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Communication Skills, Expertise and Ethics in Healthcare Education and Practice (transcribed and edited by M.G. Rossi)

Interview with
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Srikant Sarangi has been Professor in Humanities and Medicine and Director of the Danish Institute of Humanities and Medicine (DIHM) between 2013 and 2021 at Aalborg University, Denmark, where he continues as Adjunct Professor. Between 1993 and 2013, he was Professor in Language and Communication and Director of the Health Communication Research Centre at Cardiff University (UK), where he continues as Emeritus Professor. As a leading researcher in institutional and professional discourse from an applied linguistics perspective, much of his work over the past two decades has focused on healthcare communication in a variety of settings (including genetic counselling, HIV/AIDS, primary care, palliative care, telemedicine). His analytical approach combines discourse analysis, pragmatics, and rhetorical analysis to offer specific insights into healthcare practice. More recently, he has developed notions such as communication expertise and communication ethics in arguing for the centrality of humanities in healthcare.

Professor Sarangi is editor (since 1998) of TEXT & TALK, An Interdisciplinary Journal of Language, Discourse and Communication Studies (Formerly TEXT, Mouton de Gruyter) and founding editor (beginning 2004) of Communication and Medicine (Equinox) and Journal of Applied Linguistics and Professional Practice (Formerly, Journal of Applied Linguistics, Equinox). As editor of these well-established journals, he has devoted his efforts to promoting both interdisciplinary and translational research.

This interview represents an opportunity to take stock of the positioning of our disciplines – broadly characterised as discourse/rhetoric/communication studies – in the context of healthcare education and practice, while at the same time exploring intersections between rhetoric/persuasion/discourse and ethics, through the discussion of what Sarangi refers to as the framework of "communication ethics". More specifically, Sarangi puts the notions of relationality and responsibility at the core of communication ethics and extends the notion of "communication expertise", as outlined in his previous research, as a necessary point of departure from the communication skills view which currently dominates healthcare education and practice.

Rossi: *Let us begin this interview with the designated theme of this special issue. What, in your view, is the current relevance of rhetoric in the context of healthcare education and practice?*

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Sarangi: As far as I can tell, in the context of healthcare, whether it is in the field of patient-provider interaction or public health, the words "rhetoric" and "discourse" are rarely mentioned in their disciplinary sense. What is routinely mentioned is "communication". There is widespread recognition that effective communication lies at the heart of healthcare delivery in clinic/hospital settings for optimising patient outcomes. And there is as much attention paid to failures in communication and their potentially adverse consequences. This scenario is extendable to public health messaging and communication teaching in healthcare curricula globally.

Against this backdrop, there is no appetite for reinventing the wheel as far as the term "communication" is concerned. However, considerable gaps exist in how communication is theorised, analysed, and assessed and how it is taught and practised within healthcare. Within healthcare delivery systems, and especially in healthcare education curricula, communication is generally understood as a skill, a form of behaviour, and such a perspective accounts for the dominance of psychology in healthcare education and in-service training of practising professionals. There is no denying that psychology is a contributory discipline to communication studies. But one also has to acknowledge the founding discipline of linguistics/pragmatics in relation to communication, marking a significant shift away from the so-called coding model of communication (in terms of encoding and decoding of messages) towards a recognition of other intervening variables – context, message, contact, code – that mediate meaning-making, as Jakobson's (1960) model attests.

Consider, for example, communication practices surrounding the current Covid-19 pandemic. If we consider public health messaging during this period, the focus seems to be on communication concerning human behaviour in a climate of risk, uncertainty and safety. We notice the conspicuous presence of behavioural psychologists in the media, at least in the UK, explaining the significance of adherence to appropriate behavioural standards for the safety of self and others. Here "communication" amounts to behaviour, not meaning-making practices as we understand it in the linguistics/pragmatics/rhetoric traditions. The dominance of psychology is even more salient in the medical education curricula.

As discourse/pragmatics/rhetoric researchers, a precondition for engaging with healthcare education and practice, including public health, would be to change the perspective on what communication is. A paradigm shift – from communication as skill/behaviour to communication as action/meaning-making practice – is called for. Such a shift in perspective is very likely not be taken sympathetically and even resisted by healthcare educators and practitioners. It is also not just about offering alternative definitions about "what communication is", but how we go about communicating our perspective on communication itself – an act of metacommunication – which must be addressed before we can influence healthcare practitioners and educators with a change agenda. It reminds me of the basic characterisation of communication as both content and relationship – «any communication implies a commitment and thereby defines the relationship» (Watzlawick *et al.* 1967: 51) – which lies at the core of my framework of "communication ethics". Communication ethics, for me, is an extension of the notion of "communication expertise", thus moving beyond the paradigm of communication skill/behaviour.

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Rossi: *What do we lose if we think of communication only as a skill or form of behaviour?*

Sarangi: There is nothing wrong with the conceptualisation of communication as a skill or form of behaviour, but such a conceptualisation remains reductionist if at the same time we do not acknowledge that it is more than a skill-set. Historically, the skills view of communication is premised on behaviourism. It is useful here to make a distinction between social behaviourism (Mead 1934) and psychological behaviourism (Skinner 1953). Skinner ultimately reduces everything to neurophysiological stimuli and responses whereas Mead insists that the social world can be known through the observation of behaviour. Meads' social behaviourism is very much couched in his social theory of self, which «arises in the process of social experience and activity» (Mead 1934: 135), thus foregrounding the developmental and relational dimensions of human behaviour.

Relying heavily on simulation and role-play, communication skills training in medical curricula comes closer to the psychological model of behaviourism. The skills approach goes back to the Toronto consensus statement (Simpson *et al.* 1991) and the Kalamazoo consensus statement (Makoul 2001). These statements constitute the holy grail of communication training in healthcare, which have later been operationalised for teaching and training purposes through the Calgary-Cambridge Guide (1996, see Silverman *et al.* 1999) and the CANCODE model of competency-based medical education (1999, see Hodges and Lingard 2012). Notions such as rhetoric, pragmatics, discourse do not get mentioned in any of the statements or course materials. Neither are medical educators trained in discourse/pragmatics/rhetoric. As a discipline, we remain largely invisible and this must be acknowledged as we pursue our research endeavour and target potential uptake. This might be particularly relevant in the context of this special issue: if you wish to entertain introducing the notion of rhetoric to healthcare, you have to first turn the tide against the currently dominant skill/behaviour approach to communication. Such an intervention is easier said than done.

The narrowly circumscribed skills-based, behaviourist approach to communication in both medical education and medical practice has been critiqued. One of the critics is Alan Plum (1981), who rightly claims that the behavioural skills approach places skillfulness, rather than meaning, at the heart of human interaction. For him (1981: 7), «the essence of personal communication is the understanding and expression of meaning, not behavioural skilfulness […] Learning certain behavioural "skills" guarantees nothing about the meaning this behaviour will have in actual interpersonal situations». As I see it, within the medical curricula the skills view artificially separates communication (e.g. teaching active listening) from the consultation (e.g. teaching the principles of patient-centredness); and it overlooks the jointly constructed/mediated nature of interaction in a consultation as an activity type. Not only is communication reduced to a pre-defined skill-set, but it is also designated as a "soft skill", proving difficult to teach and assess. In addition to communication and consultation being taught separately, the teaching of communication and ethics is also kept apart. In my view, an integrationist angle is needed whereby we talk about communication as an act of meaning-making, and by extension, as ethical conduct.

Rossi: *But why is it so hard to bridge this gap between communication, broadly understood, and healthcare education and practice?*

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Sarangi: The problem is that healthcare education, like any educational terrain, is guilty of itemizing and streamlining disciplinary content. Communication is stripped of its meaning component with behaviour taking precedence. We notice a kind of paradox: the more communication is conceptualised as an integrated field with many contributory disciplines such as philosophy, anthropology, sociology, psychology, linguistics, the less likely it will have curricular currency in healthcare, defying ease of teaching and assessment. In contrast, when communication is conceived as skill/behaviour it easily meets the various teaching and assessment criteria and thus gains currency. However, a health warning may be issued: by soft-skilling communication in terms of teaching and assessment activities in healthcare education programmes one not only downplays the scholarly discipline, among others, of discourse/communication studies but also runs the risk of deskilling the students and practitioners who may already have been socialised into being competent communicators in everyday rituals.

As a point of departure, my characterisation of communication as "a science of interpretation" affords us to draw upon various disciplines such as philosophy of language, linguistics, pragmatics, rhetoric, sociology, anthropology and discourse/communication studies. All these disciplines have so far been at the margin in the context of healthcare education and practice. Moreover, a shift away from the skill/behaviour view will enable deeper engagement with the socio-technological changes that constantly redefine the parameters of communication in healthcare, including digital consultation, electronic patient records and e-health literacy. I firmly believe that a shift from a skill/behaviour approach to a meaning-centred approach is a feasible proposition for communication teaching in healthcare curricula as is the case with humanities curricula in universities. But one should not fall into the trap of teaching "about communication" (including various theories and frameworks). The sole interest of healthcare educators and practitioners is that communication remains a practical science, very much like ethics in the Aristotelian sense. This change agenda requires a Kuhnian paradigm shift – going through the routine stages of emergence, acceptance, challenges, rejection, and replacement – and the evidence is that we are not there yet. As things stand, the conceptualisation of communication as skill/behaviour deprives it of its expertise component as well as its ethical component.

Rossi: *The notion of communication expertise is indeed key to understanding the interface between communication and ethics. The Covid-19 pandemic has perhaps shown the relevance of this notion related to the quality of public health communication. All of a sudden, everybody has begun to notice that public health has a communication problem…Could you elaborate on this?*

Sarangi: The problems surrounding "effective communication" during the Covid-19 pandemic might be symptomatic, rather than being causative. It is not uncommon during a public crisis to draw attention to communication issues. But, again, we need to ask what exactly is meant by "communication", and what kind of expertise is involved in a communicative act. This brings us to the notion of "communication expertise" (see also "interaction expertise", Sarangi 2010a), acknowledging the many forms of expertise that we generally associate with healthcare professionals, including in the public health setting. As I have outlined elsewhere (Sarangi 2018), "communication expertise" marks a shift from communication as skill/behaviour on a dichotomous good/bad scale. Put differently, mastering a skill that delineates right and wrong behaviour without a grasp of the situated interpretive context remains inadequate (as would be the case with

memorising the dictionary but not being able to produce a contextually appropriate utterance).

To begin with, communication expertise can be traced to the foundational sociolinguistic concept of "communicative competence". Communicative competence, as a sociolinguistic notion, was developed by Dell Hymes (1972). Dell Hymes was basically reacting to Noam Chomsky's notion of linguistic competence, with the latter's focus on the innateness of the native speaker's acquisition of a language (i.e. the existence of a universal grammar). Through the notion of communicative competence, Hymes was shifting attention from language form and structure to language function and use, as well as from correctness (grammar) to appropriateness (discourse). Communicative competence means being appropriate in the use of language and other semiotic means when communicating. As Hymes (1972: 278) famously put it, «there are rules of use without which the rules of grammar would be useless» and, by extension, «some occasions call for being appropriately ungrammatical» (p. 277). Say, for instance, in an operating theatre, in an emergency ward, or when reassuring a patient or a relative in palliative care, healthcare practitioners may not always speak grammatically, and this can easily be gleaned from transcripts we produce for analysis. Here appropriateness overrides correctness as meaning-making remains a matter of degree than either/or. In a sense, Hymes was anticipating the field of pragmatics – the study of language use – spearheaded by John Austin's (1962) *How to Do Things with Words* as well as the Gricean Cooperative Principle with its attendant maxims (Grice 1975).

More generally, to understand the notion of competence, we need to contrast it with performance. Whereas competence is seen as latent and inexplicit, performance is seen as manifest and explicit. Despite this contrast, as language/communication scholars who have only access to talk/text/multimodal performance, we can analytically comment on competence (as in the case of tests/exams/assessments). The job interview serves as a good example. Although a candidate's performance is accessible via recordings and observation, his/her competence in doing tasks, managing customers, working with colleagues, and so on is being assessed based on the performance.

The notion of expertise is embedded in sociology, psychology and cognitive science; it is more nuanced and goes beyond the competent use of language and related semiotic resources. There is more to expertise than linguistic and communicative competence when we consider specific instances of professional practice – scientific/technical knowledge, experiential knowledge, legal knowledge, organisational knowledge, ethical principles, etc. So, for me, "communication expertise" constitutes not only knowledge *about* the mechanics of communication but also the channels through which the other types of knowledge *are* communicated in real-life professional settings.

Also, we need to have a better appreciation of the role of intuition in relation to expertise. Through a juxtaposition of thinking fast and thinking slow, the Nobel Laureate Daniel Kahneman (2011) considers intuition as constitutive of expertise. In thinking of novice to expertise as a continuum, we may say that it is intuition that accounts for different degrees of expertise. In other words, different levels of intuition override conscious rule-following and attest to the developmental continuum. In this sense, communication expertise is practical knowledge gained through experience and it is not so much theory-laden. Similar formulations of expertise can be seen in Schön's (1983) "epistemology of practice" and in Polanyi's (1956) "tacit knowledge" or "personal knowledge".

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Intriguingly, what is referred to as «the paradox of expertise» (Johnson 1983) suggests that the more knowledge one gains, the less one knows how such knowledge is used in practice. This points to the fact that much of expert knowledge remains at the tacit level; the expert is no longer consciously aware of what s/he knows. Knowledge about things is not the same as doing things. This has been a challenge thrown at me by healthcare educators: if we teach our students more communication theory, the less they can put such theory into practice. Such scepticism rings true as we know that becoming an expert in the discipline of pragmatics does not amount to being pragmatically competent when communicating in real-life settings. This holds for communicative competence, narrative competence, rhetorical competence, and so on. There is no direct link between acquiring expert knowledge and using it contingently in practice. In this regard, the proponents of communication as skill/behaviour perhaps regard communication as a practical science, albeit distortedly.

Rossi: *In your work, you allude to "distributed expertise" when talking about communication expertise. Perhaps you can clarify this point.*

Sarangi: The basic point is that expertise does not squarely lie with the individual. So it is useful to introduce the notion of "distributed expertise", which normally indexes a division of labour among different individuals in joint, team-based decision making contexts. The assumption here is that different experts possess different kinds of technical/scientific knowledge, so they can collectively address complex problems that are not solvable by any given type of expert knowledge. Distributed expertise is a form of shared decision making, although this latter label has somehow been hijacked to denote decision making involving healthcare practitioners and patients. A good example of distributed expertise is multidisciplinary teams in the hospital setting when confronted by complex illness conditions, for which a given expert lacks sufficient knowledge. Artificial intelligence would be another example (see Hutchins 1991 on «distributed cognition» and also Suchman 1987)

I want to extend the concept of "distributed expertise" in two ways. Firstly, expertise is no longer restricted to experts with credentials, but is noticeable in what laypeople know and do, hence the notion of "lay expertise" or "citizen expertise" in regard to child rearing, cooking, nutrition, physical/mental wellbeing, interior design, gardening etc. We could call this "democratisation of expertise", including the phenomenon of expert patients with higher levels of health literacy. In relation to Covid-19, laypeople have abundance of social media access, which may explain their vaccine hesitancy. In a clinical setting, both patients and healthcare professionals bring latent and manifest forms of expertise to the communicative encounter. Healthcare communication thus needs to be seen as communication between "experts" (Tuckett *et al.* 1985).

Secondly, distributed expertise also relates to expert decision making which is increasingly being mediated through technology – the so-called expert systems (e.g. super computers, big data, algorithms). Such expert systems can be seen as both a resource and a potential threat. It is a resource that experts (and even laypeople) access in the process of decision making, but it can potentially render the experts redundant. Here we are talking about expertise as being both an attribute of humans as well as machines, which coexists in a complementary but delicate fashion. Inevitably, this connects with notions of risk and uncertainty that constantly mobilise expertise at the

level of communicative contingencies (as in the case of public messaging during the Covid-19 pandemic).

Both these dimensions of distributed expertise are relevant to the ethical component, because technology and ethics are interconnected. Now that expertise is accessible through the internet and social media, it raises ethical issues, particularly about trustworthiness and credibility of openly accessible information.

My earlier characterisation of communication expertise as a mode of channeling and articulating different types of knowledge remains intact in the era of expert systems. Healthcare professionals need to articulate whatever information can be accessed through expert systems. Even though both patients and doctors may have access to the same information, it does not mean that they will interpret the accessible information in the same manner. Here the professional has the communicative responsibility as many patients remain potentially vulnerable because they do not have an adequate scientific basis to interpret what they read. They can misinterpret available information, so it is not just about misinformation or disinformation.

The Covid-19 pandemic has shown we have to address issues related to the quality of health information and its communication. Communication practices in the arena of public health have long been challenged, as conceived under the rubric of "public understanding of science". It is nothing new with regard to Covid-19. Over the years there has been a critique of the top-down deficit model of public health communication – which unproblematically assumes that experts know and the public does not – in light of increasing levels of e-health literacy and internet access. But what makes the Covid-19 situation stand out is that at a given time the experts also do not know much about the virus, about its transmission patterns as well as mutation. Here we have experts struggling with communicating the risks and uncertainties, explaining the conditions surrounding why they do not know. At the same time they are pressed for making decisions and communicating those decisions in a climate of uncertainty in order to contain risk, while promoting safety. This then falls within the remit of communication expertise and also extends to communication ethics as it involves responsible, accountable actions. And in this respect, I think rhetoric and persuasion are key to communication in the public health context as a way of optimizing intended influences. From a different angle, what has emerged during Covid-19 related public health messaging is the lack of transparency in communication and decision making, being laid at the door of the politicians as decision makers. The politicians are mainly seen as mediating the scientific-expert knowledge. Appeal is made to scientific knowledge at each step of decision making, with the unintended consequence that trust in both politicians and public health scientists is fast eroding.

An illustrative example is the traffic-light system about international travel and the placement of countries in red, amber and green lists. In early June, all of a sudden Portugal was moved from the green list to the amber list by the UK government, which caused British people holidaying in Portugal at the time to panic as they did not foresee this scenario. They complained that the government had not been transparent in sharing the data about the Portuguese infection rates or transmissions. Neither was the public told the exact reasons underpinning the decision to move Portugal from the green list to the amber list. Routine statements by politicians such as "we are following the science", "we are being advised by scientists" were somehow intended as a surrogate for transparency, but they failed to engender trust.

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Rossi: *Let us finally move to the realm of communication ethics. It seems the notion of responsibility is at the very core of the communication ethics framework you propose. What are the motivations that drove you to think about this framework?*

Sarangi: There are two main drivers underpinning my framework of "communication ethics": first, to rescue communication from being reduced to a skill-set – and a soft skill-set at that – and to accord communication the status of knowledge/expertise and as ethical conduct. In other words, it is, simultaneously, a departure from the communication skill/behaviour approach and an extension of the notion of communication expertise. This has inevitably led me to map out communication ethics as a distinctive approach amongst the taxonomic maze surrounding ethics, especially in relation to the healthcare domain. Communication ethics should not be confused with research ethics. However, communication ethics, as proposed here, is as much about the ethical stance of researchers in interpreting healthcare interaction ("ethics of interpretation", Sarangi 2019) as it is about healthcare professionals interacting with clients, families, and fellow professionals ("ethics-in-interaction", Barton 2011). It is generally assumed that healthcare professionals are ethically minded. Useful here is Aristotle's distinction between technical goodness and moral goodness. For Aristotle, these are two separate entities/attributes, with no one-to-one correspondence between the two. One can be technically competent/expert, but this does not mean they can take moral decisions in the best possible way. One can be a good doctor, technically speaking, but not necessarily a good, morally responsible clinician.

Communication and ethics have lived their disciplinary lives separately; they are not usual bedfellows. But they can be seen as complementary as both disciplines share fundamental commitments, especially in terms of the self-other dynamics vis-à-vis autonomy and role-responsibility in an environment of accountability and trust. While ethics remains focused on "what ought to be" as distinct from communication's orientation to "what is", a case can be made for "ought" and "is" – the ethical aspects of communication and the communicative aspects of ethics – to be married, with the marriage vow being: *speech acts = communicative acts = ethical acts*. My overall argument is as follows: on the one hand, an actor's commitment to ethical values justifies and promotes a communicative mentality (Sarangi 2004), i.e. transparency towards mutual understanding and informed decision making; on the other hand, a communicative act articulates and mediates the beliefs and values that constitute ethics in a given encounter, either explicitly or implicitly, intentionally or unintentionally. Like expertise, ethics does not reside in one's mind; it needs articulation. It is through communication we begin to appreciate an ethical judgment and an ethical mindset.

As I have indicated earlier, communicative responsibility vis-à-vis communicative vulnerability (Sarangi 2012; Sarangi 2017) lies at the core of the communication ethics framework. Patients, and more generally people, are vulnerable. So the healthcare professional has the responsibility to explain risks and uncertainties that have decisional consequences. Being technically, bio-medically competent is a necessary but not sufficient condition. In a given situated event, technical/scientific expertise has to mutate into communication expertise as a key component of professional expertise, which would extend to communication ethics. In a nutshell, all speech acts in the Austinian sense are communicative actions in the Habermasian sense and they invariably count as ethical actions. The Austinian speech acts of promise or apology

carry a communicative potential, in the least aimed at sustaining human relations, and are therefore ethically bounded.

Let me briefly revisit Gricean pragmatics – the Cooperative principle and the attendant maxims – governing human communication. I see the Gricean blueprint as ethically grounded. For instance, the maxim of quality – that you should not say what you do not believe to be true – is very much an ethical matter, as is the maxim of quantity. Consider the communicative context of clinical trials: the more detailed information you provide, the more influential you might sound. Although the Gricean maxims come across as universal principles, they must be qualified with the philosophical dictum, "for the most part". Following the Aristotelian "doctrine of the mean", one should be moderate and "act as you should". So it is down to some kind of judgment call without being a moral dictate.

Communicative actions take us to Habermas (1984: 58) and his distinction between communicative action and strategic action: the former concerns «when the participants coordinate their plans of action consensually, with the agreement reached at any point being evaluated in terms of the intersubjective recognition of validity claims» to motivate another rationally; the latter seeks to *influence* the behaviour of another by means of the threat of sanctions or the prospect of gratifications, in order to cause the interaction to continue as the first actor desires. In my view, a reframing of Habermasian communicative and strategic actions as ethical actions is needed to include relationality/responsibility and not just rationality. Apparently simple questions in a clinic setting – Is it your first pregnancy? Do you smoke? What is your diet nutrition-wise? – are ethically sensitive. For instance, if it is the would-be mother's second pregnancy, but she is attending the clinic with her new boyfriend and would-be father, and she has not disclosed to him that she had a previous child by a former partner, she is not going to abide by the Gricean maxims when responding to the question. Even though the question about first/second pregnancy is after factual information, it has potential ethical implications.

Having sketched my proposal for communication ethics, it is helpful to recognise the many contours of ethics as have been mapped out taxonomically. Here are a few familiar traditions/labels, from which communication ethics defers. Aristotelian (Nicomachean) ethics is articulated as a practical science dealing with "how individuals should best live". Kantian deontological ethics focuses on moral reasoning and universality of rule-based conduct, i.e., reason-based at the individual level as "the categorical imperative" (the end in itself) suggests. For Kant, only actions done from duty are morally worthy. This can be contrasted with utilitarian/consequential ethics as proposed by Jeremy Bentham and John Stuart Mill – whether an actionis morally right or wrong depends on its effects (the principle of utility). Unlike Kantian universal rule-based ethics, utilitarian ethics is more pragmatic, focused on actions and their potential consequences, the welfare of all individuals. Communitarian ethics comes close to utilitarian ethics in emphasising the idea of common good – shared values, ideals, and goals. As a conjecture, it is very likely that healthcare practitioners and patients are more inclined towards utilitarianism (e.g. benefits and risks of actions) rather than rule-based moral reasoning in their decision making.

Then we have biomedical ethics (Beauchamp and Childress 1979) premised on the principles of autonomy (the obligation to respect the decision making capacities of autonomous persons); non-maleficence (the obligation to avoid causing harm);

beneficence (obligations to provide benefits and to balance benefits against risks); and justice (obligations of fairness in the distribution of benefits and risks). The principles seem to be based on self-other relations, with social justice targeted at general others, but there is the absence of an explicit communicative dimension. It is worth noting that biomedical ethics conflates research ethics (the conduct of biomedical research) and professional ethics (the practice of clinical medicine). The shortcomings of the principles-based approach have been acknowledged by Beauchamp and Steinbock (1999: 5): «Ethical decision making is almost never a matter of automatically applying principles and generating an answer […] one reason is that the right thing to do often depends on the facts of the case, and these may be difficult to ascertain. […] Another reason why principles cannot be used to generate solutions in any straightforward way is that they sometimes conflict with one another as well as with other values or goals». In sum, the principles are abstract and overlapping and can be particularly nuanced in a given communicative context of professional practice.

Regarding terminology, Habermas (1990) uses the term "discourse ethics" (also labelled "communicative ethics") which comes across as an abstract philosophical treatise, directed at self-understanding and normative justification. Communication ethics, in contrast, is situated practice. Here I am approaching ethics not from philosophy, but from communication. Ethics is mainly about mapping actions on two intersecting axes – good/bad; right/wrong, allowing for nuanced configurations such as good-wrong (e.g. mandatory vaccination) and bad-right (imposition of lockdown). Also, it is ethics in communication; it is ethics in interaction, whether it concerns shared decision making, or recruitment for clinical trials, or public health messaging. In a sense, going back to Goffman (1961) and others (Strong and Davis 1978; Silverman 1987), all clinical encounters are moral encounters with ethical overtones; discussions about symptoms and treatments spill over to self-presentations (Roberts, Sarangi and Moss 2004). Although not framed explicitly as communication ethics, Mishler's (1984) distinction between "the voice of medicine" and "the voice of the lifeworld" and the former colonising the latter in clinical practice can be interpreted within the framework of communication ethics. Likewise, the seminal work of Silverman (1987) titled *Communication and Medical Practice: Social Relations in the Clinic* is an example of communication ethics in interaction. In the case of management of teenage diabetes, Silverman shows the tensions between parental responsibility and the adolescent's autonomy, which becomes more nuanced when we factor in the doctor's dilemma in striking a balance between his/her knowledge of what is in the patient's interest vis-a-vis patient autonomy. Ethical practice, like communicative practice, is not an either-or thing, but a matter of degree. In the healthcare domain, an "ethical mentality" – at par with «clinical mentality» (Freidson 1970) and «communicative mentality» (Sarangi 2004) – is not something that one either has or does not have. It is dynamically emergent, each situation requiring an ethical judgement within a given range. And the ethical judgement has to be communicated relationally/responsibly.

Rossi: *The communication ethics framework is developed within a relational and interactional perspective. What is the place for rhetoric and persuasion in it?*

Sarangi: We generally talk of rhetoric in terms of ethos (ethical – dealing with sincerity, authority, credibility, trust, including character and reputation); pathos (emotional/affective appeal); and logos (logical/rational deliberation). Going back to Habermas, he seems more focused on logos – the logical, rational, deliberative aspect.

However, strategic action can appeal to emotions, and possibly incorporate empathy – the ability to relate to the other person's feelings and perspectives – resembling a kind of detached involvement, or a display of «affective neutrality» (Parsons 1951).

Unlike the rational/deliberative aspect, the relational aspect draws our attention to the self-other dynamics (Sarangi 2010b). Communicative actions are about self-other role-relations. As Dorothy Emmett (1966: 15) points out: «what people think they ought to do depends largely on how they see their roles, and (most importantly) the conflicts between their roles». On the rhetoric front, Toulmin's seminal framework of argumentation comes to mind, organised in terms of "data (grounds) – warrant (providing backing; since-formulation) – claim (so-formulation; which can potentially be rebutted)". Such a framework is primarily based on reasoning/rationality and there is not much acknowledgement about self-other relationality. The rhetorical tradition is very much focused on how argumentation is made, although, ironically, it is targeted at illocutionary and perlocutionary effect, as having an audience effect. For the most part, the rhetorical tradition can be characterised by the so-called production bias.

Singling out persuasion, it can be approached from a rhetoric/argumentation perspective, as well as from an interactionist, self-other role-responsibility perspective. In adopting an interactionist perspective, we not only focus on how a speaker/writer persuades (in the Aristotelian sense, causes the addressee/reader to move from context A to context B) but also on the addressee who chooses to be persuaded. Let me illustrate this, given the interest in this special issue on persuasion. As I have already suggested, the very act of giving information in the healthcare context has an ethical component. Added to this, the manner in which information is given will carry a rhetorical potential. Consider a routine visit to the primary care clinic. When describing my symptoms and what they mean to me, I might say "I am having serious headaches, which is affecting my sleep for the last three days". An alternative formulation would be: "My headache is so bad, I haven't been able to sleep at all on Monday, on Tuesday, and on Wednesday". The latter formulation is far more detailed with an element of repetitiveness and may carry greater rhetorical impact. Rhetorical impact can be upgraded or downgraded through the use of various discourse devices such as repetition, listing, contrast, metaphor, reported speech, hypothetical constructions. It is this rhetotical potential of discourse devices that has led me and my colleagues to propose a framework of "rhetorical discourse analysis", focusing on the notions of account and categorization (Arribas-Ayllon, Sarangi and Clarke 2011). Put simply, accounts are made up of justifications and excuses vis-à-vis blame and responsibility while categorization has two main components: character work and event work. Such an integration of discourse and rhetoric does not necessarily resolve the interpretive conundrum. The analytical challenge of how to identify and assess rhetorical impact in situated practice remains. By engaging at the interactional level (and in reception studies) we can begin to alleviate the production bias in rhetoric studies.

I feel the framework of communication ethics can accommodate a more interactionally/relationally complex conceptualisation of persuasion, unlike its logical manifestation within rhetoric and argumentation studies. Let me briefly illustrate this by considering two scenarios.

The first scenario concerns clinical trials. Although persuasion would be seen as a "dirty word" with negative connotation and as unethical practice, it does not mean that persuasion does not happen on the production side or is not experienced on the

receiver's side. Rather than being persuasive, trial talk is meant to be informative (details about the research protocol) and supportive (a form of reassurance to trial participants that their care will not be compromised and they will be looked after in case of adverse reactions). However, the framing of topics, including the discourse devices such as listing of potential benefits (e.g. faster access to drugs), mitigation of side effects, quantification of scale, hypothetical constructions to deal with sensitive issues, reported speech, the collaborative nature of the research network and above all, the advancement of science through clinical trials – are all persuasive means, sometimes bordering on what Barton and Eggly (2009) call «unethical persuasion». The concept of "nudging" as proposed by the behavioural economist Richard Thaler (Nobel Laureate 2017) is useful. One might very gradually – perhaps strategically – nudge people towards a decision, as in the case of shared decision making (see the distinction between «decision shared» and «shared decision», Duffin and Sarangi 2018).

A more general point ensues from the above scenario. It is about the practice of information giving, with the assumption that there is no such thing as "benign" information. In a given clinic encounter, information can mutate into advice and/or instruction, depending on the interactional slot such information occupies. For instance, when a patient is explicitly seeking advice, the information provided by the healthcare professional in response to such advice seeking will be heard as advice. In the context of AIDS counselling, Silverman (1997) proposes the notion of "information-as-advice", i.e., when information is sequentially placed after an advice-seeking utterance. In genetic counselling, the so-called "famously infamous question" – "what would you do doctor if it were you?" – does resemble the information-as-advice sequence (Sarangi 2000). Here we have the occasion where the addressee chooses to be persuaded, rather than the addressor doing the act of persuasion. It is worth noting that the tree of advice seeking/giving has somewhat eclipsed as a topic of investigation in the forest of Shared Decision Making (SDM) literature. Although we routinely come across patients seeking advice and healthcare professionals offering advice in the clinic setting, the SDM framework would alternatively label them as "choices" and "options" or even ignore them altogether, as the communicative act of advice giving is seen as representing the now-dispreferred paternalism paradigm. It intrigues me how certain paradigms through their preferred terminological practices can pull a «terministic screen» (Burke 1966) over observable phenomena.

The second scenario concerns the current climate of vaccine hesitancy during the Covid-19 pandemic. In the UK, where the vaccine rollout has been a phenomenal success, there are certain sections of the public, mainly ethnic minority groups, who have not come forward for the vaccination despite their eligibility. There has been voiced scepticism, ranging from possible side effects to religious beliefs, not to mention specific ongoing medical conditions that are not conducive to vaccination. This vaccine hesitancy has been a particular concern with the newly emergent Delta variant in connection with the so-called key workers in the health and social care sector because they pose a risk to those they care for. More recently, there have been calls to make vaccination mandatory for these key workers in hospitals and in nursing homes. Singling out the health and social care key workers for mandatory vaccination is no doubt a recognition of the significant contribution they have made to society during the pandemic. Additionally, given the democratic mindset and the firm commitment to upholding human rights, free will and individual autonomy, the government's response has been – "we will use persuasion instead of compulsion". Here persuasion is seen as a democratic tool, where rational deliberation would win the day. However, in all

likelihood, such persuasion is bound to be strategic action in the Habermasian sense as it is designed to influence the other, to move someone from context A to context B. Persuasion cannot be without influence, if one is trying to get the other person to believe and agree with what the former wants. Whether it concerns clinical trials or vaccine administration or shared decision making, the communicative actions are likely to involve strategic actions, thus necessitating an ethical gaze.

The ethical gaze, wrapped up in an interactionist-relational perspective, would put emphasis on the persuasive functions of information exchange in the sense that information has "rhetorical potential", echoing Michael Halliday's notion of "meaning potential". The rhetorical potential of communicative actions is particularly salient with regard to uptake of speech acts produced in very delicate, sensitive healthcare contexts. The examples above illustrate how persuasion and ethics may not go hand in hand, thus occasioning instances of "unethical persuasion". This might be a particular challenge for scholars working with the notion of persuasion but attempting to embed it in healthcare ethics. The complementarity between communication and ethics because of their shared interests, as I have been suggesting here, is achievable, albeit through a moderate dose of "intellectual persuasion".

Rossi: *We have tried to cover a lot of ground, not as exhaustively as we would have liked because of space constraints. In a nutshell, how would you conclude the future about the place of communication research in the healthcare domain?*

Sarangi: Communication research in the healthcare domain has certainly come of age and remains viable. There is compelling evidence of this, albeit dispersed. The challenge concerns the visibility of communication research and its practical relevance to healthcare education and practice – beyond the rhetorical claim researchers too often make about their research impact. Regarding visibility on both fronts, in terms of my own professional research trajectory, I have only achieved limited success. At a broader level, my mission over the past 16 years has been to contribute to the visibility agenda via the journal *Communication & Medicine*. Looking into the future, we need a cocktail of pragmatism and moderate activism, which would mean proactively transgressing the comfort of our own disciplinary bubbles and "terministic screens". Healthcare is quintessentially an interdisciplinary field, so collaboration with colleagues from across disciplinary boundaries must be at the core of how we engage with key healthcare topics – patient-centred medicine, autonomy, shared decision making, risk, uncertainty, safety, trust etc. – as focal themes. More specifically, can we turn the tide against the skills approach, without alienating the contributions of the discipline of psychology? And beyond interdisciplinary research, I would very much emphasize the collaborative research agenda involving professional practitioners – clinicians, public health physicians, health educators, policy makers – targeted at foregrounding the relevance of communication research for efficient healthcare delivery and better patient outcomes. As I said at the very outset the healthcare profession already acknowledges the significant role communication plays in their everyday practice, but this does not quite stretch to appreciate our uniquely positioned research practice, i.e., communication as discourse, pragmatics, rhetoric etc. Collaborative research with healthcare professionals would be a step towards channelling our research outputs to the intended audience for potential uptake. The challenge remains: how do we "persuade" healthcare professionals and policy makers about the added-value of our disciplinary contribution? Primarily, communication as we practise it needs to be made visible, which may mean engaging in

a metacommunicative act – communicating about what communication is and demonstrating, in an evidence-based way, what it can deliver within the healthcare delivery systems.

This interview has afforded the opportunity to spell out the motivation behind my proposed framework of "communication ethics" – moving beyond communication skills and extending the notion of communication expertise. It has been an occasion for self-reflection regarding how we conceptualise and understand communication (rhetoric included) and ethics as two separate disciplines and then how we go about integrating them, as suggested by the label "communication ethics", in showcasing it as a practical situated enterprise and assigning it a rightful place within the taxonomy of ethics.

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