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Age ascription as a resource and a source of resistance – An interactional study of health professionals' castings of patients into the category 'old'

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ABSTRACT

This case study aims to give an understanding of what actions health professionals' castings of patients into the category 'old' perform on a medical and social level as well as what actions patients' interactional management of these castings perform. Particularly, this study aims to bring to the fore the negotiability of health professionals' perspectivating age ascriptions. This is done with the conversation analytic method (CA) according to which *altercasting* is a mutual construction performed turn by turn and shaped by the reactions of the interlocutor who can approve, resist, or modify the identity in question. The data are drawn from two Swedish television documentaries on health encounters. Three major findings are presented. Firstly, the castings of the patients into the category 'old' are in several cases embedded in metaphors that either position the patient's body in the role of a victim of old age or in the role of a machine to routinely check. Secondly, the castings with a fateful approach to old age are ambivalent; whereas they serve as resources for the health professionals' normalizing of medical projects and perspectives, they can constitute sources of problems for the patients' doctorability and/or agency. Thirdly, the health professionals' perspectivating age ascriptions are negotiable; their design facilitates resistance to them, and the patients accept, modify, interrupt or reverse them.

Introduction

In order to achieve temporary social goals people cast themselves and others into categories. This casting is done on the basis of different collections of classifications such as *gender*, *family* and *age*. Each collection has its own set of categories such as female, male (*gender*), child, mother, father (*family*), and young, middle-aged, old (*age*). In turn, each category is inference-rich; it contains a culturally constructed set of behaviors, feelings, rights and obligations that are considered typical for the role (Sacks, 1992:238 ff.). This can be exemplified by the collection of age categories. A 30-year old person is expected to desire to have a child, whereas a 60-year old person who expresses the same desire is met with skepticism. Thus, the cultural scripts on age categories have a powerful influence on what is expected of people and what is refused to them (Hockey & Allison, 2003:3–4; Coupland, 2009:855).

To cast the interlocutor into the category 'old' can be considered as face-threatening, since oldness has predominantly negative connotations in Western culture (Jones, 2006:80). Nevertheless, in a health encounter, such casting of a patient can be legitimate, since age's impact on body status is a prominent factor in medicine. However, the health professional's age categorization work needs to be interactionally accomplished by the patient who can opt to approve, resist, or modify the casting and its package of implications. The current case study aims to give an understanding of what actions health professionals' castings of patients into the category 'old' perform on a medical and social level as well as what actions patients' interactional management of these castings perform. Particularly, the study aims to bring to the fore the negotiability of health professionals' perspectivating age ascriptions.

Generally, health encounters are asymmetric in a number of respects. The health professionals are considered experts on the patients' physical condition, whereas the patients are considered laymen, although they have knowledge of their own bodies. Furthermore, the health professionals take a leading role in the interaction, since they are authorized to conduct it in this situation, by posing questions and suggesting treatments. When it comes to senior patients, the asymmetric relations may be even more far-reaching because of communicative impairments caused by e.g. dementia or stroke. Senior patients also run a risk of receiving less information, less aggressive treatment of illness, and less empathy than younger patients (Greene, Adelman, Charon, & Hoffman, 1986; Higashi, Tillack, Steinman, Harper, & Johnston, 2012; Lewis, Kilgore, & Goldman, 2003). In addition, senior patients' health ailments run the risk of being dismissed as 'just old age' (Adler, McGraw, & McKinlay, 1998:344; Palmore, 2004:44; Chrisler, Barney, & Palatino, 2016:86). Against this background, seniors' adoption of an assertive communication style for health encounters has been advocated (Savundranayagam, Ryan, & Lee Hummert, 2007:82). The impact of this communication style has been examined in an experimental

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study where physicians were exposed to professionally produced and acted videotapes depicting health encounters, with or without assertive patient behaviour. A finding was that the physicians were more likely to prescribe careful diagnostic testing to the assertive senior 'patients' than to the other senior 'patients' (Krupat et al., 1999:455). In a related study, participants evaluated conversational scripts in which senior patients either responded assertively, passively or aggressively to the physician. The assertive responses were the ones evaluated most positively (Ryan Bouchard, Anas, & Friedman, 2006). In order to activate seniors in medical encounters, workshops have been arranged where they have been trained to ask the physician questions, check their understanding, and express their concerns. However, one finding was that in order to put assertive communication skills into practice, the participants needed evidence from real life of what is possible to say to the physician (Towle, Godolphin, Manklow, & Wiesinger, 2003:232).

Another problematic feature of the health encounter between the senior patient and the health professional is that the latter is not familiar with the former's attitude to ageing. This is particularly the case in Sweden where many people do not visit a specific physician. In an interview study (Jolanki, Jylha, & Hervonen, 2000) of people aged 90 years or over, the interviewees displayed two different attitudes to old age: old age as a necessity and old age as a choice. In other words, different interviewees were oriented to different *interpretive repertoires* on old age (Wetherell & Potter, 1988:172). According to the *necessity repertoire*, frailty is seen as the essence of old age to which there is no alternative, whereas the *choice repertoire* expresses a more positive view of old age and positions the senior person as an independent and self-reliant agent (Jolanki et al., 2000). The necessity repertoire has been proven to have negative health outcomes, when internalized by senior patients. Patients who attribute the onset of their illness to 'old age', have poorer health maintenance behaviors and a greater likelihood of mortality than other seniors with the same illness (Stewart, Chipperfield, Perry, & Weiner, 2012). In the current study, attention will be given to the health professionals' selection of repertoire and the patients' acceptance of or resistance to it.

By both attending to the surfacing of different concepts of old age and to the interactional management of them, the current study contributes to *discursive gerontology* (Nikander, 2009:874–875). Furthermore, its focus on health care settings contributes to the research on seniors' experience of self in relation to their ageing bodies (cp. Paulson & Willig, 2008; Phoenix & Sparkes, 2009; Sandberg, 2013). Particularly, by bringing to the fore the negotiability of health professionals' perspectivating age ascriptions, it contributes to previous research on seniors' assertiveness in medical interaction, and provides evidence from real health encounters for use in future workshops on the promotion of seniors' communication skills.

Previous research on old age-in-interaction

In comparison to other socio-demographic categories such as gender, class and ethnicity, age, and particularly old age, in situated discourse has been understudied (Coupland, 2009:849). When studied, old age-in-interaction has typically been elicited either by an interviewer's questions or by coupling younger and older people together. The last is the case in a seminal study of old age-disclosures conducted in the 1990s. The researchers recruited a group of women within the age interval 30–40 years and another within the interval 70–87 years with the instruction that they would speak to a person of a different age. Then the women from each group were coupled and asked to get to know one another while their interaction was video-recorded.[1] One finding was that a senior's choice to construct a stereotypic or counter-stereotypic age identity is dependent on the local context and conversation partner (Coupland, Coupland & Grainger, 1991:194, 200). In a similar vein, an interview study on sexual activity in later life shows that the interviewees' relevance-making of old age depends on the immediate business of the conversation (Jones, 2006:89). Hence, a thorough analysis of old age invocation implies sensitivity to its function in the local context (Jönsson & Siverskog, 2011:62). In the present study, the particular medical context of the interaction will be considered. The analysis of the interactional management of the old age ascriptions can give insight into their functions as resources for the health professionals' medical projects as well as insight into their effects as sources of problems for the patients.

According to several studies on senior citizens, it is the health status, that influences the self-categorization as 'old' or 'not old'. Seniors in relatively good health, reject that 'old' applies to them and distance themselves from the frail and institutionalized elderly (Hurd, 1999; Paoletti, 1998; Róin, 2014). Furthermore, they construct counter-stereotypical age identities. For instance, elderly women are expected not to bother about their physical appearance, but recordings of their talk as well as interview studies display the opposite case (Elfving-Hwang, 2016; Matsumoto, 2009). Personal distance to the category 'old' is also a recurrent topic in an interview study of men and women close to their 50th birthday; although the interviewees acknowledge the changes due to age, they downgrade their personal significance (Nikander, 2009:874).

The above-mentioned studies are focused on seniors' verbalizations of their stage of life in researcher-provoked conversations and interviews. By contrast, the current study is not researcher-provoked and the setting is medical; sick or injured seniors are casted into the category 'old' by health professionals. Another distinct feature of this study is its linguistic approach; it considers the age ascriptions' design and incidence in formulations (i.e. utterances that reformulate or furnish the gist of the preceding talk) as well as the design of the patients' uptakes.

Data

The current study is based on the salience of old age ascriptions in a TV documentary on health encounters.[2] That TV data can give insight into how people do age-in-interaction has been shown in a previous study on a reality show where the participants used invocations of old age as a rhetorical device, either to accuse the interlocutor or to defend themselves (Poulios, 2009). An advantage of TV data is that it is not researcher-provoked; the topic of age is not elicited by a researcher's groupings, participant instructions or interviews. However, the interaction may have been edited by the TV production theme.

The data are drawn from two Swedish television documentaries: *Sjukhuset* [The hospital], broadcast between 2007 and 2012, and *112 – På liv och död* [112 – On life and death], broadcast in 2013. These documentaries are available to the public at the Swedish Media Database of the National Library of Sweden. *Sjukhuset* depicts medical staff and patients in a variety of situations, while *112 – På liv och död* particularly depicts ambulance staff and patients. The documentaries are produced to educate and entertain a television audience. Seventy-two segments where older persons interact with health professionals were transcribed. Then, a word search was made in the transcription document on the Swedish equivalents to *old*, *age* and *older*. Ten segments were found to contain one or several of these words. Finally, the three least edited of these segments were selected for this study. In addition, one segment from *112 – På liv och död* was included because of its incidence

[1] A similar study was conducted in Sweden in the late 1990s where participants aged 35–50 were coupled with participants aged 70–90. One finding was that the former category of participants used the experiences of their mothers and fathers as a resource to express solidarity with the latter category (Eriksson, 1999).

[2] Health professionals' age categorization work in broadcast programs is discussed in a forthcoming dissertation by Nataliya Thell. Together with Katarina Jacobsson, she analyses the conversations in a radio program between a psychotherapist and help-seeking callers, focusing on how the former uses stage of life categories as resources in negotiating the cause of the caller's problems (Thell & Jacobsson, 2016, unpublished manuscript).