Reconfiguring Self/Identity/Status/Role: The Case of Professional Role Performance in Healthcare Encounters

1. Introduction

Concepts such as self, identity, status and role are central to discourse analytical endeavours. However, these concepts are used interchangeably, and sometimes in a conflated manner (e.g., self-identity, role-identity), by scholars within and across different analytical domains with overlapping ontological and epistemological trajectories. Beginning with a broader theoretical discussion of self, status and identity from sociological and social psychological traditions, in this paper I focus on role and role performance in professional settings. Using Goffman’s work as a bridge I then offer an interactional perspective on role performance which is extended to the doctor-patient relationship in healthcare encounters. The illustrative data examples are taken from the primary care setting, drawing attention to the doctor’s competing roles, i.e., therapeutic and pedagogic, contained within the professional role-set in an ethos which is predominantly steered towards patient-centred healthcare delivery. My main argument is that an examination of professional role-performance at the interactional level is capable of offering interesting theoretical and empirical insights.
2. Self/identity/status/role: A sociological and social psychological preamble

Mead (1934: 140) advocates a social, as opposed to individualistic, theory of self: ‘The self, as that which can be an object to itself, is essentially a social structure, and it arises in social experience’. Self, viewed in this way, has developmental and communicative dimensions. Central to this conceptualisation is the notion of the other, or ‘the generalised other’: ‘It is in the form of the generalised other that the social process influences the behaviour of the individuals involved in it and carrying it on...’ (Mead 1934: 155). In a philosophical vein, Ricoeur (1992: 3) introduces his book titled ‘Oneself as Another’ as follows: ‘the selfhood of oneself implies otherness to such an intimate degree that one cannot be thought of without the other, that instead one passes into the other’. For him, the otherness is constitutive of selfhood, not a juxtaposition. The developmental, communicative dimensions of self on the one hand and its orientation to others, on the other, extend to the cognate notions discussed below – identity, status and role – both in everyday settings and in situated professional/institutional encounters.

Giddens (1991) views self (and identity) as reflexively understood by the individual in terms of his/her biography; it is a trajectory stretching from the past to the anticipated future. For Giddens (1991: 186):

A self-identity has to be created and more or less continually reordered against the backdrop of shifting experiences of day-to-day life and the fragmenting tendencies of modern institutions. Moreover the sustaining of such a narrative directly affects, and in some degree helps construct, the body as well as the self.

Here Giddens adds a reflexive dimension to the developmental and communicative trajectories of self/identity. He also seems to extend the
notion of self beyond others, to include institutional and social processes. A similar viewpoint is proposed in Hall and du Gay’s (1996) conceptualisation of identity which is constructed ‘within, not outside discourse’. ‘Discourse’ here can be taken to include both micro (contingent) and macro (historical) perspectives.

In recent years a number of studies have adopted a discourse constructionist view of identity (e.g., Antaki and Widdicombe (1998), Sarangi and Roberts (1999), Benwell and Stokoe (2006), De Fina et al. (2006)).

While reflexivity and situatedness are the hallmark of identity construction, one cannot deny the stable, social basis of identity types. As Berger and Luckmann put it:

Identity is a phenomenon that emerges from the dialectic between individual and society. Identity types, on the other hand, are social products tout court, relatively stable elements of objective social reality (the degree of stability being, of course, socially determined in its turn). As such, they are the topic of some form of theorizing in any society, even if they are stable and the formation of individual identities is relatively unproblematic. Theories about identity are always embedded in a more general interpretation of reality; they are ‘built into’ the symbolic universe and its theoretical legitimations, and vary with the character of the latter. Identity remains unintelligible unless it is located in a world. Any theorizing about identity – and about specific identity types – must therefore occur within the framework of the theoretical interpretations within which it and they are located. (Berger/Luckmann 1967: 195)

For Berger and Luckmann, individual identities are not formed in a societal vacuum. The ongoing nature of identity construction within the societal context is attested by McCall and Simmons (1966: 163) when they write metaphorically:

Identity, like freedom, must be won and rewon every day. Each identity must continually be legitimated. Legitimating one’s self-structure is like dusting a huge old house: if he starts by dusting the parlour, by the time he gets to the upstairs guest room, the parlour is already badly in need of dusting again.
The dusting and re-dusting of identity point to the need for legitimating one’s presence while remaining other-oriented.

2.1. Linkage between status and role

The key point emerging form the above discussion is the conceptualisation of identity in terms of the dialectic between the self and others, between the individual and the society.

Of relevance here is the linkage between status and role within a given sociocultural system/order put forward by Linton (1971 [1945]). According to Linton, status refers to ‘the position of an individual in the prestige system of a society’, whereas role designates ‘the sum total of the culture patterns associated with a particular status’ (p. 112). Although Linton has been criticised for a static view of status-role relationship, he does suggest that ‘a role is the dynamic aspect of a status: what the individual has to do in order to validate his occupation of the status’ (p.112). He illustrates his argument with the example of a clerk in a store who shifts his role when dealing with fellow employees as opposed to clients and in the family sphere as opposed to the workplace. Through such dynamic shifts, Linton maintains, his clerk status becomes latent as he assumes another active status or group membership. In addition to the individual, situational shifts, Linton (1971: 114) also offers an historical perspective on societal transformations with regard to the status-role inter-relationship:

Under the necessity of reorganising our social structure to meet the needs of a new technology and of a spatial mobility unparalleled in human history, our inherited system of statuses and roles is breaking down; while a new system, compatible with the actual conditions of modern life, has not yet emerged. The individual thus finds himself frequently confronted by situations in which he is uncertain both of his own statuses and roles and of those of others. He is not only compelled to make choices but can feel no certainty that he has chosen correctly and that the reciprocal behaviour of others will be that which he anticipates on the basis of the statuses which he has assumed that they occupy.
This is clearly extendable to the professional setting when we consider the role assumed by a professional vis-à-vis the expectations of his/her patients/clients. Roles are transformed over time; there are multiple roles available to any individual within a given activity but some of these roles can be situationally ambivalent and conflicting – a point I shall return to in my discussion about ‘role-set’ (Merton 1968).

**Role performance**

Goffman (1961) draws a distinction between role (theory) and role performance (or role enactment) – the latter term is reserved for the situated nature of role. Role performance, for Berger and Luckmann, amounts to mediations between macroscopic and microscopic knowledge/meaning systems. In stressing the socialisation function of role, they suggest:

> [E]ach role opens an entrance into a specific sector of the society’s total stock of knowledge. To learn a role it is not enough to acquire the routines immediately necessary for its ‘outward’ performance. One must also be initiated into the various cognitive and even affective layers of the body of knowledge that is directly and indirectly appropriate to this role. (Berger and Luckmann 1967: 94)

Institutional/professional orders assume legitimacy when manifest through role performance. According to Berger and Luckmann (1967: 92):

> [O]n the one hand, the institutional order is real only in so far as it is realized in performed roles and that, on the other hand, roles are representative of an institutional order that defines their character (including their appendages of knowledge) and from which they derive their objective sense.

It is thus possible to analyse the relationship between roles and knowledge from two vantage points. Looked at from the perspective of the institutional order, the
roles appear as institutional representations and mediations of the institutionally objectivated aggregates of knowledge. Looked at from the perspective of the several roles, each role carries with it a socially defined appendage of knowledge. Both perspectives, of course, point to the same global phenomenon, which is the essential dialectic of society.

‘Role’ is a theatrical term borrowed by social science and made popular in the writings of Goffman (1959, 1961). Goffman draws on Park (1950: 249) who maintains that:

It is probably no mere historical accident that the word person, in its first meaning, is a mask. It is rather a recognition of the fact that everyone is always and everywhere, more or less consciously, playing a role … It is in these roles that we know each other; it is in these roles that we know ourselves … In the end, our conception of our role becomes second nature and an integral part of our personality.

The situated dimension of role performance, with its ritual overtones, is further explicated by Katz and Danet (1973: 275-276):

Many roles are played in costume: physicians wear white coats, policemen wear blue ones. But even when there is no uniform that goes along with a role, people present to others, and look for in them, the external signs of who they are. It is the mundane things like clothing, accent, the newspaper one carries, which tell the story.

In addition to ‘personal fronts’, many roles have more important permanent props, including a frontstage and backstage. The front region, like the personal front, is designed to create an impression and also to mark off an area which is the backstage. The waiter is a different person in the dining room than he is in the kitchen, and customers, indeed, are not allowed into the kitchen at all. The doctor’s waiting room is carefully stocked with certain kinds of magazines, its walls have certain kinds of pictures, and, farther inside, are the doctor’s credentials, duly sealed and delivered.

In his dramaturgical orientation, Goffman (1974: 128) draws a ‘distinction between an individual or person and a capacity, namely, a specialised function which the person may perform during a given series of
occasions’. He reserves the term ‘personal identity’ for the former to underscore individual biographies and nominates the term ‘role’ to refer to the latter, i.e., the specialised function (or what he elsewhere (1961) calls, ‘the virtual self’ or ‘role self’) which applies both to the actors on the stage and the theatregoers. Goffman’s (1959) influential book titled ‘The Presentation of Self in Everyday Settings’ foregrounds both the terms – self and role. However, in his discussion of self, Goffman does not explicitly draw on Mead partly because his concerns, unlike Meads’, are more at the level of performance. Goffman (1961: 77), however, maintains that role is the basic unit of socialisation: ‘it is through roles that tasks in society are allocated and arrangements made to enforce their performance’. We can see resonance with Linton when he suggests that

While manifestly participating in one system of roles, the individual will have some capacity to hold in abeyance his involvement in other patterns, thus sustaining one or more dormant roles that are enacted roles on other occasions. (Goffman 1961: 80)

This is echoed by McCall and Simmons (1966: 131) in their formulation of the role-identity model which suggests a distinction between social role and interactive role:

Role-taking ability can thus develop both from ‘subjective’ experience with similar roles and from more ‘objective’ experience in observing others in these roles. Professionals often develop a great deal of this ‘objective’ knowledge about their clients, and the latter are often surprised by what seems to them uncanny familiarity with their own points of view. Such knowledge on the part of the doctor, the teacher, the official points up the fact that ‘empathy’ must not be confused with sympathy or emotional involvement of any kind; the professional is often quite aloof and ‘clinically distant’ from his client.

Goffman’s (1961) demarcation between the regular performance of a role and a regular performer of a role is instructive. As he exemplifies, the director of a funeral parlour performs his/her role regularly in comparison with that of the immediately bereaved or the deceased! Likewise, the
doctor performs his/her clinical role regularly in comparison with the patient or the carer, although the roles may undergo a different reconfiguration in the context of chronic illnesses.

2.2. Role embracement and role distancing: An example

Two concepts that are particularly relevant for researchers interested in language/interaction analysis are role embracement and role distance. According to Goffman (1961: 94): ‘To embrace a role is to disappear completely into the virtual self available in the situation, to be fully seen in terms of the image, and to confirm expressively one’s acceptance of it. To embrace a role is to be embraced by it’. By role distance, he points to the ‘separateness between the individual and his putative role’ – the distancing between doing and being. It is far from being embraced by a specific role.

Let us illustrate this point with an example taken from genetic counselling encounters. Although it is not very common, clients occasionally ask what are called the ‘famous/infamous questions’ whereby they insist on the counsellor’s ‘personal’ rather than ‘professional’ orientation to the problem in hand. Our example concerns a middle aged woman who has had a brain tumour that was previously operated on. She now considers a second pregnancy and is concerned about the risks involved. The counselling session is attended by her husband who initiates the famous/infamous question as follows (for a detailed discussion, see Sarangi 2000; Sarangi/Clarke 2002).

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1 The simplified transcription conventions include: (. ..): micropause up to one second; (1.0, 2.0): pause timed in seconds; CAPITAL LETTERS: increased volume; *word*: decreased volume; underlining: increased emphasis as in stress; question mark [?] : rising intonation; -: cut-off of prior word or sound; [text in square brackets]: overlapping speech; ((text in double round brackets)): description or anonymised information; (text in round brackets): transcriber’s guess; (^^^^^^^): untranscribable; =: a continuous utterance.
Data Example 1

The famous/infamous question in genetic counselling

[D = Doctor; H = Husband; W = Wife]

01 H: so it it eh- to cut a long story short, if eh your wife was in this position (God forbid) (.5) eh and you wanted another child would you say (.) the chances are so minute (.5) we can go ahead with one (.5)
02 H: [it was your-
03 D: [you’re asking- (.) you’re asking (.) two separate questions.
04 H: if you were me or-
05 D: yeah
06 H: =well yeah
07 D: but you’re- you are asking two separate questions
08 H: mmh
09 D: you see there’s the (.) the (.) the you know what you’re saying one is (.) eh (.) is there a chance of eh (.) say of a child having a tendency to get meningiomas?
(.5)
10 H: (unclear) (.) well I know I know it’s like it would be the same chances as some (unclear)
11 D: yes that’s very very unlikely
12 H: [unlikely
13 D: [so there’s that question. and then there is the question of
14 H: mhm
15 D: of would the pregnancy cause another tumour
(1.0)
16 D: and (.) I think the answer [to that]
17 H: [that’s (unclear)
18 D: =well I think (.) the pregnancy itself wouldn’t cause another tumour. (.) if there is a small recurrence eh that (.) was not
identified on the scan (. ) then I suppose a pregnancy could perhaps influence that rate of growth but (. ) it’s not going to make the difference between (. ) the tumour coming back or not coming back. (.5) it (.5) could make a (. ) a difference to when it shows itself (.5) it (.5) could make a (. ) a difference to when it shows itself

19   H:  mnh
20   D:  but it would show itself anyway. (. ) but ehm:::
21   W:  =I mean I’m going to have MRI scans- regular MRI scans (. ) each year? [(.] and eh-

[Source: Sarangi 2000]

H’s opening turn as an advice seeking move can be considered an invitation for D to distance himself from his professional counselling role and approach the client’s problem in his personal biographical capacity, hypothetically, as the husband of a wife who has had a brain tumour removed, and who now plans a further pregnancy. In terms of McCall and Simmons, D remains aloof and ‘clinically distant’. It is not uncommon in difficult situations to report what other people, i.e., other clients, do (Pilnick 2002). In this instance, the counsellor is being persuaded to occupy a role outside of the clinical sphere. In other words, D is being pushed to embody his social role as a husband. However, as can be seen from the subsequent turns, D continues to embrace his role as the counsellor (in Goffman’s terms, he is embraced by the counsellor role), which amounts to the absence of role distancing. In other words, the role-relationship between D and H is sustained in the counsellor-client frame, and not transformed into one between fellow husbands in the family sphere. In reformulating the questions that the couple are facing and in attributing risk assessments associated with a future pregnancy, D reinforces his activity-specific professional counsellor role by adopting the ‘discourse role’ (see next section) of information provider rather than as dispenser of self-preferred advice.
2.3. Multiple roles vs. role-set

The discussion above draws attention to professional role performance where the practitioner remains within the boundary of professional activity. However, within a given professional activity, it is possible to be confronted by conflicting professional roles. Merton (1968) challenges Linton’s view that each status has its distinctive role, and argues that a particular status has an array of associated roles, or a role-set, vis-à-vis social structure:

This is a basic characteristic of social structure. This fact of structure can be registered by a distinctive term, role-set, by which I mean that complement of role-relationships which persons have by virtue of occupying a particular social status. As one example: the single status of medical student entails not only the role of a student in relation to his teachers, but also an array of other roles relating the occupant of that status to other students, nurses, physicians, social workers, medical technicians, etc. […]

It should be plain that the role-set differs from the structural pattern which has long been identified by sociologists as that of ‘multiple roles’. For in the established usage, multiple roles refer to the complex of roles associated, not with a single social status, but with various statuses (often, in differing institutional spheres) in which individuals find themselves – the roles, for example, connected with the distinct statuses of teacher, wife, mother, Catholic, Republican and so on. We designate this complement of social statuses of an individual as his status-set, each of the statuses in turn having its distinctive role-set.

(Merton 1968: 423-424)

The relationships, Merton continues, are not only between the occupant of the particular status and each member of the role-set but, always potentially and often actually, between members of the role-set itself.

The distinction between multiple roles and role-set is crucially important in the context of ‘situated activity roles’ (Goffman 1961). Consider, for instance, the diffused role-responsibilities of a clergyman: ‘functions such cultural leader, teacher, medical or social worker, can be
moved into a central place by the clergyman, eclipsing his specifically religious responsibilities’ (Elliott 1972: 126). Balint (1957) provides a scenario where a young woman unduly requests a sickness leave certificate. The doctors respond to this request differently: while one issues a moral sermon, another foregrounds a discourse on social responsibility, and yet another considers this untoward request as a basis for differential diagnosis. This is indicative of professional performance within a role-set, potentially leading to different outcomes. In the academic sphere, professionals find themselves in competing and conflicting roles when acting out supervisor and assessor responsibilities simultaneously in relation to a student’s dissertation/project. While one part of the role-set is meant to be one of facilitating and scaffolding, the other part is one of gatekeeping. Similarly, with regard to the social work profession, the social worker has to balance his/her role as a gatekeeper (assessing eligibility of clients) and as a supporter/helper (Hall, Slembrouck and Sarangi 2006). As far as social work clients are concerned, Hall, Sarangi and Slembrouck (1999) report a distinction between ‘good mother’ and ‘bad parent’ as part of the same role-set in the context of child welfare case conferences.

3. Role performance/enactment: An interactional perspective

Let us briefly summarise Goffman’s (1981) well-established participant framework which encompasses production roles and reception roles:

**Production roles**

- animator (the sounding box; someone who gives the voice to the words); ‘he is the talking machine, a body engaged in acoustic activity, or if you will, an individual active in the role of utterance production’ (1981: 144).
author (the agent who scripts the lines); ‘someone who has selected the sentiments that are being expressed and the words in which they are encoded’ (1981:144).

principal (the party to whose position the words attest): ‘someone whose position is established by the words that are spoken, someone whose beliefs have been told, someone who is committed to what the words say’ (1981:144).

Reception roles

According to Goffman (1981:3), ‘when a word is spoken, all those who happen to be in perceptual range of the event will have some sort of participation status relative to it’.

ratified: the ‘official’ hearers: distinction between addressed recipient and unaddressed recipient.

(addressed recipient – one to whom visual attention is paid and to whom speaking role is transferred)

(unaddressed recipient – the rest of the ‘official hearers’ who may or may not be listening)

unratified: (overhearer or bystander (inadvertent); eavesdropper (engineered))

Against this backdrop, we can suggest distinctions between what Thomas (1986) calls activity roles and discourse roles. Activity roles (e.g., chairperson, committee member, minutes taker, news interviewer, Guest of Honour) are dependent on the activity-type the individual is participating in and are usually defined in relation to other participants (or what Goffman [1961] sees as ‘role others’). For instance, a chairperson role is only legitimate in the meeting session in the co-presence of other committee members, assuming there is a prior institutional mandate about his/her activity role. Before and after a meeting session and during coffee
breaks the activity role of chairperson dissipates and during the meeting itself there may be footing shifts as the chairperson articulates his/her own views as a committee member rather than as chairperson. Discourse roles (e.g., spokesperson, mouthpiece, reporter, overhearer etc) refer to the relationship between the participants and the message (is s/he producing it, receiving it, transmitting it on behalf of another, etc.) (see Goffman 1981, Sarangi and Slembrouck 1996). In a meeting session, committee members may respond to specific elicitations or volunteer information reporting the views of co-present and absent others, thus occupying different discourse roles. Zimmerman’s (1998) concept of discourse identity (story teller, story recipient, questioner, answerer, repair initiator) is another way of referring to discourse roles, while his concept of ‘situated identities’ (e.g., call-taker, citizen complainant) overlaps with activity roles. In data example 1, we can see that the counsellor, in a subtle manner, does not take on the discourse role of answerer as far as the husband’s query is concerned; instead he adopts the discourse role of explainer or reformulator of what has been said before, which enables him to continue to embrace his activity role of professional counsellor.

The above discussion consolidates role performance at the functionalist level, while acknowledging that role is not a rigid category of everyday activity. In critiquing Linton’s conceptualisation of role as ‘rights and duties’, Hilbert (1981: 216-217) argues in favour of an interactionist perspective:

Our recommendation is to view ‘role’ as an organising concept used on occasion by actors in social settings, and to view its utility for actors in terms of what they do with it; i.e., the work they require it to do, in sustaining the perceived stability of social behaviour, whatever their immediate purposes. Viewed this way, roles are not behavioural matrices to be described and explained but are conceptual resources actors use to clear up confusion, sanction trouble makers, instruct others in the ways of the world, and so forth.

For Goffman (1981:145), a speaker can ‘alter the social role in which he is active … what in committee meetings is called ‘changing hats’ … to
select the capacity in which we are to be active is to select (or to attempt to select) the capacity in which the recipients of our action are present.’ Such alterations in social roles are no doubt accomplished through a set of discourse roles – the relationship between the participants and the message being produced. Mehan (1983) draws our attention to the language of role in the context of institutional decision making (e.g., speaker-format relations in terms of presentation and elicitation of information which can be consequential). Likewise, Halkowski (1990), following Turner’s (1962) distinction between functionalist and interactionist approaches, demonstrates how interactants use role to accomplish interactional tasks such as issuing and avoiding accusation in the context of Iran-Contra Congressional hearings.

3.1. Professional role performance in healthcare encounters

The characterisation of the doctor’s role can be historically traced to Foucault (1972) who identifies what can be seen, following Merton (1957), as a role-set that combines aspects of education, therapy, gatekeeping as well as safeguarding the common good.

If, in clinical discourse, the doctor is in turn the sovereign, direct questioner, the observing eye, the touching finger, the organ that deciphers signs, the point at which previously formulated descriptions are integrated, the laboratory technician, it is because a whole group of relations is involved. Relations between the hospital space as a place of assistance, of purified, systematic observation, and of partially proved, partially experimental therapeutics, and a whole group of perceptual codes of the human body – as it is defined by morbid anatomy; relations between the field of immediate observations and the domain of acquired information; relations between the doctor’s therapeutic role, his pedagogic role, his role as an intermediary in the diffusion of medical knowledge, and his role as a responsible representative of public health in social space. (Foucault 1972: 53)

At a more situated level, our understanding of the doctor’s role cannot be divorced from Parsons’ (1951: 437) conceptualisation of the patient’s
‘sick role’, especially ‘the obligation – in proportion to the severity of the condition, of course – to seek technically competent help, namely in the most usual case, that of a physician and to cooperate with him in the process of trying to get well. It is here, of course, that the role of the sick person as patient becomes articulated with that of the physician in a complementary role structure’.

Although Parson’s conceptualisation of the ‘sick role’ has been critiqued on the basis of being ethnocentric (Freidson 1970), being society-centred rather than patient-centred (Bloor/Horobin 1975), and being biased towards restitution at the expense of remission associated with chronic illnesses (Frank 1995), our interest here lies in the expert, technical helping role the doctor is expected to adopt. Technical expertise, what Mishler (1984) refers to as ‘the voice of medicine’, becomes the basis of the ‘apostolic function’ (Balint 1957: 216) of the healthcare professional: ‘every doctor has a vague, but almost unshakably firm, idea of how a patient ought to behave when ill’. In its stronger version, the physician induces patients to have the kind of illness that the physician thinks is proper. How does such professional reasoning/judgement manifest interactionally and role-relationally, especially in an ethos of patient-centred healthcare delivery (Sarangi 2007, Sarangi in press)?

In the primary care setting, the doctor’s role transforms over time. While attending to acute illnesses, in recent years the primary care physician is called upon to take on a patient educator role. This latter function is likely to disrupt the rule-governed structure of the clinical encounter as symptoms presentations and symptom explanations may become interspersed with doctor-initiated explanations of disease

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2 Parsons’ conceptualisation of the sick role, although accounts for the moral dimension in terms of rights, obligations and compliance, does not give consideration to how people understand/give meaning to their illness experiences. It also does not apply to genetic conditions, where one is not sick in himself/herself (e.g., carrier status), or those who do not know when and in what form they will be affected by a condition.
causation. Let us consider a few extracts from a primary care clinic (GP = General Practitioner; P = Parent) involving two children with URTI (Upper Respiratory Tract Infection) where the doctor’s pedagogic role and his therapeutic role are conflated.\(^3\)

**Data Example 2**

<table>
<thead>
<tr>
<th></th>
<th>GP:</th>
<th></th>
<th>P:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Hello, there</td>
<td></td>
<td>Hi</td>
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<td>02</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>03</td>
<td>Hi, what can we do for Lincoln?</td>
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<tr>
<td>04</td>
<td>It’s both of them, really, she’s had what I thought was a cold since Friday, but I just kept putting it off, putting it off, but the cough just seems to be getting worse, and he’s got it as well, so I’m not sure if they’ve got some sort of infection</td>
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<tr>
<td>05</td>
<td>Right, who shall we look at first? Little one, so he’s got a cough? Anything else you’ve noticed wrong with him?</td>
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<tr>
<td>06</td>
<td>No, he hasn’t been too bad, she hasn’t been eating, though</td>
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<tr>
<td>07</td>
<td>Snuffy nose, temperature, and that stuff?</td>
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<tr>
<td>08</td>
<td>Yes, they’ve had high temperatures, I mean, they’re obviously together, so</td>
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<tr>
<td>09</td>
<td>All right, anybody else had it?</td>
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<tr>
<td>10</td>
<td>No</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>11</td>
<td>Just the kids</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>12</td>
<td>Yeah, feverish, cold</td>
<td></td>
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<tr>
<td>13</td>
<td>Right, and what do you think is going on, you mentioned a cold? What is it that worries you, something more…?</td>
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</tr>
<tr>
<td>14</td>
<td>Well, they’ve been up until (unclear), they’ve been really uncomfortable with the coughing, so I was started to think, you know, whether they had a throat infection</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Right, okay, and what did you think I might do with them today, did you have any ideas about how we would deal with that?</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>16</td>
<td>No… (unclear)… antibiotics</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^3\) I am grateful to Chris Butler for making the dataset available to me. The names have been altered to protect anonymity.
In turn 4, the parent articulates the symptoms adopting a moral self which almost borders on parental negligence (‘she’s had what I thought was a cold since Friday, but I just kept putting it off’). This apparent negligence is countered by an upgrading of the symptoms (‘the cough just seems to be getting worse’), leading to a tentatively formulated self-diagnosis (‘I’m not sure if they’ve got some sort of infection’). The GP’s subsequent formulations (turns 5, 7 and 9) – ‘Anything else you’ve noticed wrong with him?’; ‘Snuffy nose, temperature, and that stuff?’; ‘anybody else had it?’ – as statements with raised intonation are classic examples of the history taking routine requiring further specification of symptoms. They also embody the patient-centred ideology in recognising the agency and knowledge of patients (in this case, parents). In paediatric settings, Strong and Davis (1978) suggest that parents have expert and detailed knowledge about their children, so the doctor’s scientific and generalised expertise is bound to be contingent on parents’ expertise. The GP’s hyper-questioning in turn 13 – ‘what do you think is going on’, ‘what is it that worries you, something more?’ – can be categorised as perspective display series (Maynard 1991), but note that such a parental display is asked for at the history taking phase, not at the treatment phase of the encounter. Such perspective display questions at the history taking phase seem to bring out the affective stance of the parent (‘they’ve been really uncomfortable with the coughing’), while further specifying the self-diagnosis, as the tentativeness gives way to a level of certainty (‘so I was started to think, you know, whether they had a throat infection’). This leads the GP, in turn 15, to ask a further display question targeted at a possible treatment regime (‘what did you think I might do with them today, did you have any ideas about how we would deal with that?’). This results in P expressing her expectation of antibiotics albeit hesitantly as parts of what she says are unclear in the transcript.

At this stage, one would expect the onset of the physical examination phase, possibly leading to a prescription of antibiotics. However, as we can see in the next sequence, the GP chooses to shift footing from a therapeutic role to a pedagogic role, triggered by the
explicit questioning of P’s understanding about antibiotics. The interaction continues as follows:

Data Example 3

17 GP: Yes, what do you know about antibiotics? Much?
18 P: (answer unclear, sounds like, "they clear infections")
19 GP: Okay, it does treat infections due to a type of germ called bacteria, and the antibiotics kill bacteria, most infections that cause coughs and colds, etc., are due to a different kind of germ called a virus, and they don’t turn out as much help to treat viruses, only bacteria, so we need to decide what the cause is, is that all right?
20 P: Yes, right
21 GP: So I think since Camilla is the first victim, we’ll have a little look at her first, and then we’ll have a wee look at Lincoln
22 P: The coughing is a lot worse with her, she’s been bad with it, like
23 GP: Right, does she get a bit too (unclear) the asthma in the past, then?
24 P: No, not really
25 GP: No, it’s really just colds and coughs now again? Fine, now then, young Camilla, can I have little look in your mouth, please? … Thank you very much, you are good… Now, let me have a wee look at your ears, I’ll look in your lugs, that’s what we call them in Scotland …. Has she been complaining of earache?
26 P: No, doctor
27 GP: That is a wee bit red, the eardrum is a bit red, the right one’s okay, can I have a listen to your chest, please, Camilla? Have you been a miserable girl? Turn round for me, pull your top about there, can I do that?
28 Child: Yes (coughs)
29 GP: Gosh, you’re really wrapped up again, aren’t you, against the cold weather? That’s lovely, now then, Camilla, are you able to take a big breath? Do it again, marvellous, do it again… move your top… one last one… That’s super, thank you, okay, now I heard a cough when she came in, and yes, it does sound a wee bit chesty, but actually she’s perfectly clear, there’s no chestiness there, snotty, the throat looks okay… little red here.. okay, I think this is a kind of cold that children get, because the irritation here isn’t a
cough, it’s a virus infection. I don’t think that you need to treat this with antibiotics, I think what we need to do is just a case of being comfortable, in the hope to get better, let’s just have a check at Lincoln to see if he fits the same category…

30 P: (says something away from the microphone)
31 GP: Ah, that’s two children you have?
32 P: Yes
33 GP: Everything’s going to come in pairs now
34 P: She’s started nursery, she’s going to come home with a lot of it, she’s been really bad
35 GP: Okay, that’s a lovely boy, cuddle his head into your chest, let’s have a wee look, doctors are always saying… Scottish doctors are always saying "wee", that’s lovely, that’s lovely, and a little listen to his chest as well, I’ve changed a little, I’m talking English …. okay…. okay…. (Examines the child) okay, good, okay, thanks very much, again, he’s got a little bit of red down here across his back (unclear - doctor speaks slightly off microphone) snotty nose, now, he has got a little bit of a wheeze in his chest, and that happens when the airways get a wee bit inflated, a wee bit (unclear), makes it wheezy, and if that gets down into the airways, we call it bronchiolitis, and again, that’s a virus infection, and his breathing is okay, and he’s not having any problem with it, and the rate at which he is breathing… which his breathing is fine, sometimes, with this kind of bronchiolitis of babies, because the airways are already tightening because babies are small, and if this swells up, we get to run into little problems with breathing, and once you notice that he is running into that kind of problem, you start to breathe consistently, if you start him off he’s going to panic… but the whole part of it is that if you sit there quietly… if you begin to notice that he’s wheezing and breathing quickly, and breathing more shallowly, and if he’s running into serious problems, you just (unclear - speaking away from microphone) but just concentrate his breathing, and you can see that he’s breathing… (unclear - speaking away from microphone))… now, we don’t.. at this stage he’s not got a (unclear) and it’s not very common for it to happen, mostly what happens is the kids will cough their heads off for a week or more and quietly get better, Okay? And I tell you that just so you know what to do for it, if you’re getting a bit concerned, just keep a wee eye on his
breathing, but if you want, you bring him back and I’ll have a listen again, okay? As far as treatment goes at the moment (baby cries) I would simply think about a simple cough medicine to soothe them at night time, just to give them a better night, she will cough, so will this one at night time, they’re worse in the night because it always is… I don’t know why, it just always works like that, so you may well have a few sleepless nights, okay

In turn 19, the GP offers a prototypical explanation of how antibiotics kills bacteria, which delays the physical examination phase only slightly. This explanation draws distinctions between bacterial and viral infections and the educational aspect is made salient through the use of metatalk (‘we need to decide what the cause is, is that alright?’). When the physical examination ensues, the GP provides what Heritage and Stivers (1999: 1501) call the ‘online commentary’: ‘talk that describes what the physician is seeing, feeling or hearing during physical examination of the patient’ (see also Mangione-Smith et al 2003). The online commentary serves to pre-empt patient resistance if there were to be a ‘no problem’ diagnosis. But in the above extract the online commentary is accompanied by what might be called ‘off-line commentaries’ whereby the doctor steps outside the physical examination phase and offers explanations of various kinds (see Ragan 1995 for a parallel account in the context of obstetrical-gynaecological examination). We notice here the interpenetration of at least two roles of the role-set – the doctor’s therapeutic role as dispenser of treatment and the doctor’s pedagogic role as educator of patients – in addition to maintaining the discourse role of talking to the children, affectively and instructionally, as direct addressees rather than as overhearing audience (see turns 25ff). The off-line commentary foregrounds the educational role of the doctor in recruiting the parent’s participation in the future treatment of the child. It is worth noting how the GP not only moves freely between his pedagogic and therapeutic roles, but also between the different phases of the clinical encounter. The question at the end of turn 25 (‘Has she been complaining of earache’) belongs more to the history taking phase than to the physical examination
phase. We may suggest that such shifts between online commentaries, offline commentaries and asking of symptoms-related questions index the GP’s pedagogic role, while positioning the parent as an expert and spokesperson for the children especially when the latter lack speaking rights because of their age. In paediatric consultations such as this one, both online commentaries and off-line commentaries function rhetorically: the parent remains both the overhearing audience and the primary addressee in anticipation of future action plans.

In turn 29, the GP formulates his expert assessment in the form of interpretive summaries (to extend Ferrara’s (1994) terminology) which contain elements of individually-oriented diagnosis (‘it does sound a little bit chesty, but actually she’s perfectly clear, there’s no chestiness there’), as well as generally framed pedagogic explanations (‘I think this is the kind of cold that children get’). Such summaries anticipate intervention, in this case non-intervention. The decision against prescribing antibiotics (‘because the irritation here isn’t a cough, it’s a virus infection, I don’t think you need to treat this with antibiotics’), is accompanied by an explanation.

In turn 35, the GP is examining Lincoln and we again notice the interspersion of individually oriented diagnostic commentaries and more generally oriented pedagogic explanations. Consider the following:

he has got a little bit of a wheeze in his chest, and that happens when the airways get a wee bit inflated, a wee bit (unclear), makes it wheezy, and if that gets down into the airways, we call it bronchiolitis, and again, that’s a virus infection

his breathing is fine, sometimes, with this kind of bronchiolitis of babies, because the airways are already tightening because babies are small, and if this swells up, we get to run into little problems with breathing

you can see that he’s breathing… (unclear - speaking away from microphone)… now, we don’t.. at this stage he’s not got a (unclear) and it’s not very common for it to happen, mostly what happens is the kids will cough their heads off for a week or more and quietly get better, Okay?
It can be argued that such pedagogic explanations are aimed at educating the parent about the patterns of breathing, which will then form a basis for any future action. This is explicitly articulated by the GP towards the end of turn 35 (‘And I tell you that just so you know what to do for it, if you’re getting a bit concerned, just keep a wee eye on his breathing, but if you want, you bring him back and I’ll have a listen again, okay?’). Finally, the GP decides to prescribe cough medicine rather than antibiotics, as anticipated by the online ‘no problem’ commentaries, and he justifies this action ‘to soothe them at night time, just to give them a better night’.

4. Conclusion

In this paper I began by contextualising the notion of role in relation to cognate notions such as self, identity and status. It seems scholars tend to use these terms interchangeably, while agreeing on situated and reflexive performances of role, identity and self vis-à-vis an orientation to others. In focusing on discourse roles, activity roles and role-sets, I have offered selective examples from healthcare encounters in an attempt to suggest that linguistics/discourse/interaction research can contribute further to clarify the distinctive meanings of these concepts – theoretically and empirically. Using the classic figure-ground metaphor, role can be said to be the figure while identity, status and self remain the ground. As McCall and Simmons (1966: 163) suggest:

Even though a given performance is always relevant to more than one of our identities, no single performance or daily agenda of performances can serve to legitimate all our role-identities; there are simply too many of them, and they have to be tended all the time. What a moment ago was accepted as a legitimate claim to an identity may no longer be, for we recognise that people are most fickle and changeable indeed.
Extended to the healthcare setting, doctors are continually exposed to a repertoire of professional role categories (role-set) through medical education, apprenticeship and experience. In any given consultation, depending on the character of the patient and their expectations, the doctor has to momentarily and cumulatively configure relevant roles from the available role-set. This goes beyond the traditional sociological dictum that the physician’s communicative behaviour is influenced by the social status attributes of patients, i.e., ethnicity, class, gender, age etc. It seems the notion of ‘role’ with all its complexity is perhaps more operationalisable at the social interactional level, and especially in the institutional/professional domains, than the notions of self, identity and status.

References


