension. Of the remaining eight participants the unanimous reason given for not changing communication style to maximise comprehension was they perceived such a change was unnecessary due to the high standard of English language comprehension among colleagues. For example, Doctor 10 argued "everyone here speaks good English" as a reason to maintain their communication style. Similar answers were offered by other participants, such as Doctor 6 who noted speaking "good English" was a requirement of all in the hospital due to the native language of most patients being English.

DISCUSSION

The aim of this study was to research how healthcare providers at a private hospital in England (PH) perceive their communication with their colleagues, to investigate the role of social identity in this communication, and to identify the effects communication with one's colleagues is believed to have on the health outcomes and care of patients.

Convergent communication was the communication style noted among the majority of study participants as the most effective way to communicate and achieve positive patient health outcomes, and a professional, pleasant workplace. This communication was achieved through minimizing the potentially disruptive effects of a traditional hospital hierarchy, and by maximising the potential of a private hospital to achieve a pleasant, close-knit community with one's colleagues. Awareness of the disruptive effects also of language and terminology dichotomies, and of hearing difficulties was also noted as a way to achieve convergent communication.

It was discovered the majority of doctors believed their status in the hospital to be informed by their profession and, as such, attempted to minimize the disruption a traditional hierarchy could have on communication with one's colleagues. Such disruption was perceived to be caused either by a reluctance of those in other professions to communicate openly with doctors, or by a tendency to talk in a condescending way to those in other professions. Indeed, many scholars have commented in particular on the distinction between a doctor and a nurse. Dev, Metcalfe, and Sanders (2014), for example, argued "consultants have ultimate responsibility for all the patients on their ward as well as those seen in clinic" (p. 11). In defence of this hierarchy of responsibility, T. Brown (2010) asserted "obviously, doctors and nurses have different roles in the hospital. Our training is different, and so are our responsibilities" (para. 14).

Although the majority of doctors believed their profession afforded them a superiority, the majority of nursing and administration staff did not note this as a contributing factor to their communication with doctors. In fact, even within the ranks of nursing and administration there was an overarching desire to minimize the disruptive effects of a traditional hospital hierarchy and maximize a teamwork atmosphere.

Indeed, such an atmosphere was considered to be aided by the nature of PH as a private hospital. Communication informed by a friendly, cooperative environment was the consensus of opinion among participants in this study. Indeed, private hospitals have been noted as being at an advantage for time, and quality reasons (Citizens Advice, n.d.). This was indeed supported by the testimony of the majority of study participants, demonstrating private healthcare in England, at least at PH, does indeed justify the praise afforded to the sphere.

Overall, comprehension among colleagues, achieved through awareness English is not necessarily the native language of all working in PH, of terminology differences among specialties, and of the negative effects caused by hearing difficulties, was perceived to be the main aim of most study participants. Handovers were purported to be of greatest importance to doctors and nurses, and resulted in a successful outcome when communication was concise, and understood. Administration staff also purported clear communication as the aim of all communicative interactions between staff members. Though a number of participants noted communication between colleagues at PH could be better, it was the opinion of every single participant that clear, concise communication between colleagues is of paramount importance at PH.

Therefore, this study found social identity, though somewhat informed by professional role and status, takes a subordinate role to comprehension. Through convergent communication styles, and an awareness of obstacles to communication, successful patient

health outcomes, and an effective, successful workplace and professional service, are achieved.

STUDY LIMITATIONS & DIRECTIONS FOR FUTURE RESEARCH

A number of limitations were noted throughout this study. One, previously mentioned, was the ambiguity of the term “colleague”. Although it was initially intended to reveal how individuals perceived the power dynamic of their workplace, it resulted in some confusion during interviews. It is recommended future researchers in this area either define their own understanding of “colleague” to each individual study participant prior to commencing interviews, or use unambiguous terminology.

A second limitation of this study stems from the criticism of the theory of Communication Accommodation; awareness of communication changes, and ability to test such changes. CAT does not extend to empirically proving whether or not approximation strategies actually occur in communicative interactions, and so relies on individuals to report such changes. This has limitations as not everyone is aware of their own communication style. This was indeed noted in this study; a number of participants did not believe they converged or diverged to the communication of another. Apart from leaning towards a more scientific way to prove consciousness of actions, which is outside the scope of this author to understand and explain, the consciousness of approximation strategies can be improved by communication training. Communication training can be useful for raising awareness of the different ways in which humans communicate, and could result in fewer study participants expressing unawareness of their communicative tendencies. Therefore, it is suggested study participants in future research be educated in communication and communication tendencies prior to commencing interviews.

A third, and perhaps the biggest limitation to this study, was the gender divide among groups in PH; the majority of doctors were male, whilst the majority of nursing and

administration staff were female. It is suggested answers to a number of interview questions could have been different had this divide not been present. Indeed, circumventing this divide is impossible, and this is not the suggestion in explaining this divide. The suggestion is, however, to explore the effect of gender on communication strategies. It was previously mentioned in certain healthcare studies gender affects how one communicates. Further research on this topic could contribute useful data as to why certain medical and non-medical professions within a hospital are still, in 2015, dominated by a particular gender.

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APPENDICES

APPENDIX 1. INTERVIEW QUESTIONS FOR STUDY PARTICIPANTS

1. Do you change your speech patterns, or accent to match that of a colleague? If so, how?

2. Do colleagues change their speech patterns, or accent to match your own? If so, how?

3. Do you emphasize your speech patterns, or accent when communicating with a colleague? If so, how?

4. What effect do you perceive your position as *x* has on your communication with colleagues?

5. What effect does the professional role of a colleague have on your communication with that colleague?

6. What effect do you perceive working in a private hospital has on your communication with colleagues?

7. What effect do you perceive working in a private hospital has on your colleagues' communication with you?

8. What effect do you perceive your native language has on your communication with colleagues?

9. What effect do you perceive colleagues' native language has on your colleagues' communication with you?

10. What effect do you perceive your culture has on communication with colleagues?

11. What effect do you perceive your colleagues' culture has on your colleagues' communication with you?

12. What effect do you perceive your gender has on communication with colleagues?

13. What effect do you perceive your colleagues' gender has on your colleagues' communication with you?

14. Do you have confidence in a colleague who changes his speech patterns, or accent to match your own?

15. How do you perceive your communication with your colleagues affects the treatment of patients?

16. Could communication between colleagues be improved? If so, how?

APPENDIX 2. DISCLAIMER FORM FOR STUDY PARTICIPANTS

Communication accommodation between healthcare providers at a private hospital in England: How does identity talk?

This study is a study of the perception of communication between healthcare providers (doctors, nurses, administration staff) and the role of social identity, economics, language, culture, and gender in this communication.

The data will be used for research purposes only. All recordings and interview data will be transcribed and anonymized. All recordings will be destroyed on completion of transcription.

You have a right to withdraw from the study at any time.

Thank you very much for participating in this study.

Name (please print):…….....

Date:……

Signature:…….