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'Forty bucks is forty bucks': An analysis of a medical Doctor's professional identity

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A B S T R A C T

The study of narrative has focused on the narrator, often overlooking the transactional and relational role of the interlocutor, particularly in doctor–patient interactions where interactants co-construct the case. However, the role of the doctor as a narrative facilitator has rarely been explored. Using a case study from a doctor–patient interaction, this fine-grained discourse analysis demonstrates how a doctor assists his patient to construct her narrative while also enacting salient aspects of his own identity. The doctor uses discursive strategies, such as alignment, repair moves, and mitigation, which act as vehicles through which the doctor constructs his professional identity, providing 'space' for the patient's narrative, and assist in building trust and rapport.

1. Introduction and literature review

Many sociolinguistic studies of narrative in medical interactions have predominantly considered the patient as narrator without much attention to the transactional and relational role of the interlocutor, in this case the doctor. This paper explores how in this interaction, the doctor's contribution includes discursive strategies, such as alignment, repair moves, and mitigation, which provide 'space' where the patient feels comfortable to construct her narrative and assist in developing positive rapport and trust (see in-depth discussion of the notion of 'space' in the clinical approach of Narrative Medicine in Barone, 2012). We focus on how a doctor uses these strategies to construct his professional identity as he attempts to understand the patient's condition in order to communicate therapeutic interventions.

A host of studies on narratives in the medical interview have focused on how patients frame their account (e.g. Ochs and Capps, 2001). These studies have categorized the components and the internal structure of narrative (e.g. Charon, 2006), and social expectations involved in medical interviews (Heritage, 2010). Some have focused on power asymmetry, patient identity construction, and patient agency (e.g. Hamilton, 2008). Fewer studies have focused on the doctor's interactional moves (Robinson, 2006) while others have viewed the patient's narrative as a collaborative endeavor, a 'reciprocal exercise, consisting both of the act of telling the story and the act of responding to it' (Shapiro, 1993, p. 49). Regarding the patient's narrative as an interactionally co-constructed achievement highlights the potentially important facilitative and supportive role of the doctor in this interactional context. In this regard, the importance of doctors as facilitators of patient narrative has been explored in the evidenced-based medicine literature (Kalitzkus and Matthiessen, 2009) and in the linguistic literature of

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doctor–patient interaction (Boyd and Heritage, 2006). The doctor's professional identities as a facilitator of patient narrative has not been found to have been more fully investigated from a sociolinguistic perspective.

A growing number of sociolinguistic studies in healthcare settings are concerned with the role of health care providers' professional identity in the management of social relations with patients (Roberts, 2007) and in the communicative influence it has on providing health care (e.g. Gerrish, 2001). For example, exploring the discursive analysis of professional identity, Apker and Eggly (2004) investigate how medical ideology and physician professional identity are socially constructed during morning report, while Heritage and Maynard (2006) explore how a diagnostic is given. Other research has been concerned with investigating the impact that social, economic and/or political changes have had on health professionals' professional identity. As an example, Drew (2011) investigated nurses' handover meetings and the impact on professional identity caused by changes in the health and social care system in the UK from 2006 to 2010. Moreover, longitudinal studies have traced the development of participants' professional identity over a period of years, focusing on the transitional period from being a student to becoming a practicing doctor or nurse (see Apker and Eggly, 2004 for overview).

Recent studies such as the ones outlined above view professional identity display and formation from a socio-constructionist perspective. In this light, professional identity is sometimes defined as one of our various social identities (Sundin, 2001), which, in Tajfel's words, is 'the individual's knowledge that he (sic) belongs to certain social groups together with some emotional and value significance to him of this group membership' (1972, p. 292). As this definition indicates, professional identity is no longer seen as 'a property or a stable category of individuals or groups' (Blommaert, 2005, p. 207) but instead, as 'the social positioning of self and other' (Bucholtz and Hall, 2010, p. 18) that is negotiated and reworked (Davies and Harré, 1990) at every step of someone's professional interaction(s) (e.g. Lazzaro-Salazar, 2013). Identity is considered a form of socially meaningful practice, something people do 'that is embedded in some other social activity, and not something they [passively] are' (Widdicombe, 1998, p. 191). As a social activity, identity is closely linked to discursive practices as discourse becomes the tool through which social actors enact and present their social selves (Bhatia, 2004) and is 'embodied by a series of discursive practices' (Kosmala and Herrbach, 2006, p. 1394). These discursive practices serve to index innumerable identities as social actors adopt certain stances, in the sense of Du Bois (2007), as they assign meaning to roles in the course of interaction. As an interaction evolves, subject positionings are constantly negotiated and reconstructed (Haddington, 2006). As a social practice, identity construction is then a relational phenomenon that develops in social settings through social communication as interactants index and negotiate their stances as they interact with relevant others.

In the medical interview in particular, doctors present multiple aspects of self-positioning (see Davies and Harré, 1990) as necessary to achieve their interactional goals in the process of co-constructing the patient's narrative (Pennycook, 2004). These goals can be transactional, (e.g. reviewing histories, reporting results, exchanging information, and/or making arrangements), and/or relational (e.g. building rapport and constructing trustworthy relationships) (Holmes et al., 2003). Of particular interest to this study, building positive doctor–patient rapport is strongly believed to contribute to effective healthcare communication (Leach, 2005).

Understanding the patient's narrative bears important implications for the quality of patient care in the diagnosis and interventional aspects relevant to the patient's condition (Charon, 2006). It is vital then that doctors create space where patients feel comfortable to render their illness stories. Following the relationship-centered medical paradigm, the therapeutic relationship between the doctor and the patient in the medical interview heavily relies on doctors' rapport building skills (Norfolk et al., 2007; Roter, 2000). This has attracted much scholarly attention as researchers have investigated the relationship between doctors' nonverbal rapport building and patients' disclosure of illness information (Duggan and Parrott, 2001; Eggly, 2002). Most of the studies in the field focus on statements of worry and concern, reassurance, empathy, legitimation, and positive regard by analysing doctors' question formats and content, body language (Roter, 2000), or the linguistic features used to display shared awareness of patients' problems and feelings, and openness and checking techniques (Norfolk et al., 2007).

We contribute to the body of research of doctor–patient communication by considering the role of a doctor's professional self-positioning in building doctor–patient rapport, since this self-positioning becomes a vital component of creating a space for the patient's narrative. To that end, we present a micro-discursive analysis case study of a doctor–patient interview in which the enactment of the doctor's professional identity is complex as his alignments dynamically shift according to the interactional goals of the current interview.

2. Theoretical framework and data

This sociolinguistic study uses a social constructionist perspective where narratives and identities are understood to be dialogically constructed (Ochs, 1993). As an approach to understanding narrative and the construction of professional identity as locally situated, we use interactional sociolinguistics to describe how the doctor contributes to a patient's narrative as he builds his professional identity partly from the contextual resources found within the interaction. Using an interactional approach to identity (Coupland, 2001; Holmes, 2006) and focusing on how identity is constructed by participants in interaction, this analysis draws from linguistic resources made available in interactional institutional contexts (Bamberg et al., 2007).

The following analysis focuses on excerpts from one substantial doctor–patient interaction selected from a corpus of 69 medical interactions (see Barone, 2012). In the original study, participants were recruited from an academic medical center and inner city managed care clinics, in the midwestern region of the U.S. The patient in this study is a 73-year-old female who