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# Communication barriers and information-seeking counterstrategies in accounts of practitioner-patient encounters

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## Abstract

Although practitioner-patient communication has been studied in several disciplines, few researchers have applied library and information science perspectives to this form of everyday life information seeking. This article reports findings from in-depth, semistructured interviews with pregnant women and uses a constructionist discourse analytic approach to analyze pregnant women's accounts of practitioner-patient information-seeking encounters. The analysis focuses on accounts of communication barriers and on the active seeking and scanning practices that participants described as counterstrategies. This article also reports on the ways that descriptions of barriers and counterstrategies contribute to individuals' representations of themselves as information seekers. © 2002 Elsevier Science Inc. All rights reserved.

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## 1. Introduction

Patient communication with medical care providers is a form of everyday life information seeking (ELIS) that has been studied extensively outside of library and information science (LIS). Radcliff (1995) noted that communications researchers look to enduring characteristics within the participants (e.g., previous knowledge [Guttman, 1993] or communication style [Street, 1991]) or observable outcomes (e.g., patient compliance or satisfaction) to analyze physician-patient communication. LIS writers have commented on the role of libraries in physician-patient communication (Rees, 1993) and have noted parallels between physician-patient and librarian-patron encounters (Baker & Connor, 1994; Naismith, 1996; Radcliff, 1995). In addition, the “best practices” recommended for

reference interactions (Ross & Dewdney, 1994) share much with those recommended for practitioner-patient communication (e.g., Brown, 1999; Cline, 1983; Mishler, Clark, Ingelfinger, & Simon, 1989; Ong, de Haes, & Lammes, 1995; Roter & Hall, 1989; Roter, Hall, & Katz, 1988; Stewart, 1984, 1995). To date, however, there has been little attempt to analyze practitioner-patient communication in LIS terms (see Baker & Connor, 1994; Pettigrew, 1997; Wilson, 1997b).

The study of barriers in practitioner-patient communication is not new. Maynard (1991) observed that researchers who explain barriers in relation to the asymmetry of the physician-patient relationship may consider such asymmetry to be tied up with physicians' professional authority (e.g., Jordan, 1997) or with sociopolitical structures (Shapiro et al., 1983; Waitzkin, 1991), or to be enacted through the interactional patterns that make up physician-patient encounters (e.g., Fisher, 1984; Todd, 1984). Barriers have been identified relating to organizational constraints of the office encounter (Fisher, 1984; Pritchard, 1992) and to physicians' practices such as the medical framing of patient concerns (Todd, 1984) and delay in answering patient questions (Roberts, 2000). Although Fisher (1991, 1995) identified important differences between doctors and nurses, similar patterns have been reported in studies of patients' communication with nurses (Heritage & Lindström, 1998; Jarrett & Payne 1995) and pharmacists (Pilnick, 1998).

Although researchers such as Roter (1983) and Sleath, Roter, Chewning, and Svarstad (1999) have studied the situations in which patients do and do not ask questions of their physicians, analyses of practitioner-patient communication barriers have tended to focus on and elicit recommendations about the actions of the practitioner rather than the patient (Quill, 1989; Roter, 1983). In addition, few studies of practitioner-patient communication specifically address patients' information-seeking behavior. Those that do, according to Baker and Connor (1994), define the term quite narrowly to incorporate such specific practices as active question asking, seeking clarification of a previous physician's statement, or introducing a new topic (Beisecker & Beisecker 1990; Roter, 1984). LIS models of information behavior and user-centered approaches to ELIS can therefore offer new insights into practitioner-patient communication.

Savolainen (1993) has criticized information-needs-and-uses research for its emphasis on active individual human agency in the information-seeking process at the expense of larger social factors. He suggests that this emphasis on the cognitive processes of the individual fails to capture the richness of information as constructed through the interaction of the individual and the sociocultural context. Savolainen's own research (Savolainen, 1995) aims to focus analysis on the interaction between the user and the sociocultural context. Tuominen and Savolainen (1996) proposed a constructionist discourse analytic approach for studying information seekers within their sociocultural contexts; specifically, they sought to understand the ways that "discursive constructions of information are contextually designed to serve different communication purposes" (p. 92).

Potter and Wetherell's (1987, 1994, 1995; Potter, 1996) form of discourse analysis is such an approach. With theoretical antecedents in social studies of science, ethnomethodology, conversation analysis, semiology, poststructuralism, and postmodernism, constructionist (or constructivist) discourse analysis is a systematic scheme for analyzing the ways discourse is

constructed and the functions it is meant to perform. In constructionist analysis, an account is not seen simply as a realistic retelling of an individual's version of reality, but has a meaning contingent upon the function the account is meant to perform—for example, whether to persuade, accuse, or blame. The “truth” or “falsity” of an account is therefore not as important as the ways in which the account is structured. Rather than viewing discourse as an indicator of “below the surface” cognitive processes or concepts such as attitudes, constructionist discourse analysis considers the discourse itself to be the site of interesting processes and therefore focuses analysis on discursive content. Constructionist discourse analysis concerns itself with the elements that make up an account (individual words, patterns, or metaphors) and the discursive functions the account performs within the broader interactional context in which it was produced.

Discourse analytic approaches have been used to explore several aspects of health communication such as the following: the ways that very elderly patients describe drug use (Lumme-Sandt, Hervonen, & Jylhä, 2000), the ways that nurses and mothers describe appropriate behavior in the neonatal intensive care unit (Lupton & Fenwick, 2001), the ways that shared decisions are negotiated between physician and patient (Gwyn & Elwyn, 1999), and the ways that lay and clinical understandings of a disorder are developed in everyday talk (Radley & Billig, 1996) and in clinical interactions (Banks & Prior, 2001). If, as Maynard (1991) contends, the physician-patient encounter is jointly enacted by both participants, patients' accounts of their interactions with health care providers can provide a valuable source of data on the ways that patients describe their contributions to the encounter (Talja, 1999).

The present article uses such a constructionist discourse analytic perspective (Potter & Wetherell, 1987) to analyze individuals' descriptions of the barriers they encountered when communicating with medical practitioners and the information practices they used to overcome these barriers. In keeping with Tuominen and Savolainen's (1996, p. 92) recommendation noted previously, this article also reports on the ways that these descriptions contribute to individuals' representations of themselves as information seekers, thereby responding to Baker and Connor's (1994) call for a patient-centered approach to studying physician-patient communication.

## **2. Study overview**

The data for this study come from a larger study of information seeking by women pregnant with twins (McKenzie, 2001). The researcher conducted 34 semistructured, in-depth interviews with 19 pregnant women between June 1999 and August 2000. Participants' ethnic and linguistic backgrounds and marital statuses were representative of the southern Ontario region in which they lived, although they were older and better educated than the average for women giving birth in Ontario (Statistics Canada, 1999; Statistics Canada Health Statistics Division, 1999). Approximately one third of the participants (7 of 19, or 36.8%) had other children; this was the first successful pregnancy for the remaining participants (12 of 19, or 63.2%). Participants are identified throughout by pseudonyms.

The findings emerged as part of the analysis of the interview transcripts. Four things should be noted: First, as stated previously, the data analyzed for this study consist of transcripts of women's *accounts* of their encounters with physicians, not transcripts of the encounters themselves. The analysis therefore differs from that of ethnographic researchers such as Chatman (1996), whose mode of data collection and analysis allowed them to analyze what actually occurred in an information-seeking interaction. This research, in contrast, analyzed the kinds of health-information-seeking accounts that are produced during a researcher-participant interview and the ways that such accounts are constructed. Second, the barriers described here are those that arose once a pregnant woman had successfully made contact with a health care provider. Barriers also figured in women's accounts of attempting to connect with health care providers (e.g., securing referrals, arranging appointments, calling after hours); those "connection failures" are considered elsewhere (McKenzie, 2001). Third, the interview schedule did not specifically contain questions relating to practitioner-patient communication. Rather, the women provided accounts of practitioner-patient communication in response to more general questions (e.g., about their current concerns or about specific information-seeking practices). Finally, it should be noted that participants described many informative, effective, and uneventful encounters with medical care providers. The focus of the present analysis, however, is on those instances in which they described communication barriers.

### **3. Barriers to communication**

Several recent studies of library users' accounts of reference interviews (Baker & Field 2000; Dewdney & Ross, 1994; Ross & Dewdney, 1994, 1998; Ross & Nilsen, 2000) rely on the constructionist discourse analytic premise that analyzing individuals' explanations of their information-seeking encounters can offer new ways of thinking about the dynamics of such encounters. Rather than viewing a failed reference desk encounter as an instance of "a librarian trying but failing to locate the answer for the user," Ross and Dewdney (1998) suggested that by looking at the way the library user describes the encounter ("I felt like she was trying to get rid of me"), "we might see [the librarian] as successfully using closing strategies that resulted in getting the user to go away and stay away" (p. 153). Ross and Dewdney analyzed library users' descriptions of reference transactions and identified two major themes: (1) librarian communication strategies that acted as barriers to the reference process and (2) user counterstrategies that enabled users to get the information they wanted.

In several of the data collection interviews, participants described encountering barriers that prevented them from finding out what they wanted to know from their medical care providers. In accounts of such instances, pregnant women described a variety of strategies for figuring out what the care provider was thinking or doing, or for getting the provider to disclose the desired information. Although there are important differences between health care providers and librarians as information sources, the

themes of barriers and counterstrategies were evident in the participants' accounts. The participants described three major kinds of barriers: those originating with the information provider, those originating with the information seeker, and those that might originate with either.

#### 4. Barriers originating with the provider

First, women sometimes described experiencing “connection failures” (i.e., a failure to connect with an information source) even after they had successfully made an initial contact with a health care provider. Ross and Dewdney (1998) described this kind of barrier when librarians made unmonitored referrals, or simply vanished, as did Barbara's doctor in her account. As soon as her doctor had confirmed the presence of twins, and provided himself with a “logical reason for my hormone level being as high as it was,” he left her alone. According to Barbara, “The doctor said, Oh well, that explains the hormone level then. See ya!’ And he left [laughs] and it was just me lying on the bed with the technician.” When I asked Barbara whether her physician had invited questions, she replied, “No. Uh, maybe he figured the nurses would be able to answer that or what, I don't know.”

##### 4.1. Disclosure barriers

Participants described actively asking questions for which the source was unable or unwilling to provide an answer, or for which a source used oblique or evasive forms of disclosure. Rachel described how her doctor called on policy to refuse to divulge the sexes of her fetuses. “I was disappointed cause I thought the doctor would at least say, if it was okay with *him*, then it's okay [to tell me]. But he said, no, it has nothing to do with him. So, I was a little disappointed with that. 'Cause I felt it was kind of my right to know if they could tell me.” Nondisclosure sometimes included a description of technical failure or inability to perform a procedure, such as in Gayle's account: “We couldn't hear a heartbeat. My doctor's sonogram, sonar thing wasn't working properly.”

Women often described barriers related to stalling, evasiveness, or coyness. Erica gave this account of a telephone negotiation in which she tried to convince the nurse to give her the reason she was being called in for additional tests:

And they said, “Well, when they took your blood, um, the results were abnormal.” Like, they're scaring the crap out of me. I'm like, “What do you mean, 'abnormal'?” [laughs] Right? She says, “Well all your levels, were too high.” Well, what does that *mean*? So she just kept stalling, so she says, “Well, we think there might be more than one baby.”

Although the words “abnormal” and “too high” were potentially meaningful to the nurse, Erica identified them as worrisome and problematic. Natalia provided a similar description of

waiting to find out whether her assisted conception had been successful. In this account, however, the nurse initially failed to divulge anything:

Then the nurse phoned and she said, “How do you feel?” And I said, “How *should* I feel?” [laughs] And she said, “Well, how do you feel?” She repeated her question again. And I repeated my question, “How *should* I feel?” And she screamed at me, “Pregnant!”

Although Natalia described turning the question around, the nurse refused to answer and persisted in delaying the diagnosis. In each of these descriptions, participants located the communication failure with the medical care provider rather than with themselves. They placed the responsibility for other forms of communication failure squarely on their own shoulders.

## 5. Barriers originating with both participants

Participants described situations in which they had questions but gave reasons for not asking them. One woman, Patty, described the way that her doctor physically moved away from her in an attempt to end the appointment: “I found that in all doctors’ offices that I’ve ever experienced, they’re just so rushed and, you know, he’ll say, ‘Bla bla bla’ and he’s got his hand on the door and he’s walking out, and you’re going, ‘I have a question. [laughs] Wait a minute.’” In Patty’s account, the doctor’s busyness and the organization of office practices underlie the barrier. Karen explained her failure to ask her planned questions by referring to the intensity of her reaction to seeing the first ultrasound images of her fetuses: “I was taken away by the moment and didn’t ask any questions.” She blamed herself for her failure (“It’s my fault not his.”) and suggested that she should have been more alert. “I should have had the questions written down or, engraved in my brain, I need to ask this. And I thought. . . It just, it just fell out. [laughs] The thought fell out of my head and I never thought of it again until I got home.”

Several women suggested that either asking questions at all or asking their specific question might be inappropriate. Stacy’s example was common to several women: “Cause I mean, you don’t want to bug [the doctor] or whatever.” Jacquie was concerned that her inexperience meant that “sometimes you worry about things that aren’t really something to worry about but you’d like to get the answer. . . . And then you don’t want to feel like you’re [laughs] nagging them all the time, too.”

Pregnant women’s accounts of failing to ask questions contain several components. Two findings are especially significant: First, the responsibility for the failure may rest either with the practitioner or with the patient. Second, these accounts differ from those in which participants reported needing no information. All of these accounts included both questions that needed answering and corresponding reasons why the questions could not or should not be asked.

## **6. Barriers originating with the information seeker**

Women occasionally described their own failure to understand information they were given, even after they had successfully negotiated a disclosure. In these cases, they suggested that responsibility for the communication failure rested with them rather than with the person providing the information. Irene gave this account of going to the emergency room anticipating that she would have to undergo surgery for an incomplete miscarriage.

And the doctor came into the emergency room and said, “Well, there’s two,” drew me a picture and said “There’s two tiny little sacs in the uterus.” And I still didn’t catch on. I’m thinking, oh, I’m still going to have to have this surgery. . . . And he’s holding my hand and this big smile on his face and he says, “Irene, you’re pregnant.” And he goes, “And they’re where they’re supposed to be.” I go, “They?” [laughs] And then he said, “You’re having twins.”

In this account, Irene blamed her own expectations for her failure to catch the doctor’s meaning, even though she noted that his behavior was not consistent with ordering a surgical procedure (“he’s holding my hand and this big smile on his face”).

These forms of barriers in practitioner-patient communication show similarities both to Ross and Dewdney’s (1998) reference desk barriers and to barriers identified by non-LIS researchers in studies of physician-patient encounters. By considering participants’ accounts of barriers, we can analyze the ways in which pregnant women framed themselves as information seekers. When women described barriers originating with the care provider, the communication failure was clearly represented as being outside the patient’s control. On the other hand, when barriers were represented as being the problem of the patient, they were framed as failings (“I didn’t catch on”) and were accompanied by disclaimers, excuses, or apologies, along with demonstrations that the pregnant woman knew what was expected of her (“I should have had the questions written down or engraved in my brain”).

Barriers to practitioner-patient communication are therefore interwoven with descriptions of when and how pregnant women should and should not ask questions of health care providers. Participants’ accounts of their reactions to barriers similarly locate their behavior in terms of expected forms.

## **7. Information practices as counterstrategies**

Ross and Dewdney’s (1998) library users described employing several counterstrategies to keep the reference encounter going after the librarian used closure strategies. Although the pregnant women did not describe precisely the same counterstrategies as did library users, their counterstrategies served the same ends.

The women described lengthy and persistent interactions with individual information sources or with a variety of sources in pursuit of the desired information. McKenzie (2001) outlined a two-dimensional model of the information practices present in pregnant women’s descriptions of connecting and communicating with information sources. The broader term

“information practices” is used here rather than the more common “information seeking” or “information behavior” in order to encompass the entire range of activities present in accounts—both in what Wilson (1997a) calls “information behavior” and those instances in which helpful or unhelpful information comes or is given through the initiative or actions of another agent. The counterstrategies described by the participants correspond to two modes of information practice as follows:

- *Active seeking* is the most directed form of information practice and has been described by such writers as Dervin (1977, 1983) and Kuhlthau (1993). This mode includes practices such as specifically seeking out a previously identified source, conducting a systematic, known-item search, asking a preplanned question, and using active questioning strategies (e.g., list making). This category is related to Wilson’s (1997a) “active search” and Choo, Detlor, and Turnbull’s (1999) “formal search.”
- *Active scanning* corresponds to incidental forms of information seeking, such as those described by Erdelez (1997) and Williamson (1997, 1998). It involves practices such as semidirected browsing or scanning in likely locations, systematic observation of physical characteristics or behavior, identification of opportunities to ask spontaneous questions, and active listening to conversations or questions in likely locations. This category corresponds to Wilson’s (1997a) “passive search” and Choo et al’s (1999) “conditioned viewing.”

## 8. Active seeking in practitioner-patient encounters

Several women told of the ways they planned their question-asking strategies, made lists, and tried to ask to get people to answer. Kimbrough’s (1977) case study suggested that a young pregnant woman used information seeking for several purposes beyond simply finding out about labor. The woman sought information to gain control over her situation, both by means of the information she had obtained, and through the very process of asking the question. For example, when threatened with an unwanted procedure, she asked questions and elicited an information-giving response from the doctor, which delayed the procedure for 10 minutes at a time. She therefore continued to ask questions, not so much to get answers but to delay further intervention and feel in some control. Many of this study’s participants similarly described premeditated questioning strategies as a means of gaining some control in an otherwise uncontrollable situation.

Lynn felt that premeditated questions were necessary in encounters with medical professionals as shown in the following excerpt:

I like to go into any meeting with a few questions. Specially, medical people, I find that you can go in, and you can get a whole bunch of information, [laughs] and then you come out and you have all these questions. And then you realize, You know, my questions weren’t addressed.

Donna observed that “my doctor doesn’t really, if I didn’t ask that question, he wouldn’t have brought it up. My sense of him is that, he’s very good when I ask



questions, and he gives you a little, the more you ask the more detailed he gets.” Active seeking was firmly entrenched in descriptions of how to talk to medical practitioners. Several forms of active seeking figured in women’s descriptions of overcoming communication barriers.

### 8.1. List making

One of the most commonly mentioned active questioning strategies was list making. Frances described recording questions both opportunistically and systematically in a notebook she took with her to the doctor’s office:

Sometimes it would just occur to me and I’d write questions down, like even before I’d go to sleep at night. Since I’d keep it there. But yes, before I would go to the doctor’s, or I would take my book with me and *know* that I would have to wait for, like, half an hour or an hour at the doctor’s.

Barbara spoke for many when she described list making as a memory aid for managing her doctor’s appointments:

I write [questions] down so I don’t forget. As soon as they pop into my mind, I write them down. Otherwise I *will* forget. I’ll get there and I’ll say, “I *know* there was two other questions I wanted to ask,” and of course, 2 days later I’ll remember them. But by then it’s too late so, I do, I write them down.

Making a list of questions was described as an ongoing activity, to be kept in mind at all times. For women describing a short period in which to ask questions during a doctor’s appointment and a strong reluctance to “bother” the doctor between appointments, list making served not merely as a memory aid, but as a necessary strategy for the successful communication of their concerns.

### 8.2. Actively asking questions

In addition to planning what questions to ask, women sometimes described their plans for how to ask questions. Suspecting she was having twins, Christine described using humor to broach the subject obliquely, careful not to question the doctor’s authority.

So I just kind of sat on [the suspicion] a little bit, and then joked around with the doctor a little bit. ‘Cause I didn’t want to come out and say, “Well, can you check for sure? Are you positive?” I didn’t, cause I’m trusting *her*, I mean *she’s*, I’ve never been pregnant before, I don’t know how it’s supposed to feel.

Donna described her plan to ask a direct question to clarify her doctor’s directive about “leaving work early” to determine specifically what it would mean in her case.

Basically just laying out to him, you know, I have a case load of five, that’s five people a week. If I go in for, like, 2 hours at a time or an hour at a time what do they think of that? Kind of making sure that we’re both, that I’m not misinterpreting what he’s saying. He really didn’t qualify what he meant by “inactive.” Like, what does that mean?

Donna's active questioning allowed her to clarify her doctor's statement and to avoid misunderstanding.

### 8.3. Keeping the process "on track"

Participants sometimes described waiting for a medical practitioner to take the next step in a sequence of expected events. When the practitioner did not do what the women expected and the process went "off track," the women described using active information seeking to ensure that the expected next step occurred, whether the practitioner initiated it or not.

Christine's transcript, in particular, contains several descriptions of active questioning and even active informing on her part to get the process back on track. For example, Christine told how, after learning from an ultrasound exam that she was having twins, she expected her family doctor to contact her to describe any changes to her care: "I'm thinking, 'Well, okay, this is news. Surely they're going to call me.' Well then they didn't." Christine described calling the office herself, expecting some acknowledgment of her state:

[The receptionist] said, "Yeah, we got your results of your ultrasounds, whatever. Congratulations." So I'm like, "Okay, well like I'm wondering just how does it change things? Like, does that require more prenatal [classes] than most people, or show up more often or what?" She said, "Well, we usually schedule a month in advance or whatever, 34 weeks or whatever." So I'm like, "Okay," so she scheduled my next appointment for a month later.

Christine, assuming that the clinic was aware of her diagnosis, went for her appointment. To her surprise, the nurse commented on her weight.

She's [the nurse], well "Boy, you're gaining a lot of weight," she goes, "Are you eating a lot more?" And I'm like, "No not really." She just, then she said some comment about twins and I looked at her and said, "It *is* twins." And she goes "It is?" and I go, "You didn't know?" She goes [laughs] "No." . . . She had the results sitting right there in her file. She never looked at 'em.

Christine received the same reaction from her doctor: "I couldn't believe it. So she's talking with me and I'm thinking, You're the doctor. I can't believe, [laughs] I thought the doctor had to interpret the results."

Although not going so far as to call the practitioners incompetent, Christine framed their behavior as unusual and contrary to her expectations of what doctors and nurses should do ("surely they're going to call me," "I thought the doctor had to interpret the results"). In this series of accounts and elsewhere in her interview transcripts, Christine used active information practices to create for herself a role as a helper, without whose participation the medical care providers would not be able to function effectively.

### 8.4. Persistence

Related to Christine's accounts of keeping the process on track are women's accounts of persistently repeating questions, often over several days, and often to several sources in an attempt to overcome communication barriers.

Barbara wanted to find out the sexes of her fetuses, although “my [obstetrician] has told me that the ultrasound technician won’t tell me. And then my GP has, almost told me that, *he* won’t tell me.” She described her plan for checking with three different sources:

I assume that [the doctors] get copies of the ultrasounds. So, if the technician can tell from the ultrasound pictures what the sex is, then the doctor should be able to tell as well from the pictures. But I plan on asking [at the ultrasound appointment] on Friday and if the ultrasound technician tells me, then that’s wonderful. If they won’t tell me, then I plan on asking both my GP and the obstetrician.

Her strategy assumed that one or more sources would not disclose, and she built in provisions for alternatives.

Donna gave an account of discussing some test results with her doctor, in which she observed that the doctor “tended to be a little bit cursory and he just said, ‘Everything’s fine.’ And I wanted more detail. So I wanted to go over and really understand. I just find it interesting as well.” She described asking for a copy of the report so that she could “go home and [laughs] look at it more closely.” This strategy met several goals. Donna could “figure out a little bit more [from the report] and, if I’d had any questions about the report, I would have been able to ask them later.” Taking the report home gave Donna time to formulate questions, a document to refer to in later discussions, and a legitimate opportunity to take up the subject of the report at the next appointment when there might be more time.

Accounts of persistence, like descriptions of other active information practices, show information seekers as actively preparing for subsequent encounters. What is interesting about these accounts of active information seeking is that, in addition to outlining questions to be asked, they contain detailed descriptions of premeditated and proactive strategies for convincing information sources to listen to concerns, stay connected, and provide answers. These accounts therefore perform the function of portraying pregnant women as creative partners in the practitioner-patient communication process, responding to barriers with active strategies for meeting their own goals.

## **9. Active scanning in practitioner-patient encounters**

Descriptions of active scanning often formed part of accounts of routine encounters with health care practitioners. Active scanning can be visual or aural, and may involve no direct communication between the seeker and the source. In participants’ accounts, scanning the physical characteristics or behavior of other people was a surprisingly common and effective strategy for finding certain kinds of information. In other situations, visual or aural scanning provided the evidence necessary for the patient to ask an opportune question.

### *9.1. Opportune questioning*

In many cases, spontaneous or opportune questions were described in accounts of routine doctors’ appointments or diagnostic procedures, where women spent a long period of time in

a single location, in close proximity to another person. Rachel told of striking up a conversation with the nurse who was administering a test for gestational diabetes. “I said ‘Why would [the doctor] have me have the test? Like, not everyone has a glucose test.’” Amina described seeing and interpreting the ultrasound image of her two fetuses and using the image as an opportunity to ask the sonographer for confirmation of her impressions. “When the nurse began to [do the exam], I saw two balloons. [laughs] Two, not one. . . . When I saw two sacs I asked her if there is one or two [babies].” This kind of spontaneous question contrasts with the premeditated questions described previously. Rather than requiring planning and record keeping, as premeditated questions do, opportune questions rely on alert attention to surroundings. In Amina’s account, her observation and interpretation of the ultrasound image prompted her question. In other accounts, observation and listening proved informative on their own.

### *9.2. Observation and listening*

One advantage of using participant accounts of information seeking rather than recordings of practitioner-patient communication is that participants provided descriptions of nonverbal practices that would likely be invisible to an observer. For example, Olivia explained how she used the duration of an ultrasound exam as evidence that something was unusual. Olivia’s friend had told her that “it would probably take, you know, 15, 20 minutes or something like that. So I was in there and 15 minutes went by, 20 minutes went by, and half an hour went by, and I’m thinking, why is this taking so long?” The absence of an articulated question in a practitioner-patient encounter therefore cannot be simply interpreted as a failure to seek information.

### *9.3. Staying connected, monitoring the process*

Both verbal and nonverbal forms of active scanning were important components of women’s accounts of coping with nondisclosure or silence. Participants described using active scanning to monitor the situation, clarify procedures, and find out what was happening to them and why. Descriptions of this practice most often came up in accounts of physical examinations, particularly ultrasound exams. Sonographers typically performed the diagnostic portion of the exam without saying much, and then chatted with the woman and showed her the image afterwards (Mitchell & Georges, 1997). Some women described feeling uncomfortable with the prolonged silence and tried to stay connected.

Erica described watching the silent sonographer’s face and demanding to be included in the examination process. “I was kind of, I think a little annoying, [laughs], you know, like ‘Well, why are you smiling?’ or, ‘What do they look like? How do, you tell what’s what?’” On another occasion, she said, “I just keep interrupting [laughs] them with questions, like ‘What are you looking at now?’ or, ‘Do you think they’re a good size?’ [laughs] ’cause I’m just nervous.” She explained that sonographers had “always been really nice to me and answered whatever I asked them. [laughs] Except for the stuff they can’t answer. Oh I don’t know. I just like talking to them ’cause [laughs] I’m kind of bored sitting there.”

Erica's ambivalence is noteworthy. Although she refused to let the sonographer exclude her, her use of the words "annoying" and "interrupting," her assertion that the sonographers were "really nice" for responding, and her justification for her questions because she is "nervous" or "bored" acknowledge her behavior as somehow presumptuous and inappropriate. Erica identified the ultrasound exam as one occasion in which actively seeking information was not the prescribed behavior.

The active scanning practices the participants described paint a picture of watchful, attentive information seekers, seizing opportunities to clarify situations or elicit disclosure. This mode of information practice warrants more study, both in physician-patient interactions and by LIS researchers in general. As Ong, de Haes, and Lammes (1995) reported in their review, "patients are very sensitive to and observant of the non-verbal communications conveyed by their doctors" (p. 909). Stevens (1994) reported that lesbians seeking care and information from health practitioners maintained vigilance through "an exacting process of environmental scanning and behavioral observation." Women were "attuned to subtleties in language, manner, and emotional atmosphere" and acted the role of "active, thoughtful participants in health care encounters, not just hapless victims" (p. 227).

## **10. Conclusion**

Although studies of communication barriers in practitioner-patient communication are not new, taking an LIS approach can offer new insights into the interaction. Similar to Ross and Dewdney's (1998) library patrons, this study's participants described a variety of practices to keep communications going after the source failed or refused to disclose the desired information. Rather than presenting an image of uncomplicated asymmetry in the practitioner-patient relationship, the participants represented themselves as active, even vigilant, information seekers who asked premeditated questions, made lists to organize their behavior, and looked for opportunities to intervene and get feedback when a process was not going as expected. In many cases, these accounts portray information seekers as indispensable, if invisible, partners without whose active participation practitioners could not work effectively. Talja (1999) cautioned that researchers analyzing individuals' accounts of information seeking must be sensitive to the discursive functions those accounts perform in the researcher-participant interaction. Practitioners' accounts of these same encounters would no doubt contain quite different elements. It is important to consider these accounts in relation to the ways that this study's participants represented information seeking in general and themselves as information seekers in particular.

A consistent theme running through the broader study was that, in the interviews, pregnant women either represented themselves as active information seekers or provided compelling reasons why they could or should not actively seek information: information seeking was an important part of becoming "prepared" for motherhood (Browner & Press, 1997; Gardner, 1995; Marshall & Woollett, 2000; McKenzie, 2001). Representations of

barriers as insurmountable and accounts of overcoming barriers through the appropriate use of active seeking and active scanning therefore served the communicative purpose of accounting for and justifying participants' failure to conform to this norm (Tuominen & Savolainen, 1996). Attending to individuals' accounts of ELIS can alert researchers to the subtle ways in which information seeking is discursively bound up in descriptions of appropriate or inappropriate behavior and can lead to a deeper analysis of ELIS within the individual's social context.

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