

IDENTITY CONSTRUCTION IN NURSE PRACTITIONER-PATIENT INTERACTIONS

BY

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DISSERTATION

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ABSTRACT

This dissertation explores interactions between Nurse Practitioners (NPs) and patients during both inpatient and outpatient visits. Through an analysis of interactional data coupled with ethnographic observations and interviews, I focus on the ways that both patients and providers construct particular identities, that is, how they inhabit the institutional role of patient or provider through particular linguistic moves and stylistic choices.

A great deal of scholarly effort has been devoted to understanding language use in medical visits; however, these studies have focused almost exclusively on medical doctors (MDs) and have primarily taken a Conversation Analytic (CA) approach. This study departs from both of these traditions by examining interactions involving an understudied yet growing provider-type: Nurse Practitioners, and by employing an ethnographic discourse analytic methodology.

Although they have not been a focus on linguistic study, Nurse Practitioners are recognized in the field of health communication as employing a ‘patient-centered’ approach, which seeks, among other things, to create positive, long-term relationships with patients. Additionally, NPs are recognized as providing a high quality of care measured in terms of patient satisfaction and health outcomes (i.e. improved health). However, what contributes to NPs’ positive evaluations has not been examined in depth, particularly in terms of language use in medical visits.

In this dissertation, I address this gap in the literature by employing ethnographic discourse analysis that draws on multiple data sources. The analysis primarily focuses on audio-recordings of 48 medical visits with five different NPs: one working in an inpatient setting; four working in an outpatient setting. In addition to the audio recordings of medical visits, the study

also includes interviews with providers and patients, focusing on ethnographic and bio data with the former and overall satisfaction with the latter.

Drawing on both emic and etic categories of types of providers and patients, I argue that NPs, through their ability to balance both instrumental and interactional goals, are able to construct the identity of the ‘caring and competent’ provider. Using Agha’s (2007) theory of figures of personhood, I outline the ways in which NPs align with the ‘caring provider’ through linguistic moves of solidarity such as engaging in small talk, using inclusive first person plural pronouns and mitigating medical advice through the use of hedging and indirect speech. Employing these linguistic features allows the NPs to highlight and address the interpersonal goals of the medical visit, enabling them to create positive patient-provider relationships. Similarly, NPs balance the focus on the interpersonal with addressing the instrumental goals of the visit in their alignment with the ‘competent provider.’ This is accomplished through attending to their occupational and professional responsibilities including following the required medical checklist, recognizing their epistemic responsibility to patients, and creating alignments to their organizations and professional institutions. Additionally, NPs also highlight their own medical competency through the use of knowledge sharing and use of singular first person pronouns.

Patients, in their enactment of the patient role, align with a number of different identities. Some align with the ‘deferent patient,’ likely a reflection of the older, provider-centered approach; however, this identity is never sanctioned by the NPs. Instead, NPs actively encourage patients to be more proactive in their own health and encourage this; those who do so, I argue, enact the ‘good patient.’ Other patient identities also seem to derive from the new patient-centered model of health care as well as the medical neoliberal ideology, which places patients in

the role of ‘patient-consumer’ and requires them to take an active part in improving their health. Although not all patients are able to enact the medically compliant and ‘good patient’ identity, attempts that fall short of doing so are still viewed somewhat positively by the NPs, thereby aligning these patients with a number of other identities.

Support for the NP identity of the ‘caring and competent’ provider, comes from interview data with both NPs and patients. NPs construct their own professional identity as teacher and information provider. Almost all NPs interviewed make it clear that they do not ‘push’ patients but simply focus on educating patients so that they can make the best decision for themselves. In doing this, they illustrate how avoidance of giving medical directives, among other things, allows them to create positive relationships with patients and, hopefully, encourage medical adherence. Patients’ responses to satisfaction questions in post-visit interviews also support this identity. Patients overwhelmingly indicate positive impressions of the NPs in the study and report on specific aspects such as showing concern for patients and being knowledgeable.

This dissertation illustrates the ways in which employing an ethnographic discourse analytic framework allows for an analysis of identity construction in medical settings. The extent to which the identities that NPs align with are unique to NPs is a question that cannot be answered with this research alone since prior research focused on different goals and utilized different analytic and methodological frameworks. Future research should attempt more accurate and equitable comparisons of various provider types by exploring the ways in which linguistic choices aid in the construction of medical providers’ professional identities.

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CHAPTER 1

INTRODUCTION

1. Overview

This dissertation presents a discourse-analytic account of identity construction in NP-Patient visits. The goal of the research is to identify the ways in which identity is co-constructed in the institutional setting of the medical visit. I argue, as a starting premise, that the institutional setting provides a frame for the types of identities that are sanctioned. That is, the setting itself places certain participants into institutionally defined roles: that of ‘patient’ and ‘provider;’ however, these ‘roles’ are molded through interaction and alignment with certain figures of personhood (i.e. ‘the ‘good’ patient). For example, I analyze the types of patients that those in the ‘patient role’ may align with and the types of providers that those in the ‘provider role’ may enact.

Through the analysis of ‘identity’ as alignment with figures of personhood, I show the ways in which providers and patients both align with prevailing cultural notions of these institutional roles as well as how their enactment contributes to the construction of the cultural notions of what it means to be a certain type of provider or a certain type of patient. Additionally, this study focuses on a rarely studied group of providers: Nurse Practitioners (NPs). This study thus contributes to the large body of research on medical discourse by providing a detailed analysis of the ways in which NPs construct their professional role. By taking a different theoretical approach from much of the previous work on medical interactions, this study also provides a more nuanced understanding of how identity is constructed in institutionally defined spaces.

1.1. Significance of Research

The significance of this research encompasses empirical, theoretical and methodological aspects.

1.1.1. Empirical Significance

A large body of research on medical visits currently exists, specifically focused on doctor-patient visits; however, other provider types are often not accounted for in the socio-linguistic research.¹ Empirically, the focus of this study is on Nurse Practitioners, an understudied population, and one that will likely play a more prominent role in health care in the US in the coming years and decades. A number of shifts in the healthcare landscape seem to contribute to the growing presence of NPs, particularly in primary care settings. For example, the Health Resources and Service Administration (HRSA) points to two main factors creating a greater demand for primary care providers: 1) a large, aging baby-boomer population, which they argue will account for approximately 80% of the growing healthcare demand in this decade; and 2) the expansion of coverage for previously uninsured individuals due to the implementation of the Patient Protection and Affordable Care Act (colloquially referred to as ‘Obamacare’) (bhpr.hrsa.gov). Because of these two factors increasing demands, HRSA projects that the current and expected number of primary care doctors will not be able to meet this demand. In fact, they project that by 2020, there will be a shortage of over 20,000 physicians (*ibid*). In a report in the *Annals of Family Medicine*, Petterson and colleagues make more long-term

¹ In the field of health communication, research on NPs has existed for decades; however, the focus and goal(s) of this research often differ from that of sociolinguistics. This research will be discussed in Chapter 2.

projections and suggest a shortage of over 50,000 providers by 2025 (Pettersson, et al., 2012). HRSA and others suggest that the best way to meet this demand is by increasing utilization of NPs and Physicians Assistants (PAs) (Auerbach, 2012; bhpr.hrsa.gov; Crowell, 2010; Kuo et al., 2013). The increasing numbers of NPs in primary care is apparent in the Veterans Affairs (VA) system, from where some of the data for this dissertation comes. In the VA system, NPs comprise about 20% of primary care providers (Morgan, Abbott, McNeil & Fisher, 2012).

These shifts in health care suggest that NPs will become a more prominent provider in primary care, but also in other areas as they, like physicians, can specialize in a number of different areas. However, as I have pointed out, very little is known about the interactions of NPs and how their linguistic choices may impact their visits with patients.

Although this dissertation cannot account for the extent to which language may influence patients' adherence to medical advice nor can it provide a comprehensive account of how NPs are different from other providers, it does make a significant contribution in detailing the linguistic features of NP-patient visits and how both NP and patient identities are interactionally constructed in these visits. Additionally, as NPs navigate the 'middle space' of medical care in that they are not socially recognized as having the same credentials as medical doctors (MDs) yet provide a drastically different level and type of care as Registered Nurses (RNs), it is important to understand how their position as a particular type of provider is constructed, laying the groundwork for future studies that can more accurately compare different provider types.

1.1.2. Theoretical Significance

On a theoretical level, this study seeks to expand the current literature on identity construction by focusing on 'patient' and 'provider' constructions within the asymmetrical and institutional setting of medical visits. Specifically, this research examines how the institutionally

defined roles of ‘provider’ and ‘patient’ aid in the construction of identity for individuals within these roles, and how the interactional patterns are both shaped by and shape the construction of the larger cultural notions of what it means to be an NP or what it means to be a patient in these visits. Research on medical discourse has not only focused primarily on doctors, often to the exclusion of other providers, it has rarely focused on identity construction as an important way to understand the nature of medical visits. Starting from the position of identity as something that is constructed in discourse, influenced through one’s interaction with a conversational other, and at least, partly influenced by the social context, it allows for an understanding of how participants view their institutional roles, including, what is an acceptable way to ‘act as a patient’ or ‘act as a provider.’ Through examination of the various ways that patients align with different figures of personhood, this study can reveal how they view their medical visits with NPs and the types of relationships they have with them. Similarly, how NPs construct their role as certain types of medical providers can reveal what aspects of their professional identity are important for them to highlight in their interactions with patients.

1.1.3. Methodological Significance

This research also takes a wider methodological lens in its attempt to understand NP-patient visits by combining multiple data collection procedures: recordings of medical visits, ethnographic data collection and post-visit interviews.

A bulk of the sociolinguistic and discourse analytic research has focused exclusively on interactional aspects of the medical visit. For example, the Conversation Analysis and Ethnomethodology traditions that are pervasive in medical discourse research focus exclusively on ‘talk-in-interaction,’ or the language *as* context, choosing not to include in their analysis anything that is not oriented to in the discourse. Although a valid methodology for understanding

the structure and sequencing of talk, ethnographic data are not accounted for, leaving, in my opinion, a limited understanding of the larger context in which the interaction takes place. This is not to say that some studies have not considered the ethnographic context: a sub-section of medical discourse research has included an ethnographic component (for example, Ainsworth-Vaughn, 1998; Zayts & Schnurr, 2014); however, these are far less common in the literature and have not included post-visit interviews or surveys in the design or analysis.

On the other hand, a number of studies in health communication have reported results of post-visit surveys and patient satisfaction. These studies, however, rarely include a detailed discourse-analytic account of language use in visits, and therefore, do not address the question of what may account for patient satisfaction and what role language choice may play in patient perceptions.

Because of these differences in empirical and methodological approach, this study has practical implications for medical care and medical training of NPs as well as other providers whose approaches may be different. For example, the linguistic features that I outline as common in NP-patient visits as well as the uptake by patients may help inform training of communication practices for NPs and other medical providers. Although this is just a first step in understanding how discourse choices may influence patient impressions, it provides a basis for further testing correlations between language use and patient satisfaction.

1.2. Research Questions

Data analysis will follow an ethnographic discourse analysis framework (Ainsworth-Vaughn, 1998), which, by design, takes a bottom up approach, working from the data to extract the most salient features. Therefore, rather than starting from very specific, testable hypotheses,

the framework of the analysis begins from more general, exploratory research questions. These questions include:

1. How are identities of ‘NP’ and ‘patient’ negotiated within medical visits?

This research question, through the process of data collection, transcription and analysis, has led to a number of more specific questions that will be addressed in this dissertation.

These are:

- 1.1. What figures of personhood do NPs align with in their interactions with patients?
- 1.2. Do the various identities that NPs construct vary depending on individual differences or are there over-arching identities associated with this particular medical role?
- 1.3. What types of figures of personhood do patients construct?
- 1.4. Are there similarities across patients or can individual differences account for different types of patient identities?
- 1.5. What do these identities of both NPs and patients reveal about larger cultural notions of these roles?
 - 1.5.1. Can the ‘middle space’ position of the NP account, in any way, for the variety of patient and/or NP identities that emerge?
 - 1.5.2. Can the ‘middle space’ position of NPs as health care providers help inform the types of identities that emerge?
2. What do post-visit interviews with NPs and patients reveal about the professional role of the NP?
 - 2.1. What are patients’ impressions of the NPs in this study?

- 2.2. Do patient impressions correlate with the types of identities that are constructed in the medical visits analyzed?
- 2.3. How do NPs view the role of NPs within the larger medical system?
- 2.4. Why types of identit(ies) do they construct in interview settings?
- 2.5. Can these constructions help explain the linguistic choices that are made in medical visits?

1.3. Overview of Methodology

In order to address the research questions above, data were collected in two phases comprising two different research sites as well as different data collection methods. A complete description of the methods used in this dissertation can be found in Chapter 3.

Two data collection sites were chosen. The first was at a regional, community-based hospital in the Midwest. At this location, data was collected with one Nurse Practitioner, working inpatient at a hospital as a diabetes specialist. Because of this, all interactions that were recorded focused on the same general topic of diabetes management. A total of 20 visits were observed, audio-recorded, transcribed and analyzed following the general procedures described below. In addition, audio-recordings of pre-visit and post-visit interviews along with ethnographic ‘field notes’ were used to support the analysis of the visits.

The second data collection site was a government-supported Veterans Affairs hospital and community clinic in the Midwest. Four NPs were recruited for participation at this site with a total of 28 visits ranging between four and 10 visits with each NP. Similar to the first site, visits were audio-recorded (although not observed), transcribed, and analyzed for specific linguistic feature as well as more general patterns that could be associated with various figures of personhood. In addition to audio-recordings of visits, post-visit interviews were conducted with

almost all patients (23 of the 28 total visits), as well as audio-recorded ethnographic interviews with NPs and ethnographic field notes.

The audio-recordings serve as the primary source of data analysis for two main reasons. The first is that they represent the bulk of the data collection. The total amount of recorded data of medical visits for the two sites combined is over 800 minutes of data; whereas all interview data combined total only approximately 200 minutes. Secondly, and more importantly, the recorded interview data provide a better basis for addressing the primary research question(s), in that they illustrate how identities are constructed in the moment through interaction in medical visits. The interview data provided a secondary avenue for analysis of identity construction. First, utilizing the NP interview data from both sites, I could make claims about how NPs construct notions of personhood outside the medical interview with the researcher. Unlike the types of aligning moves discussed in the analysis of the medical visits, NPs often make “overt mention of categories and labels” (Bucholz & Hall, 2005: 594) in response to interview questions. Second, patient interview data were used in similar ways but also to analyze how they view the NPs through response to interview questions regarding satisfaction.

In analyzing the data, features previously presented in the literature as associated with both power and solidarity in medical visits were first categorized and then recurring discursive patterns were highlighted and noted in an attempt to identify commonly constructed identities that could be associated with socially recognized figures of personhood. Individual excerpts were collected that best exemplified the ways that both patients and providers aligned with certain recognizable figures, the clearest of which (but by no means the extent of which) were selected for inclusion in the analysis chapters.

2. Summary of Results

The general results of the study are divided into three main parts (NP identities, Patient identities and NP self-described role/patient up-take), which correlate with the four analysis chapters presented herein and described, briefly, in the following section. Sections 2.1 and 2.2 address how NP and patient identities are negotiated within medical visits (research question 1); whereas section 2.3 discusses how NPs construct their professional identity in interviews with the researcher as well as patient up-take of the NP identity, based on post-visit interviews (research question 2).

2.1. NP Identit(ies)

First, to address issues of the types of identities that are constructed by NPs in this study, the overarching figure of personhood that is constructed in these visits is that of the ‘caring and competent provider.’ Nurse Practitioners, in this study, enact the patient-centered approach, which can be understood roughly as a balancing of attention and concern between disease management and relationship management. This medical approach is described in more detail in Chapter 2.

NPs in this study actively work to lower social distance between themselves and their patients through a number of discursive moves that I argue align them with the ‘caring provider,’ which I discuss in Chapter 4. In order to align with the ‘caring provider,’ NPs, temporarily, but frequently, set aside the instrumental goals, or a focus on the bio-medical aspect of the visit, to attend to rapport building and enhancing. The ways that is most notable is through 1) engagement in small talk, 2) use of inclusive first person pronouns, and 3) use of indirect, hedged medical advice.

The ‘caring provider’ is only one part of the predominant identity that NPs construct in visits. The other part, the ‘competent provider,’ is just as important and equally aligned with by the NPs in this study. Constructing the ‘competent provider’ is enacted in three main ways: 1) following the ‘checklist’ of medical visits and controlling the topics 2) aligning with the medical community through the use of the “institutional ‘we’” and 3) knowledge-sharing and education of patients. The ways in which NPs carry out each of these aspects of the visit is described in detail in Chapter 5.

It is important to note, from the outset, that these two identities are not necessarily separate but represent the two key aspects of how NPs construct their professional identity of a ‘caring and competent’ provider. As I will discuss further in the Discussion (Chapter 9), many of the ways in which the ‘competent provider’ is enacted can also be viewed as demonstrating care and concern for the patients; similarly, the ways in which NPs lower social distance can be viewed as an interactional move that represents competency in their profession. Separation of the two components of this identity aid in the description and is done for the purposes of presenting a clear analysis; however, these two aspects should be seen as inextricably linked, forming one cohesive identity for the NPs in this study.

2.2. Patient Identities

Unlike the NP identity, patient identities take a wide-range of forms. Patients have previously been discussed in the research as passive recipients of knowledge who recognize and co-construct the asymmetrical context of the visit. This is true for the most part in my data and is represented by the ‘deferent patient’ in the analysis. However, this is not the only figure of personhood with which patients align. Others include: the good patient, the knowledgeable but non-compliant patient, the struggling patient and the non-patient. It is also important to note that

patients do not enact one particular identity throughout a visit but may align with different figures of personhood at different points in the visit.

2.3. NP Self-Described Roles and Patient Up-Take

In interviews with the researcher, NPs discuss what it means to be an NP and self-align with the professional position of NPs as ‘not doctors’ but as ‘educators’ and mediators of information. NPs also index their identity as ‘caring providers’ through voicing the stances of patients and what they believe patients ‘like’ about NPs. Comparing NPs’ reflexive identities through perceived patient impressions with actual patient impressions illustrates that for the most part, although not exclusively, patients do have very positive impressions of NPs and view them as both ‘nice’ and ‘knowledgeable.’

3. Organization of Dissertation

The remainder of the dissertation is organized as follows:

Chapter 2: Literature Review

The literature review chapter first discusses previous literature on institutional contexts and medical settings, positioning this study within that research trajectory but also illustrating how this study goes beyond what previous research has illustrated by taking a different theoretical focus. I then describe the relevant literature that informs the theoretical framework used in this dissertation. Finally, I conclude by presenting what is known about Nurse Practitioners, primarily drawing from other research traditions such as health communication.

Chapter 3: Methodology

This chapter provides an extensive description of the methods employed in data collection and analysis. A description of the data collected at each of the two sites as well as relevant ethnographic and biographical data on participants is also included.

Chapter 4: Alignment with the ‘Caring Provider’ Identity

In the first analysis chapter, I analyze how NPs align with the ‘caring provider’ identity through various linguistic resources including engagement in small talk, pronoun choice and use of indirect speech as a way of mitigating the force of medical advice. I use a number of extended excerpts from data collected at both locations to inform this analysis. Post-visit interviews with patients serve as support the analysis through patient up-take of this identity.

Chapter 5: Alignment with the ‘Competent Provider’ Identity

In this chapter, I analyze how NPs align with the ‘competent provider’ identity by controlling the discourse to focus on what is most medically pressing and relevant, demonstrating knowledge and alignment with the wider medical community through alternate use of ‘institutional we’ and first person singular ‘I’ and in the ways that knowledge is shared with patients through recognition of patients’ rights to access of medical information. Extended excerpts serve as the basis for analysis. Post-visit patient interviews are then presented as a way to show possible patient up-take of this identity.

Chapter 6: Construction of Patient Identities

In this chapter, I focus on the types of identities that patients align with in medical visits. I first outline five different patient types, illustrated through analysis of relevant excerpts. I then illustrate, through one extended excerpt, how patients may align with multiple identities at different points, arguing that aligning with particular figures of personhood is fluid and multi-faceted.

Chapter 7: Patient Impressions and Self-Described Roles

This final analysis chapter brings together some of the significant findings from the interview data that contributes to the construction of the NP identity. It first outlines the ways that NPs self-identify as certain types of providers in interviews rather than in medical visits with patients. I discuss how NPs self-described professional identity overlaps with the ‘competent and caring provider’ identity. I also include survey data from patient interviews that provide some insight into the patient up-take of the NP identity.

Chapter 8: Discussion

In this final chapter, I discuss the overall results of the analysis and discuss the extent to which the patterns of identity construction for both NPs and patients are based on the ‘middle space’ position of the NP in the medical profession. I discuss the theoretical implications of this study, particularly in light of how different approaches lead to different data and different results, making it difficult to compare the results of this study to previous literature. Finally, I end with a discussion of the limitations and possible future avenues for research based on the results of this project.

CHAPTER 2

LITERATURE REVIEW

1. Overview

A great deal of scholarly effort has been devoted to understanding language use in medical visits; however, these studies have focused almost exclusively on medical doctors (MDs) and have primarily taken a Conversation Analytic (CA) approach. This study departs from both of these traditions. First, I focus on Nurse Practitioners as a relatively understudied provider in sociolinguistic and discourse analytic research. Therefore, this study draws on research outside of the scope of linguistics, primarily from the field of health communication, to provide background on what is known about NPs and their approach to health care (section 2). I also position this research within the wider field of medical discourse, starting with what is known about institutional contexts and medical settings as well as doctor-patient interactions. Rather than focusing on how language shapes and defines the medical visit, I focus on how language use within this setting reveals patterns of identity construction of patients and providers (section 3). I conclude this chapter with a description of the theoretical concept of ‘identity’ as well as the framework of ‘figures of personhood,’ which guides the analysis in this dissertation (section 4).

2. Review of Nurse Practitioner Research

The first section below describes what a Nurse Practitioner is, including education, scope of practice, general data, and NPs’ medical approach, commonly referred to as ‘patient-centered’ care. It then presents research suggesting the expanding role that NPs have played in the past two decades as well as projections of their increased role in the coming decades. I then conclude this

section by describing the research on Nurse Practitioners that has come out of the field of health communication, drawing on what contributions that body of research makes and what this dissertation seeks to add in that direction.

2.1. What is a Nurse Practitioner?

Nurse Practitioners are a sub-group of Advanced Practice Registered Nurses (APRN) who work in a variety of settings and specialties. NPs hold either a MS in Nursing (MSN) or Doctor of Nursing Practice (DNP) degree, which requires an additional two to four years of full-time education beyond the four-year RN degree (www.explorehealthcareers.org) as well as 500 to 700 supervised clinical hours (Iglehart, 2013).

Similar to medical doctors (MDs), NPs may specialize in their degree programs and can seek employment in a variety of inpatient and outpatient settings as well as medical specialties (e.g., primary care, women’s health, emergency, oncology, surgery, etc.). According to the Bureau of Labor Statistics, there were 105,780 NPs practicing in the US as of May 2012; approximately 45% of them were employed in primary care (United States Bureau of Labor Statistics, 2013). The mean salary for NPs in 2012 was \$91,450 per annum. Table 1, below, outlines the number of NPs employed in the five most common industry-type locations as of May 2012 (reproduced from <http://www.bls.gov/oes/current/oes291171.htm>).

Table 1. Industries employing NPs

| Industry | Employment |
|---|-------------------|
| Offices of Physicians | 48,690 |
| General Medical and Surgical Hospitals | 27,760 |
| Outpatient Care Centers | 7,610 |
| Colleges, Universities and Professional Schools | 3,160 |

Table 1 (cont.)

| | |
|---------------------------|-------|
| Home Health Care Services | 3,050 |
|---------------------------|-------|

As Table 1 indicates, not only do NPs work in a variety of specialties, they are also employed in a number of different industry settings. The majority of NPs work in physicians' offices, which may include primary care or specialists' offices. The second most common is in inpatient hospital settings. The NPs in this study work in either hospitals or primary care offices, representing the two most common settings for NPs in the US.

Estimates of the number of NPs practicing in the US vary. According to a study by Auerbach (2012), the number of NPs was somewhere between 86,000 and 128,000 in 2008, depending on the definition of NP- the lower number representing anyone who self-identified as an NP. The American Association of Nurse Practitioners reports over 157,000 NPs in the US as of 2014 (AANP National NP Database, 2014). These numbers illustrate that there is a steady increase in the number of NPs practicing in the US, suggesting that they are becoming a more prominent player in the healthcare landscape.

NPs, unlike MDs and Physicians Assistants (PAs), do not come from a medical school background and receive very different training. As mentioned at the beginning of this section, NPs hold either a Master's or Doctorate degree in Nursing; however, the path to this advanced degree varies. For example, Registered Nurses (RNs) may hold either a Bachelor's degree (a 4-year program) or an Associate's degree (a 2-year program), but those who do not hold a Bachelor's degree are required to complete the requirements for a BSN (Bachelor of Science in Nursing) or attend one of the many new 'bridge programs' that provide education to cover the gap between an Associate's and a Master's degree, often being granted a BSN in the interim

(www.explorehealthcareers.org). This is the case for one of the NPs in this study, Karen, who transitioned from an Associate's to a Master's through an accelerated program. There has been discussion within the NP community that NPs will be required to hold a DNP in order to practice, likely in an effort to increase the level of education of NPs and to raise the perceived status of NPs. However, despite some resources speculating that this change will be in effect by 2015 (c.f. www.explorehealthcareers.org), as of the date of this dissertation, no such requirement has been implemented.

NP programs vary in length not only dependent upon whether an NP chooses to complete the MSN or DNP degree but also on specialty. For instance, the options for APRN degrees at the University of Pennsylvania include: Adult Gerontology, Family Practice, Neonatal, Pediatric, Psychiatric-Mental Health, Nurse Anesthesia and Nurse Midwifery and range between 12 months to 24 months (www.nursing.upenn.edu). Upon completion of the degree program, NPs must complete a national board certification exam as well as state-level licensure processes.

In the US, states differ in terms of the level of autonomy that NPs may have. In Indiana and Illinois, the two states where NPs in this study practice, NPs may be designated as Primary Care providers, meaning that a patient may choose an NP as their primary care provider; however, NPs may not practice independently- both Illinois and Indiana require what is known as 'physician oversight' (<http://www.bartonassociates.com/nurse-practitioners/nurse-practitioner-scope-of-practice-laws/>), a somewhat vague term that refers to some level of supervision by an MD. What this means in practice varies and is often dependent on the organization and/or physician (personal communication). In the Veterans Affairs system, NPs see patients independently but have a coordinating physician who reviews their charts bi-weekly and provides guidance when questions arise. In the community hospital, the NP also sees patients

independently but works with a team of physicians, none of which ‘oversee’ her practice but will coordinate care with her. NPs in both of these states are not given independent prescribing rights; however, the agreement with a ‘overseeing’ physician does mean that they can prescribe medication for patients without getting individual approval from a physician.

2.1.1. NPs and the Patient-Centered Approach

Although not explicitly defined as such, the patient-centered approach has been recognized as the hallmark of NP practice (Cunningham, 2004). Patient-centered care, which takes an alternative approach to older, more traditional, physician-centered health care has increased in popularity since the 1970s (Robinson, Callister, Berry, & Dearing, 2008). The patient centered model, as outlined by Stewart and colleagues (2000) is defined by six main components: 1) consideration of patient’s experience with illness rather than focus on the disease itself; 2) taking a holistic view of the patient; 3) negotiation of treatment and disease management; 4) focus on long-term health promoting behaviors and disease prevention; 5) development of the provider-patient relationship; and 6) the realistic accomplishment of these goals. Roter and Hall (1992, 2004), similarly, define patient-centered talk as engaging in ‘positive talk’ (i.e. providing encouragement, reassurance, agreement and approval) and avoiding ‘negative talk’ (i.e. confrontation or direct disagreement) and note that it correlates with better patient outcomes.

On their website, AANP presents NPs’ “unique” approach as follows:

What sets NPs apart from other health care providers is their unique emphasis on the health and well being of the whole person. With a focus on health promotion, disease prevention, and health education and counseling, NPs guide patients in making smarter

health and lifestyle choices, which in turn can lower patients' out-of-pocket costs
(<http://www.aanp.org/all-about-nps/what-is-an-np>)

The focus on holistic health and education, as AANP promotes, correlates well with the definition of patient-centered care (Stewart, et al., 2000), since both highlight treating the whole person rather than the illness as well as greater concern for long-term health through focus on disease preventions and healthy lifestyle decisions.

2.2. NPs in the Changing Healthcare Landscape

Although Nurse Practitioners have been a part of the healthcare landscape since the 1960s, their numbers have been steadily increasing (explorehealthcareers.org), a trend that is expected to continue with current changes in healthcare. Runy (2007) reports that changes in federal mandates that restrict residents' hours have increased the number and scope of practice of NPs in inpatient settings. Similarly, the recent implementation of the Patient Protection and Affordable Care Act of 2010 (PPACA) creates a projected increase in individuals seeking medical care. As of May, 2014, over eight million people have signed up for coverage through the health insurance marketplaces (United States Department of Health and Human Services, 2014) and an additional 1.5 million who were previously uninsured are now eligible for coverage (obamacarefacts.com). With this increase also comes growing concern of the primary care physician shortage (Goodson, 2010). With only about 30% of all US physicians practicing in primary care, an amount totaling approximately 200,000 primary care physicians (National Center for Health Care Statistics, 2011), many argue that they will not be able to meet the demands of this drastic increase in insured individuals. Petterson and colleagues (2012) project that an additional 52,000 primary care providers will be required.

This shift in the landscape of healthcare has led to some arguing for expanding the roles of NPs (Auerbach, 2012; Crowell, 2010; Kuo et al., 2013), including lowering restrictions in all states to allow NPs to practice independently (Kuo et al., 2013). Kuo and colleagues also claim that loosening restrictions on NPs is cost-effective (2013). This potential shift in the make-up of health care, particularly in primary care, and an increased presence of NPs, suggests that NPs' interactional style and their focus on patient-centered health care may alter the landscape of health care in the US. Auerbach and his colleagues (2013) project that by 2025, physicians will represent only about 60% of all primary care providers; a drop of 11% from where they currently are. They suggest that the ratio of MDs to NPs in primary care will be 2:1, respectively (Auerbach et al., 2013). In the Veterans Affairs system, NPs make up approximately 20% of all primary care visits and fulfill similar roles as MDs (Morgan, Abbott, McNeil & Fisher, 2012).

In sum, these shifts in the medical landscape of the US, suggest that a greater number of individuals will see NPs rather than MDs, suggesting a clear need for a better understanding of how NPs operate, particularly in comparison to their MD counterparts.

2.3. Health Communication Research on NPs

A great deal of research on NPs has come out of the field of health communication, particularly in the past two decades. Most of these studies focus on health outcomes for patients who see an NP compared to other providers, such as MDs and Physician Assistants (PAs). For example, Ohman-Strikland and colleagues (2008) report that family practice offices that employed NPs provided better care for patients with diabetes than offices with MDs alone or MDs and Physician Assistants (PAs). However, the specific role of the NP in this difference is not the focus of the study, and therefore, is not discussed in the article, leading to the questions of what, if any, correlation can be made between NPs and improved diabetes care. Stanik-Hutt

and her fellow researchers (2013) also report on positive health outcomes associated with NPs in comparison with MDs. They reviewed 37 journal articles and found that NPs were comparable to MDs on patient outcomes including: 1) patient satisfaction, 2) number of emergency department visits and hospitalizations following treatment, 3) blood glucose and blood pressure levels, and 4) mortality rates. Additionally, they found that patients who were cared for by an NP had better cholesterol levels than those who received care from an MD. The results of these studies indicate that the quality of care provided by NPs is comparable to that of MDs and, in some cases, may even be better. However, whether the reasons for this are due to an NP interactional style has not been addressed.

One of the few studies that has examined the interactional practices of NPs was conducted by Seale, Anderson, and Kinnersley (2005) who compared NPs and doctors, focusing solely on the treatment and diagnosis phase. They found that NPs' discussion of treatment options was significantly longer than that of doctors, with specific focus on how the treatment would work along with a discussion of side effects. They also noted that Nurse Practitioners recommended a greater number of treatment options to their patients, presenting a more patient-centered approach (2005). Although this study provided a great comparison between these two types of providers, it focused only on the diagnosis and treatment phases, ignoring other aspects of the medical visit such as openings and closings, an important site of identity work particularly in terms of rapport-management (as will be discussed in Chapter 4).

Other research involving NPs has focused mainly on patient satisfaction, often in comparison to Physician Assistants (PAs) and MDs. Early research on the roles of NPs in primary care indicated that these providers were rated as providing a comparable level of quality of care based on patient satisfaction (Levine et al., 1976; Merenstein, Wolfe & Barker, 1974).

More recent studies have pointed to similar findings, indicating that NPs are often given higher ratings of patient satisfaction compared to physicians (Newhouse et al., 2011; Seale et al., 2005). Patients often report being more responsive to Nurse Practitioners' communication style and claim they would more likely to adhere to the plan of treatment (Baratt, 2005; Charlton, Dearing, Berry and Johnson, 2008). Budzi, et al. (2010) surveyed patients seen by NPs, PAs and MDs at Veterans Affairs medical centers. Overall, survey respondents were more satisfied with the care they received from NPs than PAs and MDs and claimed that they preferred to see an NP rather than a PA or a physician. Some of the reasons for the preference were cited as NPs' focus on disease prevention, health education and a higher level of attentiveness during the medical visit. All of these studies focus solely on post-visit surveys, leaving a gap in terms of understanding how post-visit impressions may correlate with linguistic choices during the medical visit itself.

These studies seem to suggest that patients almost overwhelmingly prefer NPs; however, Redsell and colleagues (2007) report that a majority of patients, when given the choice between an NP and a general practitioner (i.e. an MD), responded that they felt more confident consulting with a physician when they felt that their symptoms were serious. These results suggest that despite the positive attributes associated with NPs, patients may still view them as having a lower level of medical knowledge and skill than an MD, a factor that could arise in the medical visits themselves, particularly in how NPs and patients co-construct their identities, respectively.

2.4. Interim Summary

As the data on NPs illustrates, they are a major player in providing healthcare in the US and are expected to continue to be an important and increasingly visible provider. Although a great deal is known about the outcomes and satisfaction level of patients who visit NPs, very

little is known about their discursive choices and the ways in which they construct their identity as a professional provider in medical visits.

3. Institutional Discourse and the Medical Visit

This section reviews relevant literature on medical discourse, primarily from the research traditions of Linguistics and Sociology. This section begins with an overview of the significance of studying language within an institutional context, including a discussion of what is meant by ‘context’ as defined by different research agendas. It then reviews the literature on doctor-patient interactions, the primary focus of medical discourse research.

3.1. The Importance of Institutions

As early Conversation Analysts and Ethnomethodologists have noted, institutional discourse differs from ‘everyday’ or ‘ordinary’ talk in a number of ways. Sacks, Schegloff and Jefferson’s (1974) seminal work on the organizational structure of talk, dealing with ‘everyday’ interactions points out that in everyday interactions, talk is characterized by its ‘free’ qualities. That is, order of speakers is free- anyone can hold the floor, select next speaker or even select him/herself as next speaker. Similarly, turn length is also relatively free and determined by the interactants: any speaker can hold the floor for an extended period of time or for very short periods. Finally, content is also quite free: topics may be introduced by anyone and there are no topics, per se, that would be considered inappropriate or out of place for everyday talk, in general. This does not mean that any turn length or any topic could be sanctioned by participants, it simply illustrates that the context of what is acceptable is constructed in the moment by the participants themselves and by the previous discourse and not necessarily by the setting.

Institutional discourse, conversely, is defined by many (c.f. Arminen, 2005; Drew & Heritage, 1992) in opposition to everyday talk. Taking the three components mentioned above

(free order, length and content), institutional talk is asymmetrical in terms of who has access to the floor at any given point. Those with institutional power have greater control over the ordering of speakers as well as how long each person may hold the floor. Topics, similarly, although not necessarily controlled by one participant, are often limited by the institutional setting itself. As Arminen explains, interaction is recognized as institutional when “the parameters for participation are constrained not contingently but conventionally” (2005: 44). This seems to suggest that participants in institutional interactions, at least to some extent, recognize the conventions of the institution and recognize their assigned roles in the interaction. Candlin (2000), argues that, in interactions between Registered Nurses (RNs) and patients, there may not be overt markers of the power asymmetry; however, “there is an unspoken recognition by both parties that the nurse with institutional power has a right to information, and the patient, in his [sic] sick position will benefit from making disclosures” (241). Although a seemingly obvious argument, this ‘unspoken’ recognition’ illustrates the psychological awareness of the institutional setting and each participants’ role that individuals have.

The institutional setting may also play a role in how utterances are interpreted (Arminen 2005; Levinson 1979; Sarangi 2000). Drawing on Levinson’s (1979) theory of ‘activity-types,’ one can understand a given institutional context (i.e. a medical visit) as a particular type of activity, one that is distinguished both from the so-called ‘everyday’ interaction as well as any other speech event. Levinson argues that activity types both “constrain what will count as an allowable contribution” and “help determine how what one says will be ‘taken” (1979: 393), illustrating how participants are not only interacting with each other but with the context itself. Sarangi (2010) notes, “healthcare encounters, with encompassing variations across sites, certainly count as activity types where constraints on contributions imply a corresponding set of

inferential schemata [emphasis in original]” (402). Sarangi provides, as an example, the differing ways that a question such as ‘how are you doing?’ may be interpreted differently within the medical visit compared to a more ‘everyday’ conversation. Outside of the medical visit, he argues, this question is likely taken-up as a formulaic greeting; however, in medical visits, patients will often respond by explaining their current health status rather than with a similarly formulaic response, indicating their situational interpretation of this question as an inquiry of their health and reason for the visit. Furthermore, through an experimental study, Bonnefon and Villejoubert (2006) illustrate how the term ‘probably’ may be taken up differently by patients even within visits. In this study, the authors compared interpretations of a doctor’s use of ‘probably’ paired with a prognosis deemed to be mild compared to one that is severe. With a more severe condition, participants interpreted ‘probably’ as a politeness marker rather than a hedge, marking a provider’s uncertainty. Participants’ interpretation, therefore, comes from both the content of the message (i.e. severity of illness) as well as the contextual factors of the speaker’s role as physician and the institutional context. As the authors argue, receiving a negative medical diagnosis can be face threatening; participants may assume that a provider is attending to their face needs rather than providing an accurate assessment of the physician’s degree of certainty. Similarly, Drew and Heritage (1992) illustrate how a remark from a health visitor gets interpreted differently by a new mother and new father. What the father interprets as simply a harmless remark the mother takes to be a criticism due to the institutional position of the health visitor as a person of authority. They argue that the mother’s response reveals her understanding of the context and the roles that each play in this interaction. Conversely, the father’s alternate interpretation indicates a lack of recognition of the institutional context. Rather than trying to account for the differing interpretations of the nurse’s utterance, Drew and

Heritage seemingly use the father's response as an unmarked up-take and a point of comparison for the mother's interpretation as being defined by the institutional context.

3.1.1. The Institutional 'Context' of Medical Visits

One of the problems faced by researchers studying institutional interactions is determining what 'counts' as context. That is, what is it that participants are responding to in these visits, which Arminen (2005) refers to as the "potential infinite richness of the context" (32)? As Arminen notes, in institutional settings there are multiple layers and sociolinguistic factors that participants may orient to including participants' gender, age, ethnicity, socio-economic status as well as the particulars of the institution itself including the larger culture in which it is situated, the organizational structure of the institution and the ideologies associated with it. Because of this complexity, researchers have primarily prescribed to a Conversation Analysis –(CA) approach of analysis. That is, rather than trying to account for the wide array of contextual features, CA analysts have limited themselves to the immediate context of the discourse and what is oriented to in the talk. Therefore, unless particular constraints of the institution (e.g. required policies and procedures) are referenced in the discourse, then they are not considered part of the 'immediate' context and are not included in the analysis. Because of this very focused, albeit limited, attention placed on the talk-in-interaction, Conversation Analysts studying medical visits have provided a wealth of data on the internal structure and interactional norms that have come to define this institutional setting as well as patterns of talk between doctors and patients.

3.2. Doctor-Patient Interactions

Over thirty years of research on doctor-patient visits has given us an extensive understanding of these visits. The key foci of these previous studies include an analysis of the

internal structure of medical visit. The research on this is tremendous, comprising multiple edited volumes, but beyond the scope of this dissertation since the organization of talk is not the focus of this study. Rather than presenting an extensive account, in section 3.2.1, I focus on the general findings and patterns of talk that have been discussed in the literature. The following two subsections focus on aspects of the medical visit that are particularly relevant to this dissertation, namely, the way that the medical visit, as an institution, is linguistically constructed as well as a brief argument on the import of linguistic choices as they relate to patient health outcomes. This section ends with a discussion of how this research differs in both scope and methodology from the previous studies.

3.2.1. Internal Structure of Medical Visits

Byrne and Long (1976), were the first researchers to provide a general overview of the structure of the medical visit. They divided the visit into six distinct parts: 1) the opening, 2) problem presentation, 3) medical exam (includes both verbal and physical aspects), 4) diagnosis, 5) treatment, and 6) closing. Since then, much of the research has focused on one of these specific structural aspects (Byrne & Long, 1976; Heath, 1992; Heritage and Clayman, 2010; Heritage & Robinson, 2006a, 2006b; Heritage & Maynard, 2006; Peräkylä, 1998) with the hope of understanding not only what the interactional norms are, but also in what ways structuring of any given aspect of the medical visit can affect the outcome. For example, Roter and Hall (2006) note that the amount of information patients provide during the opening phase is significant in overall outcomes, particularly in terms of the number of problems that are addressed in the visit. Diagnosis and treatment phases have been well studied as they often reveal the asymmetric nature of the visits most notably due to the emphasis on unequal access to knowledge as well as the face-threatening act of giving directives.

3.2.2. Power in Medical Visits

Because of the inherently asymmetrical nature of medical visits, many studies have focused on linguistic and interactional instantiations of power in terms of interactional moves by both providers and patients. Providers' claims of power have been noted through turn-taking and turn management including the use of questions in assigning speaker roles (Byrne & Long, 1976; Heritage and Clayman, 2010). For example, Heritage and Clayman (2010) point out that the use of yes/no questions act as a way for doctors to control what information gets shared by limiting patients' talk to simply responses to questions and not allowing patients to introduce new topics.

Tag questions have also been examined as a way of indicating a particular stance and preferred alignment, as they can indicate more clearly what the provider's preferred response is (Boyd & Heritage, 2006). For example, 'You don't smoke, do you?' frames the question in a way that encourages agreement with the statement, and indicates the provider's position on smoking. By framing part of the information gathering phase of the medical visit in terms of already having the information but simply seeking confirmation from the patient through the use of certain question types, the provider enacts his/her position of power and authority and limits the amount and type of contribution that patients can provide.

Patients often seem to show deference to the provider's authority through passivity and silence (Heath, 1992; Stivers, 2007). Withholding responses and silence (Heath, 1992; Stivers, 2007) can be seen as acceptance and deference to the doctor's authority during the diagnosis. In fact, Heath (1992) found that even minimal responses (e.g. 'oh', 'really') during the diagnosis phase were quite rare despite his assessment that the doctor was encouraging a response (e.g. through the use of pausing or gaze/posture). This deference to the doctor's authority and the patient's awareness of the asymmetry of the power relationship is also seen in patient's

presentation of problems (Heath, 1992; Heritage & Clayman, 2010). Patients essentially feel the need to justify the visit or prove that they are sick enough to warrant a visit, as if it is an imposition on the doctor. Ainsworth- Vaughn also argues that patients can assert power by controlling the topics, offering possible diagnoses, and even proposing their own line of treatment, although the way that this do this is often through indirect means including hedging or suggestions of alternatives (1998). Gill, Halkowski and Roberts (2001) also point out patients' use of indirectness when proffering a candidate diagnosis or request for testing, likely in deference to doctors' perceived authority.

3.2.3. Importance of Linguistic Choices in Medical Visits

Even though the majority of the research has centered on doctors and their displays of power, these studies can inform research involving other types of providers by applying the same careful focus on individual linguistic choices. The import of questioning practices, for example, is clear in the studies discussed in the previous section. This is also true in other aspects of the medical visit. For example, a number of studies (Byrne & Long, 1976; Roter & Hall, 2006; Silverman, Kurtz & Draper, 2005) have pointed to the connection between openings and overall patient satisfaction, likely because of the tone that can be created at the outset of a medical visit. Various types of openings have been shown to lead to longer length of problem presentation on the part of the patient. Specifically, the more general the opening question and the more it may resemble "small talk" rather than "work talk" (Holmes, 2000), the more the patient is willing to talk (Heritage & Robinson, 2006).

Similarly, in an intervention study by Heritage, Robinson, Elliott, Beckett, and Wilkes (2007), they found that when doctors asked patients if they had "*some* other concerns" (a question with positive polarity) rather than "*any* other concerns," (a question with negative

polarity), patients listed more medical issues significantly more often: 90.3% when ‘some’ was used compared to 53.1% with ‘any.’ Looking beyond just whether or not patients shared more concerns, Heritage and colleagues (2007) also found that 50% of the ‘additional problems’ were rather serious, including chest pain, heartburn, neck/shoulder/back pain. This particular study illustrates quite well how seemingly minor linguistic choices on the part of the provider in the opening phase of the medical visit can have significant effects on patient health.

Studies such as those discussed in Sections 3.2.1-3.2.3, although important in providing a description of medical visits and an understanding of the general dynamics of doctor/patient interactions, should not be the end goal in themselves. Research that pushes the boundaries beyond just description to a more comprehensive analysis is necessary in order to lead to a greater understanding of the contextual factors that institutional settings present. Therefore, taking a broader approach to what is ‘context’ and what is contextually relevant requires a different data collection and methodological approach. This broader approach also offers the opportunity to provide greater insight into how participants within medical visits are orienting to the multi-layered contextual factors that exist in medical visits.

3.3. A New Way of Looking at Medical Discourse

The majority of the prior research on medical visits has taken the narrow view of ‘context’ as limited to the language itself. From this, a great deal has been learned about how medical visits are organized and how physicians (since this has been the focus) and patients orient to the asymmetrical power differential of the medical visit. Rather than taking this approach, in this dissertation, I argue that looking beyond the immediate context of what is oriented to in the discourse allows for a greater understanding of institutional settings and the roles and identities that participants enact in these settings. As van Dijk (2008) argues, discourse

is just one part of the context where participant roles and relations, interactional goals, social spheres and domains can all be included as comprising context. The importance of taking a more comprehensive view of context in institutional settings has been argued by Wodak, Krydanowski, and Forchtner (2012) in their examination of language use in European Union meetings as well as by Ainsworth-Vaughn (1998) and Sarangi and Roberts (1999) in medical visits.

Although I agree with Arminen (2006), and other CA researchers that it is impossible for a researcher to be able to access all aspects of context that participants are aware of and acting in response to, or to be able to identify what particular aspect(s) of context may be salient to participants at any given moment of interaction, I also believe it is nearsighted to not even consider aspects of context that the researcher can become aware of. Sarangi (2010) also argues for a more holistic approach to data collection that includes not only recordings of interactions but also interviews and ethnographic data. For example, in my data collection at the Veterans Affairs clinics (VA), through informal interviews with NPs, I discovered that the VA provides a list of questions/topics, generated through a computer program in which the NPs must answer through the course of the visit by typing in the answers. This information helps understand why NPs are asking similar questions at similar times in the visit- essentially it allows for an analyst to recognize when an NP goes ‘off script,’ if you will, from simply addressing the requisite questions to delving more deeply into a particular topic with a patient. Although NPs rarely reference this in the discourse (there is one example that will be discussed in Chapter 4), and patients may be unaware of this requirement on the NP’s role, NPs are certainly aware of it as it is guiding their work. Therefore, adjusting the scope of data collection to include in the analysis ethnographic and interview data as well as taking a different theoretical approach, the aim here is

not to understand how participants' discourse constructs the medical setting but how the medical setting contributes and guides the construction of participant identities within this institutional space. Put another way, the goal is not necessarily to understand the 'talk' itself but to use the 'talk,' along with other aspects of the context, to understand social roles and how individuals construct positions of self and other.

4. Theoretical Framework

Because the goals of this study on medical discourse differs from the bulk of prior research, it takes as its starting point a different set of assumptions and follows a different theoretical framework. Taking the institutional setting as a given rather than something to be discovered through discourse analysis, the focus then can shift to the construction of identities within the institutional roles of 'patient' and 'provider.' In this section, I will provide a theoretical conception of 'identity' based on prior research. I then outline the theoretical model of 'figures of personhood' which guides the analysis of the data herein. Finally, I argue that this model provides the best approach to the analysis of identity by contrasting it to the way that identity has been looked at in previous medical discourse research.

4.1. Theorizing Identity

Identity has been the subject of much sociolinguistic and anthropological research over the past twenty years. In their 2004/2005 work, Bucholtz and Hall synthesize a number of ways in which identity has been conceptualized in the research and put forth five principles that, taken together, provide an informed understanding of the complexity in both operationalizing the term 'identity' and in attempting to understand how identity is constructed through linguistic and other semiotic means. Starting with a very broad definition of identity as "the social positioning of self and other" (2005: 586), the five principles they outline are: emergence, positionality,

indexicality, relationality and partialness. Although I find their five principles informing, I find it more useful to collapse these categories down into two, more general aspects: identity as multi-faceted (positionality and partialness), or what identity is, and identity as dialogic (emergence, indexicality, relationality), or how identity is realized. Drawing on Bucholtz and Hall's categories as well as the work of other researchers, I synthesize their five principles into two main components of identity.

4.1.1. Identity as Multi-Faceted

One of the clearest ways to understand what identity is to consider the various aspects that can be included as part of one's identity, which Agha terms "inexhaustible" (2007: 234). Ochs (1993) similarly argues that social identity is "a cover term for a range of social personae, including social statuses, roles, positions, relationships, and institutional and other relevant community identities one may attempt to claim or assign in the course of social life" (188). As an attempt to tease apart what identity is, Ochs suggests that it encapsulates what one might consider part of the more static aspects of their identity, what Bucholtz and Hall refer to as "macro-level demographic categories" (2005: 592) such of race, ethnicity, gender, age, etc. Moreover, it also includes community-level understanding of these categories, that is, how one performs gender or 'motherhood', for example, has been shown to be based on cultural norms and cannot be viewed outside of that ethnographic lens (Ochs, 1992; Ochs & Schieffelin, 1984). It can also include institutionally defined roles or "cultural positions" (Bucholtz and Hall, 2005: 592) such as the roles of patient and Nurse Practitioner that are constrained, and to a certain extent defined by the institution itself. Finally, identity also encompasses more temporary, interactional identities, or what in CA research is commonly referred to as "participant roles," (Arminen, 2005; Zayts & Schnurr, 2014) which include aspects such as 'questioner,' 'listener,'

or ‘advice-giver.’ This understanding of identity as being inclusive of multiple aspects of self is an important one to make as it illustrates that at any given interactional moment, only certain aspects of one’s identity may be highlighted or oriented to in the discourse. This conceptualization of identity, then, leads to the second component of identity, which is that it is dialogic.

4.1.2. Identity as Dialogic/Discursive

Identity as dialogic should be understood in two important ways; the first relates to Bucholtz and Hall’s emergent property, the second relates to the Bahktinian notion of interdiscursivity.

First, returning to the notion of identity as multi-faceted, at any given moment we may choose to highlight different aspects of our identity through discursive “positionings” (Davies & Harre, 1990) or orientation to these aspects through stance-taking, for example. Aronsson (1996, 1998; Aronsson & Saaerlund-Larsson, 1987) refers to these processes as ‘social choreography’ likening identity construction to a dance between two conversational partners, each aiding in the identity construction of the other through alignments or disalignments. In addition, certain aspects may be highlighted through the particular social settings or context in which we are interacting. For example, the institutional setting of medical visits has the effect of foregrounding the culturally defined roles of ‘patient’ or ‘provider’ as being more salient than perhaps other aspects of identity, such as age or socio-economic status. To be clear, I am not arguing that demographic aspects of identities may not also become salient in medical settings; instead, I want to emphasize that the setting itself automatically brings to the forefront the institutional roles and the identities that are associated with these roles. Individual agency in identity construction can be seen as only playing *a* role not *the* role in how identities are constructed in

discourse. Because identity encompasses temporary positions and roles, it is only those temporary interactional moments that these aspects of our identities may ‘emerge.’ The notion that identity is “emergent” through discourse, suggests that we do not outwardly ‘wear’ all aspects of our identity as we move through our days or our lives. Instead, it is through interaction, through discourse, that our identities may shift and become defined or redefined.

A second, important part of identity as dialogic is that we are not starting *carte blanche* in our constructions of identity. To suggest that identities are fully-constructed in discourse, is to discount the role that prior discourses and understandings of the social context play in shaping our identities. This can best be understood through Bakhtin’s (1981) notion of interdiscursivity and the ways in which our discourses are connected. He describes language as “entangled, shot through with shared thoughts, points of view, alien value judgment” (276) in which it becomes impossible to remove the layers of meaning that build up or saturate individual words or strings of discourse. Blommaert describes this process as such: “Whenever we speak we produce the words of others, we constantly cite and recite expressions, and recycle meanings that are already available” (2005: 46). This concept is echoed by Gee (1999) who uses the metaphor of humans as ‘carriers’ of Discourses rather than creators of it. We can understand this to mean that using particular linguistic choices can index particular identities that are already circulating. Bucholtz and Hall, similarly, point out that the “use of linguistic structures and systems that are ideologically associated with specific personas and groups” (2005: 594) is one way in which identity can be analyzed in interaction. This alignment with specific personas and groups is what Agha (2007) refers to as “emblematic figures of identity” (237) but more commonly referred to in the literature as models/ figures of personhood, a term I find useful for understanding how identities are constructed in Nurse Practitioner-patient visits.

4.2. Figures of Personhood

The theoretical concept of figure of personhood is helpful in interpreting how identities are constructed in medical encounters as it considers both the social recognition of particular institutional roles play in identity as well as the ways in which we, as discourse participants, align with socially recognized or “enregistered emblems” which mark a particular social persona. For example, over time, discourses are used to index particular types or figures. That is, when someone speaks a certain way, it is the language that they use that allows others to say, ‘you are X kind of person.’ Davies and Harre explain this concept quite succinctly:

Participants may not be aware of their assumptions nor the power of the images to invoke particular ways of being and may simply regard their words as “the way one talks” on *this sort* (emphasis original) of occasion. But the definition of the interaction being “of this sort” and therefore one in which one speaks in this way, is to have made it into this sort of occasion (1990: 49).

This description illustrates the social recognition, even if we are somewhat explicitly unaware of where it comes from, of particular identities that may be associated with particular types of discourses, precisely because of the indexical valued connecting the discourse with a certain figure/model of personhood. As Wortham et al note, “such models circulate in discourse throughout a community, and people rely on them, in part, to make sense of themselves and others” (2011: 194). Similarly, social actors may use language in a particular way as an attempt to create an association or alignment with a particular, circulating figure of personhood, and it is through the examination of conversational participants’ alignments with these figures that cultural identities are constructed. Koven explains, “cultural identities’ emerge through participants’ recognition of, performance of, and alignments toward such recurrent figures”

(2015: 388). In the case of medical visits, what it means to be a ‘patient’ or a ‘provider’ is socially understood, much in the same way that Davies and Harre (1990) explain that individuals are aware of the social norms for talk for particular occasions. Beyond the institutional roles of ‘patient’ and provider’ though, individuals also recognize and perform recurring cultural identities of particular types of providers- the ‘caring provider’ compared to the ‘in a hurry provider’ or the ‘unfriendly provider’- or particular types of patients such as the ‘deferent patient’ or the ‘compliant patient.’ It is through the use of linguistic resources that individuals are able to enact these figures of personhood and/or recognize the figure that others are aligning with.

4.3. Identity in Medical Settings

Although a fairly unexplored topic in the medical discourse research, a number of recent studies (Rees & Monrouxe, 2010; Suoninen & Wahlstrom, 2009; Zayts and Schnurr, 2014) have examined patient and provider identities. Suoninen and Wahlstrom (2009), for example, focus on identity construction of ‘fatherhood’ in family therapy counseling. They illustrate how, over the course of six family therapy meetings, participants co-create positions and how the interactional setting allow the identity of ‘fatherhood’ to emerge. This is an important study that takes into account the role of the setting, however, unlike the present dissertation, it is less concerned with the institutional roles that participants play. Reese and Monrouxe (2010) take a different approach and focus on how both providers’ and patients’ identities as “witty, intelligent and powerful” (p. 397) are constructed through laughter or ‘laughables’ (or referents of laughter), which does consider particular types of patients and providers. Other similar studies focus on identity in illness but do so through examination of online forums (e.g. migraine sufferers: Marko, 2012) and interviews (e.g. diabetics: Connor et al., 2012; Hamilton, 2003; Saunders,

2011). The latter, which rely on researcher-led interviews with individuals with diabetes, do so from the perspective of past experience of non-compliance or ‘what went wrong and why.’ These studies provide insights into patients’ views of their role in chronic illness, but fall short in considering the identity construction within the medical visit.

One earlier study on identity comes from Aronsson (1998), who acknowledges that institutional settings partly determine the shape of discourse, however, she minimizes the role that the setting/context has and the extent to which institutionally defined roles play in how we are sanctioned or allowed access to certain discourses. In her analysis, she illustrates how a father in family therapy sessions begins ‘orchestrating’ interaction in the way that the therapist does. However, as she points out the father is only ‘allowed’ to do this – to play the part of ‘cotherapist’- if it is an accepted role that is sanctioned by other participants. Although her analysis is clear and well-grounded in explaining the father’s appropriation of the ‘therapist’ role, it does not consider the extent to which participants are limited by the institution or the ways in which participants orient to the setting as much as to each other (Arminen, 2006). For example, the only reason the father’s attempt at this interactional move is contested is because of his institutionally defined role as patient rather than therapist. Applying the framework of ‘figures of personhood’ to this data, then, would illustrate how the father is drawing on the ‘enregistered emblematic’ discourse of a therapist in an attempt to shift his position as a certain type of patient. Rather than considering his attempt at ‘orchestrating’ as a trying to take on the role of ‘cotherapist,’ I argue that he is enacting a certain kind of therapy patient through his linguistic moves. Furthermore, what may be more insightful in understanding language use in institutional contexts would be how this type of patient is either sanctioned or dismissed by the therapist, which is not discussed in the analysis.

A recent study by Zayts and Schnurr (2014) follows a similar framework as this dissertation, by examining Registered Nurses (RN) and the various identities and roles they construct in genetic counseling sessions with expectant and new mothers. They identify a number of roles that RNs take on including what they view as a more traditional role for RNs, that of information provider and counselor, which they argue fit the “professional duties” as put forth by the Hospital Authority of Hong Kong, likely the governing organization under which the RNs work. In addition to these expected roles, Zayts and Schnurr argue that the RNs in their study also construct roles of co-decision maker and cultural mediator,² roles that “go beyond [the] prescribed professional set” (2014: 351). What Zayts and Schnurr, then, seem to be arguing is that some of the ‘participant’ identities of the RNs are outside the professional role/position of nurses. I would argue that the RNs in their study are enacting what it means to be an RN in a genetic counseling session, at least in terms of how the RNs themselves view their professional role. Rather than seeing ‘cultural mediator’ and ‘co-decision maker’ as going “beyond” their professional role, these interactional positionings can be understood in terms of how RNs enact the identity of nurse. Further, taking on these participant roles may, in fact, allow the RNs to accomplish their transactional goals with patients, thereby enacting their “professional duties.”

Overall, this research represents a move in the right direction in terms of better understanding professional roles and the ways in which these roles are co-constructed in

² Zayts & Schnurr (2014) use of the term ‘role’ to mean a particular aspect of the larger construct ‘identity,’ as in the role of ‘counselor.’ I view these terms differently as I consider the institutionally defined positions of ‘provider’ and ‘patient’ as ‘roles,’ whereas interactional moves and enactments within these roles are ‘identities.’

interaction. It also illustrates how identity construction can be applied to the analysis of medical visits with various types of providers. However, by limiting their view of identity to interactional or ‘participant roles’ rather than more socially recognized ‘cultural identities,’ Zayts and Schnurr present an incomplete picture of the institutional role of the RN or how this role may be partially shaped by the specialized institutional context of genetic counseling sessions.

Utilizing Agha’s ‘figures of personhood’ as a theoretical framework for the analysis of identities in this dissertation provides a fruitful way of understanding how identities are constructed within particular frames of understanding of what it means to inhabit the space of a particular role through alignment (or disalignment) with understood, socially recognized concepts of personhood, that is, by addressing the cultural notions of what it means to be a NP. This theoretical framework, and the subsequent analysis and conclusions derived from it, is a departure from the way that identity has previously been studied in medical settings bridging the gap between discourse, institutional roles and multi-layered identity formations.

5. Discussion

As this chapter has illustrated, this dissertation brings together two distinct research traditions, namely medical discourse and identity construction. Although a few studies have focused on identity construction in medical visits, they do not consider how larger social and cultural notions of the institutional roles of ‘patient’ or ‘provider’ get enacted and reinforced in interactions.

In this dissertation, I draw on prior work on doctor-patient visits, which has carefully and thoroughly described the ways in which the analysis of talk-in-interaction reveals the institution of medical visits, to account for specific patterns of speech in the data. However, moving beyond the more commonly applied CA approach to medical discourse, and considering ‘context’ in van

Dijk's (2008) frame as inclusive of discourse as well as interactional goals, social relations, physical spaces and domains of talk, I argue that discourse in medical visits not only reveals patterns of the visit itself, but can also illustrate how talk constructs particular social identities through alignment with 'figures of personhood.'

This chapter has also provided a fairly comprehensive understanding of the role of Nurse Practitioners in medical care, addressing the educational background, occupational mission statement, if you will, as provided by the American Academy of Nurse Practitioners, and their scope of practice. NPs currently work in multiple domains of healthcare (as Table 1 shows) and across many medical specialties; however, from a sociolinguistic perspective, very little is known regarding how they construct their professional identity through discursive choices or how patients may enact what it means to be a patient in a visit with a non-physician provider.

CHAPTER 3

METHODOLOGY

1. Overview

In order to address the research questions presented in the Introduction to this dissertation, I collected audio-recordings of medical visits between Nurse Practitioners and patients. A total of five Nurse Practitioners and 48 patients participated in this project as well as ethnographic observations of each location and interviews with providers and patients, where possible. Data collection came in two phases, outlined below in terms of the two corpora collected in each phase. Data collection procedures as well as detailed information about setting, providers and visits are recorded here. Since data collection procedures were slightly different at the two locations, the description of each location and the information regarding the procedures differ slightly.

2. Data

Data for this dissertation were collected in two phases and consist of two related but different corpora. The first corpus involved one NP working in an inpatient hospital. The second phase of research was conducted at two Veterans Administration Medical Center locations and involved four NPs. The different settings (inpatient vs. outpatient) and different institutional organizations (community hospital vs. government hospital organization) provide a variety of contexts in which the NPs in this study practice. The goal of combining the two corpora for analysis is to provide a more comprehensive account of the nature of NP-patient visits and the types of identities that get constructed in these visits than what could be accomplished with either data set individually.

2.1. Corpus 1: Inpatient Hospital

The data from this phase consist of audio-recordings of inpatient medical visits involving a Nurse Practitioner (NP) working with patients with diabetes and pre- and post-visit interviews with the NP.

2.1.1. Audio-Recordings of Medical Visits

The corpus comprises medical interactions with 20 different patients, totaling approximately 284 minutes (see Table 2 for a complete listing of all interactions). The data were collected over a two-month period in 2012 at a Midwestern hospital in the United States.³ The average length of each medical visit is 15 minutes, but interactions in this corpus range from just over two minutes to approximately 45 minutes. The variation in length is somewhat typical for inpatient visits in which providers make their rounds with patients. In the case of this NP, June,⁴ she is not required to see a specified number of patients each day but prioritizes who she will visit based on a number of factors, including the blood glucose readings from the previous day, recommendations by one of the providers on her internal medicine team, and necessary follow-up visits on previous meetings with individual patients. She may see some patients multiple times in one day (although more than twice is quite rare) and may see the same patient only once or many times, depending on the length of hospitalization and the perceived need for diabetes management by June or one of the internal medicine doctors on her team. Only one visit per patient was considered for inclusion in this project.

³ The project was approved by both the Institutional Review Board (IRB) at the University of Illinois as well as the hospital's IRB. The Nurse Practitioner and the patients gave their consent to participate in the study; additionally, patients agreed to sign a Health Insurance Portability and Accountability Act (HIPAA) waiver, authorizing the researcher access to their medical information.

⁴ Pseudonym

2.1.2. NP Interviews

In addition to audio-recordings, semi-structured interviews were conducted with the NP both before and after each visit. Information regarding the NP's prior knowledge of the patient and goals for the visit was gathered during pre-visit interviews in which June would follow something analogous to a 'think aloud' protocol, verbally explaining what she was making note of while reading a patient's electronic chart and describing her 'plan' for the visit based on the information in the chart including biomedical data as well as notes from other providers. Following each visit, I asked open-ended questions focused on the NP's reflections on the 'success' of the interaction, loosely defined as reaching specific goals set out prior to the medical visit (e.g. patient education, agreement of dosage, specific needs assessment). Because of the length of time working together, these often involved me asking a very general question such as, "How do you think it went?" which would elicit a variety of responses from the NP including: what she felt like was important in the visit, how she felt the patient viewed her, how likely she felt the patient would be to follow her advice, why she decided on the particular 'tactic' in explaining certain aspects of diabetes management to the patient and/or in determining the insulin or medication dosages.

2.1.3. Participants

June, the NP in this corpus, is the diabetes specialist on an internal medicine team. Her role with patients is multi-faceted, the main task being to set or adjust insulin dosages for patients both while in the hospital as well as upon discharge. She also fulfills the role of diabetes educator by answering patients' questions, ensuring they understand what to do when they go home, and aiding in making certain that resources are available for patients, specifically in terms of access to medication, since many patients do not have insurance or the financial ability to pay

for their insulin. She sees as many patients as she can in a day based on need (i.e. blood sugar readings) including initial and follow up visits, many of which are arranged to discuss specific topics and to provide education to patients and their family members. She must balance spending as much time as needed with each patient and seeing as many people as she can. Therefore, the more time she spends with one may be taking her away from others.

A total of 20 patients consented to be involved in this study (13 females and 7 males, ages ranged from 28 to 82). Table 2 provides demographic and visit information for each patient in this corpus.

Table 2. Corpus 1: Patient/Interaction Data

| Name | Age | Gender | First or Follow-up Visit | Length of Visit |
|--------------|---------------|--------|--------------------------|-----------------|
| Ms. Anderson | 51 | Female | Follow up | 15:54 |
| Mr. Bray | 33 | Male | Follow up | 48:21 |
| Mr. Clark | 70 | Male | Follow up | 9:49 |
| Ms. Davidson | 28 | Female | First visit | 15:20 |
| Ms. Evans | # (early 50s) | Female | Follow up | 11:42 |
| Ms. Ferguson | 82 | Female | First | 6:43 |
| Ms. Grant | # (mid 40s) | Female | Met previously | 19:12 |
| Mr. Harris | 41 | Male | First | 20:09 |
| Ms. Ingles | 44 | Female | Met previously | 9:23 |
| Mr. Johnson | 76 | Male | First | 14:18 |
| Ms.Kiel | 53 | Female | Follow up | 5:36 |
| Ms.Lambert | 33 | Female | Follow up | 3:48 |

Table 2 (cont.)

| | | | | |
|-------------|---------------|--------|----------------|-------|
| Ms.Martin | 35 | Female | First | 17:45 |
| Ms.Newell | 44 | Female | Met previously | 10:43 |
| Mr. Oswald | 65 | Male | Follow up | 8:44 |
| Ms.Piper | 53 | Female | First | 33:30 |
| Ms. Reed | # (early 40s) | Female | First | 2:05 |
| Mr. Stevens | 46 | Male | First | 7:20 |
| Mr. Tucker | 34 | Male | First | 30:46 |
| Mr. Vaughn | 52 | Female | First | 16:40 |

Exact age unavailable; Number in parentheses represents the researcher's approximation

*Pseudonyms

As Table 2 indicates, 10 of the visits were the first meeting between the NP and the patient; seven were follow-up visits, meaning that the NP had previously met with the patient at least once during the current hospitalization; and three were initial visits for this hospitalization but the NP had met the patient during a previous hospitalization.

2.2. Corpus 2: VA Medical Center

The second phase of data collection involved four NPs working in outpatient primary care offices at a VA medical center.⁵ These data were collected over a two-month period in late

⁵ The project was approved by both the Institutional Review Board (IRB) at the University of Illinois as well as the VA's IRB and internal board of the Department of Research and Development. The Nurse Practitioner and the patients gave their consent to participate in the study; additionally, patients signed a Health Insurance Portability and Accountability Act (HIPAA) waiver, authorizing the researcher access to their medical information.

2014. Data for this project consisted of audio-recordings of medical visits, post-visit interviews with NPs and post-visit interviews with patients.

2.2.1. Audio-Recordings of Medical Visits

A total of 28 visits were collected with differing numbers of visits with different providers based on availability and time constraints. A full list of all visits is included in Table 3, below. The data consist of over 550 minutes (approximately nine and one half hours) of audio-recordings of medical visits; the average visit time is just over 17 minutes. Data were collected at two VA locations, both described in section 2.2.4- a suburban outpatient clinic and a cardiac clinic housed within an urban hospital (the main location of this VA medical center). Visits in the cardiac clinic are scheduled for twenty-minute time slots. Primary care visits are scheduled every 30 minutes which includes transition time between patients, including following up on updating medical records and greeting new patients, so it is not surprising that NPs spend about 20 minutes with each patient. The one exception is for patients who are new to this particular VA Medical Center (not necessarily those who are new to a particular provider), who are allotted 60 minutes per visit. There are only two of these in the data set: Mr. Rogan and Mr. Yoder.

2.2.2. Interviews with Patients

Following each recorded visit, the researcher met with the patient to ask him (in this case, all were male) a series of questions about the previous medical visit, focusing primarily on general impressions but addressing some of the areas that have been highlighted in the research.

The questions were as follows:

- 1) What was your primary reason for this visit?

- 2) Did you have other concerns that you wanted to address during this medical visit? If so, were you able to address them?
- 3) Did the NP seem knowledgeable about your particular medical problem(s)?
- 4) Did the NP answer your questions satisfactorily? If the answer is no, then please explain what the problem was.
- 5) Did you feel that the NP treated you with respect? If the answer is no, then please explain.
- 6) Did the NP explain your treatment options to you? How involved do you feel you were in deciding what treatment(s) to follow?
- 7) Would you recommend this provider to a friend or family member?

The purpose of question 1 was to compare patient understandings of what the purpose of the visit was with what was actually discussed, or the extent to which this was discussed in the visit.

Initially, I planned on also comparing the answer to this question with the NP's response to a similar question, but as discussed in Section 2.2.3, below, NP interviews did not cover aspects of specific medical visits. Question 2 draws on prior research, primarily a study by Heritage, Robinson, Elliott, Beckett, and Wilkes (2007), focusing on whether or not the patient felt encouraged in bringing up other medical concerns. Questions 3-6 are adapted from Roter and Hall's (2006) "Patient Satisfaction with Medical Care" questionnaire. Question 6 focuses particularly on the negotiation of treatment, as this is a source of much discussion in the research on medical care, in general, and an area that has previously been shown to be distinct for NPs (Seale, Anderson, and Kinnersley 2005). The final question elicited patients' overall satisfaction with their provider. The wording of this question was borrowed from the American Academy on

Communication in Healthcare's patient satisfaction survey (aachonline.org). The wording seeks to focus on satisfaction with the provider rather than the possibility of patients responding to other aspects of the visit, such as wait time, availability of other services, or satisfaction regarding the diagnosis and/or treatment. Following these seven questions, patients were asked to give their age and occupation and to share any additional information.

I chose to conduct interviews rather than using questionnaires, partly due to a lack of reliable data using the latter method in a previous project. Interviews were also selected in order to allow for elaboration or clarification (if necessary). The interviews took place immediately following each visit, in an effort to minimize any issues with memory that may come with asking questions at a later time or using a mail-in or online survey, which may be completed at any time. Most questions are worded as yes/no questions but with an opportunity for elaboration (i.e. 'Did you have other concerns that you wanted to address during this medical visit? / Were you able to address them?'). One reason for this was to minimize bias and confusion by avoiding lengthy or awkwardly worded questions or by biasing participants through leading questions (Choi & Pak, 2005).

Patients were given the right to take part in the audio-recorded medical visit but opt out of the interview if they feel this is too time consuming for them. This decision was made so as not to exclude anyone who was willing to have their medical visit recorded but did not want to stay for the interview portion. Most patients did participate in the interview: 23 in total with only five either explicitly opting out of this portion of the data collection or seemingly forgetting to return to the researcher after their medical visit. The far right column of Table 2 indicates which patients participated in the interview and which did not.

2.2.3. Interviews with Providers

In addition to patient interviews, I had planned to conduct two types of interviews with NPs. Ideally, I would have interviewed each NP following each visit or at the end of a morning or afternoon session (consisting of 3-5 patients) in the same way that patients were interviewed, in order to assess their impressions of the visit. This, however, proved to be somewhat time-consuming and intrusive for the NPs, who often had quite a bit of paperwork to do following each visit. For this reason, only a few follow-up NP interviews were conducted and, were ultimately not included in the analysis.

Each NP was interviewed at the end of the data collection process in order to collect background data. The basic questions asked are as follows:

- 1) How long have you been practicing as an NP?
- 2) How many years of education did you have in total?
- 3) How long did you work as an RN before continuing education to become an NP?
- 4) When did you start working for the VA?
- 5) Why did you choose to work in primary care?
- 6) Why did you choose to work in the VAMC?
- 7) How many patients do you typically see in a day?
- 8) What restrictions or regulations, if any, do you see as preventing or impeding on your ability to provide quality care to patients?
- 9) Where do you view the role of NPs in the medical system today?
- 10) Do you feel that your role as an NP will be different in the future?

Questions 1-7 focus on general information including years of practice as an NP (as well as years of practice as an RN prior to becoming an NP), length of employment at the VA, and reasons for choosing primary care. These questions were included to possibly account for differences in interactional practices. Questions 8-10 addressed how NPs view their role as an NP within the wider scope of the medical field. Additional questions were included on an ad hoc basis to address ethnographic observations or to clarify procedures at the VA so as to better understand the organizational constraints within which these NPs were working.

2.2.4. Setting

The research was conducted at two VA locations in the Midwest: a main hospital located in an urban setting and a community clinic located in a suburban neighborhood.

The community clinic is located in a suburban area and is stand-alone clinic composed of smaller clinics (e.g. women's health, optometry, audiology) as well as an onsite pharmacy, phlebotomy lab and radiology lab. Most of the patients that come to this clinic live in suburban areas and travel less than 30 miles for visits. Most of the patients, as reported by one NP, and supported by my observations, have private insurance and a private doctor, meaning that they see a primary care physician outside of the VA, and typically come to the VA for an annual check up only. The benefits of being in the VA system are that patients can get more affordable prescriptions (and the convenience of mailed medications without additional paperwork) and access to affordable, sometimes free, tests and immunizations. However, for many of them, the VA is not close to their home and the desire to have access to a medical provider in their home town is appealing and worth the added expense of private/employer health insurance and/or Medicare.

Nurse Practitioners who work at this clinic each have their own office that contains a computer station (with a chair next to it) and an examination table. The offices, however, are sparse and contain no personal displays of family photographs or other personal effects. NPs working in this setting wear long white coats with the VA hospital's logo, their name and title. This is the same type of coat that MDs wear, making their appearance virtually indistinguishable from the doctors, with the only exception being the title that is monogrammed on their white coats.

The main hospital is located in an urban downtown neighborhood. The downtown location provides a greater number of services and often serves a different population in terms of race/ethnicity and socio-economic status. Patients recruited at this location were in the cardiac clinic and were attending follow-up appointments to assess medication management. Each patient in this clinic had previously undergone cardiac surgery and was then required, on a regular basis (often around 3-6 months), to get blood work taken and discuss the results with the NP, who would then make medication adjustments as necessary.

In each of the locations, I spent a number of days in the clinic, meeting with patients to recruit and consent them prior to their visit with their NP and then afterward to interview them about their visit.

Providers who work at this hospital, including the NP in this study, have offices outside of the clinic area. Julie, the NP I worked with, went to the clinic within the hospital to meet with patients. Rather than having her own examination room, she selected one of many rooms based on availability. Because of this, no personal information or displays of family photos or other personal items were present in the examination rooms. Similar to the suburban clinic, NPs working in this setting also wear long white coats with similar monogramming.

2.2.5. Participants

The four NPs from this study vary in terms of the length of time practicing as an NP as well as length of time working at the VA. General information about each NP is listed below:

1. **Julie** works in the cardiac clinic at the main hospital location. She started at the VA as an RN and also worked part time in the private sector for approximately five years before getting her Master's degree in nursing (MSN) to become an NP. She has worked as an NP for 17 years, all of which have been at the VA.

Karen, Laura and Sarah all work at the community clinic in the men's health clinic (women have a separate clinic with a separate set of providers).

2. **Karen** went into an accelerated program to complete her MSN and did not practice as an RN; she has been an NP for 14 years, all at the VA.
3. **Laura** worked 13 years as an RN, including time spent as a medic in the army. She has been an NP for 18 years, all of which have been with the VA.
4. **Sarah** worked six years as RN before and during graduate school. She has been practicing as an NP for 14 years: eight years in the private sector; six years at the VA. Sarah explained to me that she prefers working in the VA because of the autonomy and the lowered demands in the number of patients that she sees in a day (more about this will be discussed in Chapter 7).

Table 2, below, outlines the details for each patient. It is organized based on the patients for each NP along with general information about each visit. Since some patients did not participate in the interview, information about age is missing for three of the patients; for others who did not participate, their age was explicitly mentioned in the medical visit with the provider.

Table 3. Corpus 2: Patient/Interaction Data

| NP | Patient Name | Age | First or repeat visit | Length of Visit | Post-visit Interview |
|-------|--------------|-----|-----------------------|-----------------|----------------------|
| Julie | Mr. Adams | 79 | first visit | 20:55 | Yes |
| Julie | Mr. Bailey | 73 | repeat visit | 14:51 | Yes |
| Julie | Mr. Carlson | 65 | repeat visit | 19:46 | Yes |
| Julie | Mr. Deaver | 67 | first visit | 17:43 | Yes |
| Julie | Mr. Ulrich | 71 | first visit | 15:21 | Yes |
| Karen | Mr. Eggers | 65 | repeat visit | 12:54 | Yes |
| Karen | Mr. Franklin | 52 | repeat visit | 20:45 | Yes |
| Karen | Mr. Griffin | 82 | repeat visit | 16:10 | Yes |
| Karen | Mr. Hough | 90 | repeat visit | 19:03 | Yes |
| Karen | Mr. Ide | 68 | repeat visit | 13:05 | Yes |
| Karen | Mr. Jones | 82 | repeat visit | 15:18 | Yes |
| Karen | Mr. Ketchum | 61 | repeat visit | 9:02 | Yes |
| Karen | Mr. Lowell | 39 | first visit | 20:47 | Yes |
| Karen | Mr. Martin | 71 | repeat visit | 16:47 | Yes |
| Karen | Mr. Newell | 58 | repeat visit | 7:15 | Yes |
| Laura | Mr. Vaughn | ? | repeat visit | 25:51 | No |
| Laura | Mr. Barnes | 46 | repeat visit | 11:01 | Yes |
| Laura | Mr. Caldwell | 75 | repeat visit | 24:45 | No |
| Laura | Mr. Davis | 71 | repeat visit | 18:47 | Yes |

Table 3 (cont.)

| | | | | | |
|-------|---------------|----|--------------|-------|-----|
| Sarah | Mr. Odell | 78 | repeat visit | 20:36 | Yes |
| Sarah | Mr. Price | 61 | first visit | 21:59 | Yes |
| Sarah | Mr. Quinn | 86 | first visit | 16:23 | Yes |
| Sarah | Mr. Rogan | 66 | first visit | 46:18 | Yes |
| Sarah | Mr. Stevenson | ? | repeat visit | 8:52 | No |
| Sarah | Mr. Thompson | ? | repeat visit | 23:53 | No |
| Sarah | Mr. Wells | 79 | repeat visit | 11:50 | Yes |
| Sarah | Mr. Yoder | 28 | first visit | 35:17 | No |
| Sarah | Mr. Zellner | 53 | repeat visit | 19:43 | Yes |
| Sarah | Mr. Abernathy | 53 | repeat visit | 27:31 | Yes |

2.3. Choice of Audio over Video

For both phases, I used a small audio-recorder to record the visits between participating NPs and patients and in all interviews. The choice of audio over video recording was done in an attempt at minimizing possible feelings of intrusion on the part of the participants. This is a somewhat controversial decision since the advantages of video recordings are that they can include important interactional features such as physical orientation and gaze. However, I believe that the use of a video camera has the potential to make participants much more conscious of the fact that they are being recorded; while the presence of a small audio recorder in the room may be more easily forgotten, thus minimizing the effects of the ‘observer’s paradox’ (Labov, 1972). Video also raises the concern of maintaining participant’s confidentiality and anonymity (Sarangi, 2010). As the researcher, I was present during the inpatient visits and attempted to

position myself outside of the gaze of the patient and the NP so as to minimize my presence. During the outpatient visits, I was not present, primarily due to the small space of the inpatient provider's office. I felt that my presence would have been noticeable and could have increased discomfort, particularly on the part of patients, which would lessen the chances of collecting naturally-occurring data.

3. Transcription and Categorization of Data

Following data collection, each visit and interview was transcribed, following CA-style transcription conventions as outlined by Gail Jefferson (cited in Atkinson & Heritage, 2006) with conventions for length and placement of pauses, simultaneous and overlapping speech, and prosodic features such as stress and intonation included in the transcript (see Appendix for a full list of conventions used). The transcriptions follow what Ochs (2006) refers to as a 'modified orthography,' which shows the ways in which words are pronounced rather than their actual spelling. This includes spellings such as 'lemme' or 'gonna' when they are pronounced this way rather than 'let me' or 'going to.'). All identifying information was changed, including pseudonyms for participants, other medical providers referenced in the interactions and names of cities, hospitals, and other identifying locations in order to maintain the anonymity of participants.

Data were then categorized based on features discussed in prior research on medical visits (c.f Heritage & Clayman, 2010). This includes aspects that have traditionally been examined in medical interactions, including:

- Talk time by both participants: quantified in terms of number of words spoken rather than turns or lines since turn length as well as line length can vary greatly

- Use and type of questions: identified by type, including a) open-ended questions/Wh-questions; b) Y/N questions; c) and tag questions. Rhetorical questions were categorized separately because of their different meta-function (Sarangi, 2010)
- Topic shifts: identified as both shifts away from and back to the medical focus or instrumental task (Maynard & Hudak, 2008) as well as shifts from one medical topic to a new medical topic

Additionally, based on previous work on NP-patient visits (Defibaugh, 2014a, 2014c), I also identified the following linguistic features:

- Pronoun choice: focused primarily on the use of first person singular and plural (including both inclusive and exclusive uses) pronouns
- Indirect speech: distinguished based on participant (i.e. patient indirectness vs. provider indirectness) as well as meta-function such as offering a candidate diagnosis (Gill, Halowski & Roberts, 2001) or providing a medical directive
- Semantic roles: primarily focused on agent, patient, recipient, experiencer as a way in which patients position themselves in relation to their illness and/or role in treatment

4. Data Analysis and Excerpt Selection

Data were analyzed in the tradition of ethnographic and discourse analytic accounts of medical visits (Ainsworth Vaughn, 1998; Sarangi & Roberts, 1999) with the particular theoretical framework of ‘figures of personhood’ as described in Chapter 2. Although perhaps less systematic than a turn-by-turn account of discourse that can provide a description of focal themes and organizational structure (Sarangi, 2010) as is typical for conversation analysts, the process of analyzing data was more in line with the process Whitehead (2006) describes in her analysis of narratives as involving “reading and immersion, identification of stories,

identification of topics, summarizing stories and sequences, constructing a representation of the narrative” (2006: 2240). First, ‘figures of personhood’ were identified based on a number of factors. For providers, the figure of the ‘caring and competent provider’ aligns with the patient-centered model of healthcare and what is commonly recognized in the literature as a ‘good provider’- one who has both technical as well as interpersonal skills (see Ong et al., 1995 for a summary of the literature). Linguistic features that seemed to align providers with one or the other of these two aspects (‘caring’ vs. ‘competent’) were categorized as such. To some extent these categories of ‘caring’ and ‘competent’ align with linguistic features associated with solidarity and power, respectively; however, these linguistics features were not taken as predetermined ways of constructing a particular identity but provided a starting point for examination of alignment with particular figures and the construction of the NPs’ professional identity.

Examples from each medical visit were then identified in both individual transcripts as well as catalogued in a Microsoft Excel spreadsheet. Identification of patient identities was a more complex process since there is little research to build on in terms of the kinds of patient identities that exist. Instead, patient identities were identified based on three general factors: 1) emic categories referenced by NPs in the interviews (i.e. ‘he is the full of excuses kind of patient’); 2) identities sanctioned by NPs in the visits (i.e. what it means to be the ‘good patient’); or 3) recurrent patterns of discourse and other actions by patients identified by the researcher. Similarly, each medical visit was then analyzed in terms of what linguistic features aligned the patient with one or more of these identities.

4.1. Selection of Excerpts

One of the difficulties discourse analysts face is in deciding which excerpts to include and how much of a given interaction is necessary to provide for the reader. Excerpts were selected based on a number of factors. The first is that they exemplified the linguistic behavior under analysis in some way, meaning that they provided the clearest examples of the ways in which identities were constructed. Similarly, excerpts were selected to illustrate patterns across the five NPs in this study in order to accurately represent the similarities across providers. Finally, in deciding how much of a particular interaction to include, I followed Sarangi's advice which is to give as much data as is necessary to "provide ease for cross-referencing vis-à-vis analytic commentaries" (Sarangi, 2010: 400). What this means is that excerpts should encapsulate all features discussed in the analysis and all interactional turns that are necessary to understand the analysis. In many cases, this meant including one or two turns (occasionally more) prior to the start of the analysis in order to situate the object of analysis within the interactional context. Similarly, in most cases, intervening lines of discourse that do not necessarily contribute to the analysis were left in order to minimize distortion of the interaction and for transparency in the analytic process. There are some exceptions, of course, when the purpose was to illustrate a particular pattern throughout an interaction. One example of this is in the analysis of 'inclusive we' in Chapter 4 in which excerpts from the entire visit were included. In this case, it would be impossible and unnecessary to include the entire transcript; so, small segments taken from different places in the transcript were used. Line numbering was maintained so that the reader can see the place in the transcript where each excerpt was taken.

5. Discussion

This chapter has provided an overview of the data collection and methodologies utilized to address the research questions presented in Chapter 1. Overall, the data collection process was designed to provide an informative and comprehensive account of Nurse Practitioner-patient visits. Although only five NPs in total were recruited for this study, they represent three different types of visits. Data from visits with June provide the perspective of an NP working in a hospital with patients who have a chronic disease, diabetes. Visits involving Julie also focus on chronic illness, heart disease, in this case, but represent patients who are fairly healthy compared to those who have been hospitalized. Finally, data from visits with Karen, Sarah and Laura are primarily concerned with routine, preventative health. Additionally, the combination of audio-recordings, interviews and ethnographic observations aids in providing an understanding of the larger context in which these medical visits take place. Each of these aspects will be discussed, where relevant, in the following four analysis chapters. Finally, the data analysis procedure and selection of excerpts hopefully provide a fairly objective presentation of the identity constructions of NPs and patients in medical visits.

CHAPTER 4

ALIGNMENT WITH THE ‘CARING PROVIDER’ IDENTITY

1. Introduction

As outlined in the introduction, an important component of the patient-centered approach, and what distinguishes it from the provider-centered approach, is the focus on the whole patient and the patient as an individually unique person with social and environmental influences that may affect their overall health and their ability to adhere to treatment recommendations. Nurse Practitioners, then, can construct their identity as a ‘caring provider’ by placing a certain amount of emphasis on the social aspects of the visit: developing long-term, patient-provider relationships, taking a holistic view of the patient, allowing for negotiation of treatment and disease management, and balancing these goals with the instrumental goals of the visit. Spencer-Oatey (2002, 2005) refers to the focus on interactional goals (as opposed to instrumental goals) as rapport-management, which can take the form of rapport enhancing (i.e. building), rapport maintaining (i.e. keeping the status quo), rapport neglect (i.e. indifferent or lack of concern) and rapport challenge (i.e. purposeful disregard). In their analysis of doctor-patient communication research, Ong, DeHaes, Hoos and Lammes (1995) outline the three key goals of medical visits as: creating a good interpersonal relationship, exchanging information, and making treatment-related decisions. The need for creating a strong provider-patient relationship, for them, goes beyond the patient-centered approach but certainly can be viewed as a primary component of it. They outline a number of ways in which a ‘good’ relationship can be defined including having “good manners,” “laughing or making jokes, making personal remarks, giving the patient compliments, conveying interest, friendliness, honesty, a desire to help, devotion, a non-

judgmental attitude and a social orientation” (1995: 904), each of which could be considered part of the ‘caring provider’ identity.

Although the construction of the ‘caring provider’ may be accomplished through a number of different linguistic and para-linguistic means, for the purpose of this dissertation, I will focus on three main aspects, all of which have the potential of lowering social distance by enhancing or maintaining rapport. The first is the ways in which NPs engage in small talk with patients. Small talk can be seen as one way in which providers are able to build long-term relationships with patients through a focus on interpersonal rather than instrumental goals (Section 2). Secondly, through the use of the first person plural pronoun ‘we,’ NPs are able to create a sense of shared connection and shared responsibility for the patients’ health, which can also be seen as a way of encouraging long-term relationships and a level of “devotion” to use Ong, et al.’s (1995) term and social orientation toward a common good. This is discussed in Section 3. Finally, as outlined in Section 4, the ways in which medical directives are presented to patients through indirect speech can be seen as performing two main functions: 1) allowing for patient negotiation and input and 2) avoiding placing too much imposition on patients, thereby, creating rapport with patients, which can also contribute to improved provider-patient relationships. Although each of these aspects can (and will) be analyzed in terms of how they create a particular interactional environment for the patient, they also, reflexively, aid in the construction of a particular identity for the Nurse Practitioners - that of the ‘caring provider.’

2. ‘Small Talk’ as Rapport Management

One way in which NPs align with the ‘caring provider’ is through the use of small talk. In this section, I first provide a working definition of small talk based on prior literature. I also describe the specific type of small talk that I include for analysis, what Hudak and Maynard

(2000) refer to as TST, or topicalized small talk. Note that I am not making a theoretical argument by including only TST examples, but, as I argue, focusing on this type of small talk illustrates the ways in which NPs prioritize rapport and relationship building. I then offer two extended examples that illustrate this argument.

2.1. Operationalizing Small Talk

Perhaps the earliest analysis of small talk comes from Malinowski's discussion of 'phatic communion' which he defines as "a type of speech in which ties of union are created by a mere exchange of words," the primary function of which is social rather than informational (1923, reproduced in Coupland and Jaworski, 2006: 297). Malinowski includes such topics as "inquiries about health, comments on weather, affirmations of some supremely obvious state of things" (296) as purely relational talk. More recent work on small talk, most prominently and thoroughly presented, is Justine Coupland's (2000) edited volume entitled simply, *Small Talk*. In the introduction, Coupland points out that it is often difficult to neatly separate small talk from other types of talk, particularly in service encounters (medical visits included) because these types of talk can bleed into one another. From a researcher's perspective, it may be difficult to determine when work talk transitions to small talk or vice versa. Additionally, as Coupland argues, in medical encounters, "Talk about social circumstances and family connections may trigger discussion of environmental matters which could be relevant to the clinic's and the doctor's professional responsibilities" (2000: 22). Therefore, identifying clear, unambiguous examples of small talk can be somewhat complex, particularly if one were to attempt to quantify either instances of small talk or amount of time spent on small talk topics. Consider the following exchange from my own data:

Excerpt 4-1: NP Karen & Mr. Eggers

1. NP: let me examine you
2. PT: I'm ## well I've cut back a little bit but I'm in the gym everyday
3. NP: oh you do you exercise everyday
4. PT: yeah
5. NP: excellent for how many minutes
6. PT: well about forty five minutes for the whole workout
7. NP: good where do you go
8. PT: I got to the Bartlett civic center
9. NP: oh nice
10. PT: where it costs me forty dollars a year
11. NP: forty dollars a year that's excellent
12. PT: hhh yeah
13. NP: good for you cuz
14. PT: and then you know in the summer time I ####
15. NP: yeah but the more you exercise the better you'll feel all the way around in so many
16. different aspects
17. PT: well its like I go in and I do six miles on the stationary bike and then in the summer
18. I'll do another ten twelve on my own bike hhhhh
19. NP: oh yeah that's excellent good good good

When the patient introduces the topic of his exercise routine, should this be considered small talk that is completely separate from the instrumental goals of the medical visit? Many of the details

defined boundaries between different types of talk and more accurately represents how talk functions. This does not necessarily remove the difficulty of determining the extent to which talk can unambiguously be considered small talk, but it does alleviate the problem of trying to fit excerpts into neatly separable categories. Returning to the example discussed above, I would argue that it fits somewhere between ‘work related talk’ and ‘social talk’ because it contains features associated with each. Although examples such as this are frequent in the two corpora, for this dissertation, I focus only on examples that are unrelated to the instrumental tasks and fit more clearly and unambiguously on the right side of the continuum.

2.1.1. Small Talk in Medical Encounters

Small talk in medical settings has received some attention, primarily in the work of Douglas Maynard and Pamela Hudak and work by Sandra Ragan. Maynard and Hudak (2008) define small talk as sequences of talk not related or “not necessary to the instrumental task” (2008: 663). In these definitions, they view small talk as talk that is not related to the purpose or focus of the medical visit. This definition is certainly helpful from an analytic perspective in that one can easily identify small talk by content that is not ‘work-related; however, as the example above illustrates, in practice it may be much more difficult to tease apart what a provider is doing when engaging in ‘small talk’ that may be connected in some way to the patient’s overall health, while not directly related to the purpose of the visit. In their 2011 work, however, they refine this definition (in my view) by labeling it as “concrete sequences forming pro-social actions of one kind or another that move away from instrumental tasks” (Hudak & Maynard, 2011: 637), where ‘moving away from’ recognizes the fluid categories as Holmes (2000) presents them. This definition also allows for what they refer to as ‘co-topical’ instances of small talk in which the topic may be related tangentially to medical care or even to the focus of the visit, but that there is

a shift in framing from the instrumental to the social.

Ragan (2000) also employs a framing model (although she does not use this term) to define small talk in her data set of female providers interacting with female patients. She, however, does not see small talk, or what she terms ‘sociable talk’ as a departure from work talk but as an essential aspect of it:

Sociable talk, i.e. relational communication between provider and patient is tantamount to the task, in that the ‘task’ of these health-care interactions is not merely to interview, examine, diagnose and treat/proscribe; it is also to co-create a relational climate that facilitates these critical medical achievements. (269)

Similar to Ragan (2000), I argue, in this chapter, that small talk, even when the topic is unrelated to the instrumental tasks of the medical visit, contributes to the patients’ overall health, primarily by creating a stronger patient-provider relationship.

2.1.2. Types and Functions of Small Talk

As mentioned above, Ragan argues that the function of ‘sociable talk’ is not separable from the function of other types of talk in that all talk within the medical visits she analyzed contributes to achievement of medical goals. This certainly seems to be the case in Ragan’s data in which providers share personal stories of their own medical care including personal use of medications as a way to provide advice for the patient.

Maynard and Hudak (2008) define small talk as primarily a way to ‘disattend,’ or use small talk “to push instrumental tasks of various kinds to the background” (662) of the medical visit. They identify two ways in which small talk can ‘disattend’ to the instrumental tasks. The first is ‘disattentiveness-in-simultaneity,’ or instances of small talk that co-occur but not necessarily align with instrumental tasks, including small talk that occurs while a provider is

looking through at patient's chart at the beginning of the visit, or during transitional phases of the visit when both participants are not just interactionally but also physically re-aligning to the next phase or task, often through movement from the desk to examination table or vice versa. The second type Maynard and Hudak describe is 'disattentiveness-in-sequence,' or the ways in which both patient and provider may use small talk as a tool to shift the talk away from the instrumental task, described particularly as a topic-avoidance strategy. Although quite informative in its attention to the possible functions of small talk within this particular institutional setting, this article provides little understanding of the variety of small talk in terms topics. Also, unlike Ragan (2000), the authors present small talk as functioning separately from, rather than contributing to, the instrumental or interactional aspects of the visit, a limiting view of the function and import of small talk when looked at through the lens of identity construction as this dissertation does.

In a more recent article, Hudak and Maynard (2011) attempt a taxonomy of small talk as it occurs in medical visits between doctors and patients. They distinguish types of small talk based on two dimensions: topic and length. First, on the dimension of topic, Hudak and Maynard separate what they term TST: or 'topicalized small talk' from 'co-topical' small talk. Topicalized small talk is talk that is not related to the topic of the visit or to either participant's institutional identity as doctor or patient. This could be categorized on the far right side of Holmes' (2000) continuum. Co-topical small talk, while related in topic to the medical visit, is a departure from the instrumental tasks associated with the visit. The other dimension of small talk is determined by length. While TST may extend over a number of turns, and requires, by definition co-construction by both participants, 'minimal small talk' can be understood as attempts at small talk that are not taken up by the other participant, and 'brief small talk,' which is taken up but

quickly (defined as within 6 turns) shifted back to work talk.

Although all three of these studies, taken together, provide a somewhat comprehensive account of the form and function that small talk can take in medical visits, alone none of them seem to be able to account for the full range of small talk that occurs in my data. For example, although Hudak and Maynard's classification of small talk is helpful in categorizing the occurrences in the NP-patient visits that I analyzed, it does not seem to account for either the social or instrumental work that small talk can accomplish nor the ways that it can index a particular identity or type of provider. Ragan's (2000) study, on the other hand, illustrates how small talk can, through the topic choice, do the work of the instrumental tasks; it does not address small talk that may fall outside of the 'co-topical' category, as the two examples below do.

2.2. Small Talk as Identity Work

In this section, I present two examples of small talk that are both TST, that is, not related to the instrumental tasks, yet still seem to perform a function beyond direct accomplishment of such tasks. The following two examples of small talk occur at the end of each visit. Maynard and Hudak (2008) report finding a number of examples of small talk occurring during the closing of the visit, but they do not analyze these "in favor of illustrating how it (small talk) co-occurs with such activities as moving from one phase to another and with potentially competitive instrumental actions" (648). This suggests that small talk, particularly of the type analyzed here, is not necessarily unique to NPs- it is likely that all providers engage in the kind of small talk discussed in these examples- however, since it has not been the focus of research, little is known about how it can accomplish identity work in this particular form. The two excerpts here differ both in the relationship between the NP and patient (i.e. whether it is an initial or repeat visit)

and who initiates the small talk. Table 4 provides information about each of these examples, highlighting both similarities and differences.

Table 4. Small Talk Examples

| Excerpt | Patient | NP | 1 st or repeat visit | Topic | Length of exchange | Who initiates? |
|---------|--------------------------|-------|---------------------------------|---------------------------------------|--------------------|----------------|
| 4-2 | Mr. Quinn (with wife) | Sarah | 1 st visit | Lunch plans/ Thanksgiving shopping | 00:58 | NP |
| 4-3 | Mr. Bailey | Julie | 3 rd visit | Cats/ raccoons | 3:06 | PT |

2.3. Constructing the ‘Caring’ Identity for the Institution

Excerpt 4-2 occurs at the end of the visit between Sarah, Mr. Quinn and his wife, Mrs. Quinn. This is the first meeting between the Quinns and Sarah. It is also important to note that Mr. Quinn will not be a regular patient for Sarah. Mr. Quinn’s previous provider recently left the VA and the new provider had not started seeing patients yet. Therefore, this can be seen as a ‘one-off’ visit for Sarah.

Excerpt 4-2 Mr. Quinn, Mrs. Quinn & Sarah

Note: Mrs. Quinn marked as MS

1. NP: so whatever happened when Sherry left you didn’t get your ↑recall and [it was just a
2. PT: [yeah
3. NP: mess, so

27. cooking but I'm I already got the sweet potatoes I'm gonna make [them
28. NP: [hhhh
29. MS: and I'mna make up the pies tomorrow I >already got it all< so (.) no: don't have to
30. go to the store no more
31. NP: I know all [right well thank you so much I'll show you a shortcut if you don't
32. MS: [It's terrible
33. NP: have to go anywhere else

In line 5, Sarah initiates what appears to be a closing through her use of a pre-closing marker “okay” with an elongated vowel and falling intonation followed by ‘all right,’ also recognized as a pre-closing, signaling a shift from the previous topic to the ‘terminal exchange’ (Schegloff & Sacks, 1973). This is fully realized when she wishes the Quinns a ‘wonderful Thanksgiving.’ For their part, the Quinns seem to recognize Sarah’s move to end the visit by responding briefly to her in lines 7-8. However, rather than moving to the closing, Sarah again offers a sort of pre-closing with her directive for Mr. Quinn to take his wife to lunch. Although she is introducing a new topic, she does not seem to be inviting a discussion, which would be more salient had she asked about their lunch plans rather than presenting it as a directive. This move, in itself, can be seen as a kind of rapport building strategy, referencing a joke made by Mr. Quinn earlier in the visit about his wife being his secretary. Similar to the previous exchange, Mr. and Mrs. Quinn both respond minimally to Sarah’s ‘directive.’ Once again, in line 14, Sarah has the floor and the opportunity to end the visit, but again introduces a topic and initiates a more extended small talk exchange, primarily between Mrs. Quinn and herself. As Holmes (2000) points out, it is typically the person in the higher position of power or authority in asymmetrical

interactions who has the “deciding voice in licensing” small talk (52). Sarah, in this situation, has the authority to decide 1) whether or not to initiate small talk in the first place and 2) how long it will go on. There are multiple places in this exchange in which Sarah could offer another pre-closing and “shut down” (Schegloff & Sacks, 1973) the topic including lines 9 and 14 (discussed previously) and lines 20 and 25 in which Sarah continues to share more of her recent grocery store experience. In these moves, she invites participation from both Mr. and Mrs. Quinn and extends the medical visit with a topic that is not relevant to the instrumental goals of the visit.

This type of small talk would be classified by Hudak & Maynard (2011) as a TST (topicalized small talk) in that it is not related to the instrumental tasks of the medical visit. It cannot even be interpreted as accomplishing medical tasks, as Ragan’s (2000) data illustrate, because of the irrelevance of the topic to the patient’s health. However, it would be incomplete and inaccurate to argue that this exchange does not have some function in the visit. I argue that Sarah’s engagement in small talk aids in her construction of the ‘caring provider,’ however, not necessarily in terms of caring for the patient’s health. Instead, it constructs a particular type of person, namely a provider who acknowledges the patient (and in this case, the patient’s spouse) as an individual who is not defined by his/her institutional role alone. Sarah aligns with the ‘caring provider’ by relating to Mr. and Mrs. Quinn on a more personal level.

West (2006) argues that closings are a significant aspect of medical visits as they allow providers to “produce a continuity of care in their primary care visits” (411). This argument is mainly based on Button’s (1991, cited in West 2006) claim that closings can create a sense of an ongoing relationship, essentially framing each individual visit as one in a series of interactions that together define the provider-patient relationship. Tracy and Naughton (2000), in an analysis of small talk also point out the significance of ‘endings’ in maintaining relationships. Viewed

within this analysis, the small talk at the closing of this visit could also be seen as contributing to an ongoing relationship; however, the relationship is not with Sarah, per se, but with the particular VA clinic where the interaction takes place. Mr. Quinn's primary care provider, another NP at this clinic, previously left the VA, causing the clinic to reschedule Mr. Quinn's appointment for a later date and with a different NP. Sarah, in fulfilling her responsibilities as a provider at this clinic, is seeing Mr. Quinn for this visit but explains to him early on that he has been assigned to the newest NP, who had not begun seeing patients yet. Therefore, Sarah's engagement with the Quinns at the end of this visit can be understood as constructing an identity for the institution rather than solely for herself. Constructing a particular institutional identity is often congruent with individual identity work in institutional settings (Tracy and Naughton 2000) and is just as important in creating and maintaining relationships.

2.4. Creating Rather than Reflecting the Patient-Provider Relationship

The next example of small talk similarly occurs at the end of visit. Unlike the previous example, the NP, Julie, and patient, Mr. Bailey, know each other; this is their third meeting as part of a regular follow-up and medication check from a previous heart attack and will likely be one of many future visits as well.

Excerpt 4-3 NP Julie & Mr. Bailey

1. NP: okay good good (1.0) um (.) all right let's head up ↑there [and
2. PT: [you got any cats up at your
3. hou- hhh
4. NP: I have three why do you ask
5. PT: I got 'em all over the place

6. NP: ↑do you
7. PT: I got a little they're newborn (.) [what is he about four months boy is he ever a sweet
8. NP: [ah:::
9. PT: he's dark gray and he's got white feet in the front and white legs in the back and is he
10. ever and ↑intelligent is he ever a nice cat ya know=
11. NP: =they're impressive aren't they?
12. PT: ohh [I can't believe they got different personalities [too
13. NP: [YES [they sure do
14. NP: I have two boy cats that I've had for about (.) ah (0.5) ten twelve years (.)
15. PT: yeah
16. NP: and a black kitten female [followed my daughter home, (.) [from the park
17. PT: [yeah [eh so you had a kit-
18. NP: and she stuck ↑around (.) you know the other two tried to scare her ↑off and she just
19. we have a dog too
20. PT: yeah
21. NP: she kept comin' back (.) she stuck around and so we: (.) adopted her and I took her
22. to anti-cruelty to get her [↑neutered (.) only to find out that she was already neutered,
23. PT: [yeah
24. yeah?
25. NP: but she has no chip so we don't know if an ↑agency did that and just left her (.) but
26. she's claimed our house [her house
27. PT: [I had a little girl cat (.) that one I think that little gray one's
28. a male he's a short hair but he's got ya know

29. NP: uh huh
30. PT: is he ever nice he purrs when he sits on you [hhh ya know
31. NP: [YES aren't they they're wonderful
32. aren't they?
33. PT: yeah (1.0)
34. NP: so how ↑many do you have, (2.5)
35. PT: I hate to say it I got about seven of ['em over there
36. NP: [no kiddin' (.) do you keep 'em inside
37. PT: they're in the basement ya know [I got a basement in the house
38. NP: [that's nice
39. well its [cold do they go outside (0.5)
40. PT: [yeah
41. they'll jump (.) I'll let 'em out sometimes [but they'll come back=
42. NP: [yeah =mine too mine too
43. PT: I had the basement window open so they could come in and out? (2.0) then I got a
44. raccoon in the house,
45. NP: now how can that happen when you got two cats
46. PT: I got railroad tracks down the street
47. NP: oh:::
48. PT: I went down the furnace stuck the blower was stuck on [so I had to go down there
49. NP: [yeah
50. PT: and man- manually twist and I'm down there I had a big bag of snickers bite ↑size
51. and they were gone one morning and I said 'where did them snickers' they can't-

52. there wasn't nothin' ripped open or nothing the whole bag it wasn't open yet ya
53. know
54. NP: yeah
55. PT: the big bag the whole bag I'm lookin' and lookin' and I said 'who got the ↑snickers'
56. you know had to be the ↑raccoon ya know cuz when I was sittin' in the basement by
57. the furnace
58. NP: yeah
59. PT: I seen him jump up on the laundry tub at the window right there to get ↑out [ya know
60. NP: [yeah yeah
61. PT: it was him you know
62. NP: so what did you do so he wouldn't come back
63. PT: I I started closing the top door cuz I still wanted the cats to get in downstairs
64. NP: oh:: got it (.) [so he followed the cats comin' in
65. PT: [so he couldn't
66. PT: yeah he must've=
67. NP: =holy cow we had a raccoon come in our house [about three years ago
68. PT: [yeah
69. NP: through our ↑ceiling fan in my daughter's [room,
70. PT: [yeah
71. NP: and the cats were hissing at it (1.0) so my husband let the let the window open and
72. he's like 'what should I do let the window open?' I'm like 'well either >his friends
73. are going to come in or he's going to go out< [I don't know but shut the door' so we
74. PT: [yeah I don't know I didn't see no

75. NP: left the door open
76. PT: fight or nothin' I didn't hear no fightin'
77. NP: wow yeah (.) [city limit huh
78. PT: [there was a possum years ago (.) yeah I got railroad tracks a block I'm
79. by DuPont if you know where that area is over there
80. NP: yeah::
81. PT: 86th and Lincoln?
82. NP: yeah
83. PT: and the uh Bay Bridge is over there but I think they ride in on the trains or how
84. they get there
85. NP: hhh they're lookin' for some place where they can get some food [and some warmth
86. PT: [yeah I don't wanna
87. set set up camp though
88. NP: yeah I know
89. PT: all over the place
90. NP: isn't that somethin', (.) all right let's go get your ah appointment and then you can
91. get the bus before the students

This excerpt starts with Julie initiating the closing, marked by the pre-closing markers of 'okay' and the stated plan of action 'let's go up.' In this example, the patient, Mr. Bailey, is the one to initiate small talk by interrupting Julie and asking her if she has cats (line 2). This topic is quite surprising as no previous discussion of pets occurred in the visit nor is there any visual indication (i.e. desk photos, lapel pins, etc) that Julie does, in fact, have pets; this is confirmed by her

surprised reaction to this question ('why do you ask?'). Similar to the previous example, there are many opportunities at various points where Julie could have easily ended the non-relevant discussion of cats, but instead she engages in this topic through encouragement of Mr. Bailey to share his experiences as well as initiating turns that focus on her similar experiences. The first of these opportunities occurs in line 6, following Mr. Bailey's claim that he has cats 'all over the place.' Julie's question, marked with an initial rising intonation aligns with Mr. Bailey, encouraging him to continue and share more about his cats. A few lines later, in line 13, Julie again has an opportunity to shift away from this topic and back to the instrumental task of closing the visit, but instead she chooses to continue with this small talk topic by describing her pets in lines 14-26. Even within this extended description of how she came to acquire one of her cats, she, as the person in the higher position of power, could initiate a closing once again at each turn. Instead, she continues to share more of her experiences. This is clearly a topic she is excited about and one that highlights her identity outside of her institutional role of provider, which is brought out by the patient sharing a similar aspect of his non-patient identity.

Lines 32 and 34, marked by either a pause following Mr. Bailey's turn or an utterance internal pause, also seem to be clear opportunities for Julie to change the topic, but instead she asks more questions of Mr. Bailey. From lines 37-66 Mr. Bailey describes an event in which a raccoon got into his house. Here Julie aligns with this story through minimal responses (lines 42, 47, 49, 54, 58, 60) and questions (lines 45 and 62), allowing Mr. Bailey to hold the floor for an extended period of time. She also shows affiliation with him in line 42 with her response of 'mine too mine too,' essentially highlighting similarities between his experiences and her own. This affiliation is further solidified when she shares her own, similar story of a raccoon getting into her house (lines 67-75).

Similar to the previous example, although much more elaborate and lengthy, small talk in this excerpt constructs an identity for the NP and the patient that is separate and distinct from their institutional identities. By engaging and encouraging this topic, Julie is able to lower the social distance between her and Mr. Bailey by highlighting similar experiences of 1) owning multiple cats and 2) having raccoons get into their homes. Through this, she constructs an identity of herself as a ‘caring provider.’ What may be most interesting about this particular example is that it does not, in fact, reveal a prior relationship or connection between Julie and Mr. Bailey; instead, it seems to have the effect of creating one. Prior to this visit, as we were going through the patient list, discussing which ones she knew and which she was meeting for the first time, she mentioned that she didn’t really like meeting with this patient because of his poor hygiene. Through the extended small talk, Julie was able to find a way to connect with Mr. Bailey, likely creating a connection for future visits, along the lines of West’s (2006) argument. Although I cannot confirm that this topic was taken up in future visits or that it had a significant effect on how Julie was able to provide care for Mr. Bailey, this exchange clearly was salient to her, confirmed by the fact that she mentioned it in the post-visit interview as well as when I met with her weeks later for additional data collection.

2.5. Interim Discussion

Small talk is fairly frequent overall in the visits I examined, particularly when analyzed in terms of the many forms that small talk can take (Hudak & Maynard, 2011). There is, however, great variation in terms of who initiates small talk, when it gets taken up, and what types of topics are taken-up. It is also worth noting that all NPs in this study engage in small talk to some extent but some seem to prioritize it more than others. Julie, for example, engages in small talk with every patient, although this type of extended departure from the instrumental tasks in the

example presented in section 2.4, as well as the position of small talk during the closing is marked. The examples here are not meant to provide a comprehensive account or be fully representative of the type of small talk that occurs; instead they are intended to illustrate that small talk does a great deal of identity work. The examples included here cannot be seen as entirely, or even primarily, distantending as they both occur at the close of the visit after a pre-closing. In both, the small talk seems to be a brief departure from the closing. Similarly, because the topics are not related to prior discourse or relevant to the patient's health, they are distinct from the kinds of small talk that Ragan (2000) outlines, which, similarly create affiliation between provider and patient, but do so within the instrumental frame of the visit.

3. Pronouns of Solidarity

Pronouns are an additional way that NPs can construct the 'competent provider' identity. Silverstein (1976) argues that pronouns belong to a larger category of deictics that he refers to as 'shifters,' because the referent that a pronoun selects shifts depending on a particular context. In its simplest understanding, pronouns and deictics *only* carry referential meaning when used within a particular context. Therefore, the use of shifters like pronouns can help define the context, and as Wortham (1996) notes, can index speakers' footing. Pronouns can index multiple levels of meaning as well. Brown and Gilman (1960) illustrate that for languages that have a T/V distinction, the use of T (informal), which prototypically is understood as indexing solidarity, can also index power. For instance, in asymmetrical settings the use of T by one and V by the other interlocutor can index a higher positioning of power by one participant. This illustrates the ways that pronouns can signal affiliation or disaffiliation but must be analyzed within a larger understanding of the context. Similarly, Wortham (1996) notes that personal pronoun usage can act as either an affiliative or a distancing move. Because English does not distinguish between an

inclusive or exclusive 'we,' it can signal affiliation with an interlocutor (i.e. inclusive 'we') or with another (either present or non-present- i.e. exclusive 'we'). Focusing on classroom interactions, Wortham (1996) illustrates how the use of 'we' by co-teachers creates particular stances in relation to each other and the students. A similar case can be made for the use of first person plural pronouns in the data presented here.

In prior research on pronoun use in medical settings, Rees and Monrouxe (2008), for instance, note that in the context of medical visits, inclusive 'we' can have the effect of "masking power asymmetry" (175) thereby constructing a more equitable interactional relationship between provider and patient. Similarly, in their large-scale study of 373 visits in the UK, Skelton, Wearn & Hobbs (2002) point out that the use of inclusive 'we' can be seen as a way of promoting patient-centered care or a sense of partnership in the patient's health. In a report on Skelton and colleagues' (2002) study, Dobson (2002) argues that although the intent of inclusive 'we' by a provider may be cooperative, the impression may just as likely be paternalistic and condescending. However, neither Skelton and colleagues nor Dobson conducted interviews with patients to assess their impressions of providers' use of inclusive 'we.' Kinsman et al., (2010) did compare doctors' use of 'we' with post-visit patient assessments and found that there was not necessarily a positive or negative correlation of first person pronouns and satisfaction rates. The extent to which patients were responding the use of 'we,' specifically, rather than other aspects of their providers' communication style, however, is unclear. Using patient up-take and their own use of inclusive 'we' as a gauge of patient impressions, I have argued elsewhere (Defibaugh, 2014b) that the use of first person plural 'we' may be interpreted as positively evaluated by patients in NP-patient visits. This can be seen most clearly when patients,

themselves, use ‘we’ in similar ways as providers to suggest a shared interpretation of responsibility and ownership.

Drawing on this research, I outline in this section how the use of inclusive ‘we’ can function in three different ways: 1) including the patient in the NP’s action of setting the agenda; 2) assigning responsibility for the patient’s health to both the NP and the patient; and 3) including the NP in the patient’s required actions following the visit. Following this, I show how patients similarly use inclusive ‘we,’ suggesting that their uptake of providers’ use of ‘we’ is not necessarily negative.

3.1. NP’s Use of Inclusive ‘We’

In the following excerpt, Sarah, meeting with Mr. Price for the first time, uses ‘we’ in a number of different ways. Excerpt 4-4 includes six mini-excerpts (noted by ellipsis between each elided section of the transcript) in which ‘we’ is used inclusively. This excerpt illustrates both the frequency of ‘we’ (whether interpreted as inclusive or exclusive) as well as the ways that inclusive ‘we’ can be interpreted.

Excerpt 4-4 NP Sarah & Mr. Price

13. NP: okay so let me just pull up your note from her and **we’ll** kinda start from

14. there

...

145. NP: yeah [sounds like **we** need a lot to do [right? [okay

146. PT: [and [prostate checked out and [all that

147. NP: well **let’s** start here then **let’s** look at your blood work and see where **we’re** at I

148. definitely don’t like your blood pressure and **we’ll** talk about that in a second (.)

149. one of the things I tested you for was hepatitis c and it came back positive=
...
193. NP: **we** could to an ekg today but I'm worried about your blood pressure before I
194. give you [medication cuz **we've** gotta get that back down your blood pressure
195. PT: [ah
196. NP: was two hundred when she checked it again it was one ninety-eight that's very
197. high okay that's stroke high
198. PT: yeah
199. NP: so **we're** gonna get this back under control **we'll** get an ekg today **we'll** kinda get
200. a baseline once **we** kinda get everything leveled out that might be somethin' **we**
201. might give you some Viagra and that might help
...
278. NP: ah::: **we're** (2.5) do you (.) want to try to stop smoking?
279. PT: I got gum hhhhhhhhhhhh [hhhh I got the gum
280. but I left-
281. NP: all right **we'll** put that on the back burner then how 'bout [that
...
324. NP: okay it's *your* blood pressure probably **we're** gonna get this down, (.) I'm gonna
325. send *you* home with a blood pressure cuff, (3.0) all righty gonna do the ekg
326. now, when **we're** done with the ekg I'm gonna have you go to pharmacy no I'm
327. sorry I'm gonna write this down
...
334. NP: I mean for the erection issues but **we're** gonna and your prostate is a little high so

335. that's what **we're** gonna talk about with them um everything else looks okay but
336. for that you need to go to lab today too so **we** got a lot to do

Following Wortham (1996), I have mapped all of the pronouns that Sarah uses in this extended excerpt in Table 5, below. The excerpt includes all instances of first person plural pronouns that are either clearly or ambiguously inclusive. Those that are unambiguously exclusive have been omitted unless they co-occur with inclusive 'we.' One example of this is in line 200, 'we might give you some Viagra,' which could not be interpreted as including the patient, Mr. Price; however, it occurs within an utterance in which three other uses of 'we' could be interpreted as including Mr. Price. A discussion of exclusive 'we' is in Chapter 5.

Table 5. First and second person deictics in excerpt 4-4

| Line | Speaker | Deictic | Referent | Context |
|------|---------|---------|------------------------------|------------------------------|
| 13 | Sarah | me | NP | describing action |
| 13 | Sarah | we'll | NP + (PT) ⁶ | setting agenda |
| 145 | Sarah | we | NP + (PT) | setting agenda |
| 147 | Sarah | let's | NP + (PT) | setting agenda |
| 147 | Sarah | let's | NP + (PT) | setting agenda |
| 147 | Sarah | we | NP + (PT) | setting agenda |
| 147 | Sarah | I | NP | providing medical evaluation |
| 148 | Sarah | we'll | NP + (PT) | setting agenda |
| 193 | Sarah | we | NP+ (PT) + (VA) ⁷ | plan for medical procedure |

⁶ NP + (PT) indicates that the NP can be understood as the primary referent

Table 5 (cont.)

| | | | | |
|-----|-------|-------|------------------|--------------------------------|
| 193 | Sarah | I | NP | expressing concern |
| 193 | Sarah | I | NP | proscribing Rx |
| 194 | Sarah | we | NP + (PT) + (VA) | plan for improving PT's health |
| 199 | Sarah | we're | NP + (PT) + (VA) | plan for improving PT's health |
| 199 | Sarah | we'll | NP + (PT) + (VA) | plan for medical procedure |
| 199 | Sarah | we'll | NP + VA | assessing medical condition |
| 200 | Sarah | we | NP + (PT) + (VA) | improve PT's health |
| 200 | Sarah | we | NP + VA | proscribing Rx |
| 278 | Sarah | we're | NP + ?? | incomplete utterance |
| 281 | Sarah | we'll | NP + (PT) | setting agenda |
| 324 | Sarah | your | PT | describing PT's condition |
| 324 | Sarah | we're | NP + (PT) + (VA) | improve PT's health |
| 324 | Sarah | I'm | NP | prescribing/directives |
| 325 | Sarah | you | PT | recipient of NP's directive |
| 326 | Sarah | we're | NP + (PT) + (VA) | carrying out medical procedure |
| 326 | Sarah | I'm | NP | prescribing/directives |
| 326 | Sarah | you | PT | recipient of NP's directive |
| 326 | Sarah | I'm | NP | apologizing |
| 327 | Sarah | I'm | NP | describing action |
| 334 | Sarah | I | NP | clarifying previous utterance |

⁷ NP + (PT) + (VA) indicates ambiguity in terms of who (all) is included in the referent

Table 5 (cont.)

| | | | | |
|-----|-------|-------|------------------------|----------------------------------|
| 334 | Sarah | we're | NP + ?? | ?? incomplete utterance |
| 335 | Sarah | we're | (NP) + PT ⁸ | interaction with other providers |
| 336 | Sarah | you | PT | recipient of directive |
| 336 | Sarah | we | (NP) + PT | describing actions |

3.1.1. Including Patient in NP tasks

The first five uses of 'we' and/or 'let's' (lines 13, 145, 147-148) all reference what the plan is for this particular medical visit, or as Table 5 describes them, 'agenda setting.' Sarah outlines what will be addressed first (line 13: 'we'll start from there' and line 145 'let's start here) as well as what topics they will cover (line 147: let's look at your blood work and line 148: 'we'll talk about that in a second'). These tasks of setting the agenda are essentially Sarah's responsibility and part of what constructs her identity of the 'competent NP' (see Chapter 5). However, the use of 'we' and 'let's' in these examples has the effect of bringing Mr. Price into the action of setting the agenda. In fact, a more accurate description of these tasks would be for Sarah to use 'I' instead of 'we' or 'let's' since it is she who controls the topics and decides where to 'start.' She is also the one to 'look at [his] blood work' and interpret the results. The use of 'we' then does not literally mean that Mr. Price is an active participant in these tasks or that he is also performing them; instead, it gives the *effect* that he is a part of the process of determining what will be discussed and will be actively involved in interpreting data from his test results. This inclusion in the 'agenda setting' arises later on in line 281, when Sarah, referencing Mr. Price's smoking habits, uses 'we' in delaying this topic until a later date: 'we'll put that on the

⁸ (NP) + PT indicates that the patient can be understood as the primary referent

back burner.’ By including Mr. Price in these decisions regarding the content of the medical visit, she gives the effect of diminishing the power differential in terms of who is ‘in charge’ thereby lowering social distance and encouraging Mr. Price to be a more active participant in the medical visit.

3.1.2. Highlighting Dual Responsibility

Another effect that the use of ‘we’ has in this particular excerpt is of creating a shared sense of responsibility for the patient’s health. This can be seen in the use of ‘we’ in line 194: ‘we’ve gotta get that back down,’ line 199: ‘we’re gotta get this under control’ and line 324: ‘we’re gonna get this down,’ where ‘this’ and ‘that’ both refer to the patient’s blood pressure. Unlike with the previous examples, which can be understood as primarily referring to the NP but bringing the patient along, the use of ‘we’ here seems to clearly select both the NP and the patient as agents. What is implicated in the use of ‘we’ is both: ‘I will get your blood pressure down through prescribing the appropriate medication and dosage’ and ‘you will get your blood pressure down through appropriate actions such as better diet and adherence to medication.’ The use of ‘we’ then implicates both the NP and the patient as being responsible for the patient’s health going forward. Although her role is much smaller and requires one single action compared to Mr. Price’s requisite daily adherence to medication and possible dietary changes, Sarah includes herself as being a responsible agent in his health. Through this use of ‘we,’ Sarah constructs the ‘caring NP’ by making her role in Mr. Price’s health equally salient and important rather than focusing on his responsibilities.

3.1.3. Including NP in Patient Tasks

The use of ‘we’ at the end of this excerpt has a slightly different meaning than what was discussed in the previous two sections in that the deictic can be understood to primarily reference

the patient (marked in the table as (NP) + (PT)). In lines 334 and 335, through the use of ‘we,’ Sarah includes herself as the subject and agent of the actions ‘talk’ and ‘have things to do.’ Based solely on the transcript and the use of ‘we’ in these two lines, one would assume that Sarah was, in fact, going to go with Mr. Price to ‘talk’ to ‘them’ (e.g. other providers) and completing other unspecified tasks. However, even the most ‘caring’ of NPs do not go with patients to other appointments. In opposition to the use of ‘we’ in section 3.1.2, a more accurate description of what is going to happen at the end of this visit would be something like ‘that’s what you’re gonna talk about with them’ and ‘you’ve got a lot to do.’ By including herself in Mr. Price’s actions, she creates a sense of sharing in future tasks. Sarah is able to construct the identity of ‘caring NP’ by including herself in Mr. Price’s obligations, giving the effect of fully sharing in the responsibility for his health going forward.

3.1.4. Effect of Repetition

Viewed independently, each of the examples of inclusive ‘we’ discussed in sections 3.1.1-3.1.3 illustrate how Sarah constructs an identity of the ‘caring NP.’ Through the various uses of ‘we’ she is able to bring the patient in as a co-participant in setting the agenda for the visit, sharing responsibility for improving the patient’s health by implicating both parties’ roles in improving Mr. Price’s blood pressure, and giving the impression of being a co-participant in his tasks following the visit. There are also other uses of ‘we’, as outlined in Table 5, in which it is not clear whether Sarah is including Mr. Price in the deictic referent. These examples are marked in Table 5 as NP + (PT) + (VA) indicating that ‘we’ may be exclusive: referring to Sarah and the VA, the organization she works for, or inclusive: Sarah and Mr. Price, or all-inclusive: Sarah, Mr. Price, and the VA. For example, in lines 199-200, Sarah utterance ‘we’ll kinda get a baseline’ could include Mr. Price and/or other providers. Resolving the ambiguity in cases like

this, I argue, is not particularly important. Instead, ambiguous references such as this can still create an alignment between the NP and the patient, particularly when taken along with the referents that more clearly include Mr. Price. Similarly, the fact that these examples of ‘we’ are used repeatedly throughout the visit- in the excerpt above a total of 16 can be interpreted as inclusive of Mr. Price- gives an overall effect of inclusion even in the cases in which the intended meaning might have been exclusive. Taken all together they have the effect of inclusion in all aspects of Mr. Price’s health and construct a sense of shared responsibility and shared ownership of illness.

3.2. Patient Use of Inclusive ‘We’

As some researchers have argued, the use of ‘we,’ despite providers’ likely use as a marker of inclusion, can be interpreted as patronizing. Dobson (2002) points out, in his review of Skelton, Wearn & Hobbs (2002) that “patients and companions never included the doctor when they said ‘we,” which Dobson interprets as a possible failure in creating an inclusive, patient-centered atmosphere in the visits studied (2002: 1). The noted absence of inclusive ‘we’ in patients’ discourse described above is not consistent with the data in my corpora. Although less frequent than NPs’ use of inclusive ‘we,’ patients in my data also use ‘we’ inclusively. The first two examples are taken from inpatient data with June. In each case, June has met previously with the patients and has already begun to develop a relationship with them. In excerpt 4-5, June first uses ‘we’ to describe a procedure that the patient, Ms. Anderson had, much like Sarah’s utterance “we’ll get an EKG” (line 199, Excerpt 4-4, above), in which the NP includes herself in the patients’ activities. In line 1, below, June begins the interaction by asking, “we had the MRI?,” noted by the rising intonation at the beginning of MRI. The patient in line 2 picks this up by echoing the NP’s turn as an answer to the question.

Excerpt 4-5 NP June & Ms. Anderson

1 NP: ##### uh **we** had the ↑MRI

2 PT: **we** had the MRI and they said that they could see

The fact that the patient uses the inclusive ‘we’ to include the NP as the experiencer of the MRI may be simply a result of priming from the previous turn, in which she repeats the pronoun choice of the NP; however, it may also suggest that the patient is aware of and accustomed to the NP’s use of ‘we’ as a way of putting herself on equal footing and even in a shared experiencer-role with the patient. In fact, Ms. Anderson could have used ‘I’ rather than ‘we’ in her turn. Had she used ‘I,’ it would have clearly marked her turn as indexing dis-affiliation with June, specifically excluding her from the referent, suggesting that she viewed June’s use of ‘we’ as patronizing or inappropriate. Similarly, Ms. Anderson could have avoided a pronoun altogether and simply responded with ‘yes’ before continuing with the rest of her turn. This choice would be more ambiguous in terms of Ms. Anderson’s uptake. Viewed from this position of possible alternatives, it seems clearer that the patient, in this particular visit, did not interpret the NP’s use of ‘we’ negatively. It is also worth noting that there is no delay in the patient’s response to the NP’s question and no indication of a hesitation as if deciding which pronoun to use. Instead, she seems to feel comfortable including the NP within this reference, despite the fact that the NP neither had an MRI nor did she order it for the patient.

Another example of a patient using the inclusive ‘we’ with June occurs in Excerpt 4-6. The patient, Ms. Evans, has also been hospitalized for an extended period and knows June fairly

well. Unlike in 4-5, in this excerpt, Ms. Evans initiates, rather than repeats, the use of inclusive ‘we’ when talking about insulin decision-making.

Excerpt 4-6 NP June & Ms. Evans

1 PT: are **we** [getting

2 NP: [okay lady

3 PT: are **you** doin’ okay figurin’ out where **we’re** at with the insulin

4 NP: yes **we** are you’re doin’ fine

After using ‘we’ in line 1, the patient then recasts the question using ‘you’ in lines 3 when assigning the role of who is ‘figurin’ out’ the dosage, but again uses ‘we’ to refer to a shared ownership of the outcome of the decision making (line 3). Inclusive ‘we’ in this case involves the patient including herself in the NP’s tasks and actions, much like Sarah including Mr. Price in the act of setting the agenda for the visit. It is unlikely that the patient would do this if the NP had not already created the sense of shared ownership, particularly in the decision making, as line 1 indicates, and certainly in the results of that decision making as line 3 and 4 indicate. In these two examples, we can see uptake on the part of the patients, not necessarily in direct response to June’s use of ‘we’ but as reproduction of her use of inclusive ‘we’ in their own discourse.

A similar use of inclusive ‘we’ occurs in the data from the VA clinics. The final excerpt is from a visit between Karen and Mr. Eggers. Although they have met previously, it has been approximately one year since the last visit. Therefore, there is less of a sense of repeated use of ‘we’ by the NP that would influence the patient’s use of ‘we.’ Additionally, unlike the previous

two excerpts in which the first use of ‘we’ by June in 4-5 and Ms. Evans in 4-6 can clearly be interpreted as inclusive, Karen’s use of ‘we’ throughout this excerpt is ambiguous in terms of whether or not the patient is included in the referent. The uptake by Mr. Eggers, however, is that of inclusive ‘we,’ marked by his own use.

Excerpt 4-7 NP Karen & Mr. Eggers

63. NP: I know I’m sure there’s some nerve damage (.) yeah if it becomes a problem and

64. you want to do some more things ↑about it **we** could do some more testing (0.5)

65. EMGs and circulatory tests

66. PT: I thought **we** did that (.) they actually said I didn’t have neuropathy

67. NP: yeah right

68. PT: hhh it’s okay what is it if I don’t have neuropathy what is this

69. NP: **we** did an EMG you’re right in July of thirteen

70. PT: hhhhhh and like I said they had to put my feet in hot water just to h-

71. NP: it’s very mild right

72. PT: yeah

73. NP: nothing () um when you turn sixty-five we like to screen your um aorta which is

74. your major artery for an aneurism we do it through an ultrasound it’s just a screen

75. test and anyone over the age of sixty-five () and we do it at the main clinic

76. would you be willing to go

77. PT: () um let me put it this way didn’t **we** do that last year

78. NP: **we** did a ultrasound?

79. PT: **we** did something um there that they checked on my heart **we** did a stress

80. NP: not on your heart yeah **we** did a stress test this is an ultrasound of your aorta to
 81. make sure an aneurism which is like a ##### didn't burn yeah you're right **we**
 82. did a stress test
 83. PT: yeah I knew **we** did so-

Similar to the extended excerpt of 4-6, Table 6, below, provides a summary of the use of 'we' by both Karen and Mr. Eggers in Excerpt 4-7.

Table 6. Deictic mapping of Excerpt 4-7

| Line | Speaker | Deictic | Referent | Context |
|------|------------|---------|------------------|---|
| 64 | Karen | we | NP + VA + (PT) | conduct/participate medical tests |
| 66 | Mr. Eggers | we | PT + (NP) + (VA) | participated in medical tests |
| 69 | Karen | we | NP + (VA) + (PT) | conducted/participated in medical tests |
| 73 | Karen | we | NP + VA | preference about medical testing |
| 74 | Karen | we | NP + VA | conduct medical tests |
| 75 | Karen | we | NP + VA | conduct medical tests |
| 77 | Mr. Eggers | we | PT + (NP) + (VA) | participated in medical tests |
| 78 | Karen | we | NP + (VA) + (PT) | conducted/participated in medical tests |
| 79 | Mr. Eggers | we | PT + (NP) + (VA) | participated in medical tests |
| 79 | Mr. Eggers | we | PT + (NP) + (VA) | participated in medical tests |
| 80 | Karen | we | NP + (VA) + (PT) | conducted/participated in medical tests |
| 81 | Karen | we | NP + (VA) + (PT) | conducted/participated in medical tests |
| 83 | Mr. Eggers | we | PT + (NP) + (VA) | participated in medical tests |

In lines 64, 69, 78, 80 and 81, 'we' can be analyzed as either inclusive or exclusive. In 64, for example, Karen says "we could do some more testing." Here the use of 'we,' cannot be disambiguated entirely, mostly because of the use of 'do,' a verb that does not specify a precise action, namely whether Karen means conduct/administer tests or participate/be tested, the former indicating an exclusive meaning in which 'we' references only medical providers and the latter indicating an inclusive meaning which includes the patient, or the person who is tested. Despite the ambiguous meaning of 'we' in line 64, Mr. Eggers' response of 'I thought we did that' suggests that his uptake of 'we' in line 64 is inclusive; otherwise, one would expect him to use 'you.' A similar pattern of ambiguous reference by Karen followed by a disambiguated inclusive interpretation of 'we' by Mr. Eggers occurs in lines 78-83. It is understandable that Mr. Eggers would include himself in these references because of the lack of specificity of intended meaning of 'do tests.'

The use of 'we' in lines 73-73, particularly line 73: "we like to screen" seems to be more clearly exclusive as it is only providers who 'screen,' and, more importantly, it is only providers who express preference or desire to conduct certain tests based on the age of the patient. This use of 'we' seems to index, quite clearly, either Karen and the VA clinic or Karen and the medical community who decides when certain tests are appropriate. 'We' in the following two lines describe how and where the ultrasound procedure that she is referencing in this turn is typically conducted. Taken together, all three of these first person plural pronouns seem to have an exclusive meaning. Despite the apparent lack of ambiguity in this turn, Mr. Eggers again responds with the use of 'we' suggesting a likely inclusive interpretation of Karen's utterance. An additional interpretation is that Mr. Eggers is not responding necessarily to the pronoun use, per se, but to the general content of the message, which is about a particular medical test he

believes he has already had, hence his confirmation-check in line 77. Either way, Mr. Eggers frames this check as an inclusive 'we' indexing that both he and Karen were involved in the previous test. This excerpt seems to suggest that even ambiguous uses of 'we' as along with repeated use of 'we' gives patients the impression of inclusiveness to the extent that they also use inclusive 'we.'

The use of inclusive 'we' on the part of the patients in each of the three excerpts above indicate that, unlike what was reported in prior studies, patients do, sometimes use inclusive 'we' to include the provider in their own actions of having tests done and include themselves in the act of decision-making. Their use of inclusive 'we' may be influenced by the NPs' discursive moves rather than individually motivated; however, it does suggest that NPs' use of 'we' is likely not interpreted as patronizing by the patients in this study.

3.3. Interim Discussion

The prior examples of NPs' use of inclusive 'we' illustrates, at a minimum, an effort to create a shared sense of responsibility and ownership in the patients' health. That is, it is clear that the intention for NPs is to construct the 'caring provider' despite the up-take. The issue, however, lies in determining whether patients view the use of inclusive 'we' positively or negatively. In order for this identity to be constructed, it must be sanctioned by the patients-essentially co-constructed. However, clear positive up-take by patients is rare, if it exists at all; that is, patients will not necessarily respond to an NP's use of 'we' by explicitly voicing approval or disapproval. Instead, the best indication is to consider patient's own use of 'inclusive' we, as I have done. Although researchers have suggested that inclusive 'we' may have a patronizing effect, there is no definitive evidence of this in their research or my own. It is, in my view, impossible to argue that first person plural pronouns are always interpreted as either paternalistic

and condescending or ‘caring’ and democratic. Instead, as I have shown, patients’ use of inclusive ‘we’ in Excerpts 4-5, 4-6, and 4-7 reveal a neutral, if not positive, interpretation of the provider’s use of ‘we’ as creating sense of shared experiencer and decision maker, suggesting that at least in these examples the effect matches the NPs’ likely intention. Therefore, the use of this pronoun can be seen as contributing to the patient-centered approach of focusing on development of relationships and what Ong, et al. (1995) refer to as a “social orientation” toward a common goal.

4. Indirectness in the Formulation of ‘Medical Advice’

The final section of this chapter is devoted to the way in which the ‘caring provider’ is constructed through medical advice. In order to appropriately contextualize this argument, it is first necessary to understand what medical advice is from a speech act perspective since this aids in the interpretation of linguistic forms and possible motivations (i.e. politeness and avoidance of fact-threats). Section 4.1 does exactly this. Section 4.2 provides a definition of indirectness that I follow in the analysis of the two excerpts presented in sections 4.3 and 4.4. The first illustrates extensive use of mitigation in advice giving; the second presents an example of off-record, indirect advice. Together these two examples show some of the ways in which NPs use indirectness when giving advice.

4.1. Categorizing ‘Medical Advice’

When attempting to categorize medical ‘directives’ based on a type of speech act, they seem to straddle the line between advice and instructions. One way to view them is as a type of directive or request. However, this definition does not seem to fit the function or, in pragmatic terms the cost/benefit ratio, specifically at whose ‘cost’ is the action performed and who ‘benefits’ from said action. According to Leech (2014) a directive “seeks an accommodation

between competing goals: the goal of benefiting S [the speaker] or some third party, and the goal of placating O [the interactional other, often referred to simply as the hearer]” (p. 135-136). However, medical directives do not fit this definition in two important ways: 1) the goal of medical directives is not competitive- both parties share the same goal; and 2) ultimately both the cost and the benefit both belong to the hearer (or in Leech’s terms ‘O’). This is true whether medical directives involve lifestyle changes, what one might view as having a high ‘cost’ or taking medication, something that will likely be of lower ‘cost’ to the patient. Similarly, they cannot be considered ‘orders,’ despite often being colloquially referred to as ‘doctor’s orders,’ because as Leech points out, orders lack the component of optionality; they are given by a person in authority to someone in a lower position but with the expectation that they will be followed. As the great deal of research on non-compliance and non-adherence can attest (Buckalew & Sallos, 1986; Cooper, Love & Raffoul, 1982; Haynes, Wang & daMota-Gomes, 1982), ‘doctor’s orders’ are very often not followed and providers can rarely, if ever, impose a penalty on patients for non-compliance.

4.1.1. Somewhere Between Instructions and Advice

Unlike directives or requests, instructions have a collaborative function in that “two parties are working toward a common goal, usually for the particular benefit of H to do something, usually on the account of S’s special competence” (Leech, 2014: 137). Following from Leech’s description of instructions, medical ‘directives’ do seem to fit this definition in that they are specifically for the benefit of the patient and are based on the specialized knowledge of the provider. In addition, unlike orders, instructions have a certain level of optionality, likely because the benefit is only for the hearer. However, Leech argues that instructions “lay outside the realm of (im)polite behavior” (137) which would suggest that they are done bald, on-record

rather than off-record and indirect. Therefore, if medical directives are a kind of advice, then we should expect them to, at least most frequently, take the form of imperatives. Conversely, considering them to be something more in the realm of advice, which can similarly be viewed as benefiting O, and likely at the cost of O, since S is “proposing a course of action to be taken by O” (204), also falls short in one important way. As Leech notes, the reason that indirectness and mitigation are often found in advice is because there is a feeling that S claims “*implicit* superiority [emphasis added]” (205) over H; however, in the case of medical visits, as has been noted, there is a clear difference in knowledge and position that would make S’s claim of superiority, at least in terms of advice-giving, explicit rather than implicit. They could then be considered something akin to ‘professional advice,’ which would, once again, suggest less of a need for hedging and mitigation and more bald, on-record choices. Although advice and instructions fall into two distinct categories for Leech, medical instructions/advice seem to lie somewhere in the middle of these two. They mimic instructions in their reliance on the providers’ “special competence” yet often include mitigation, which is most associated with advice. For my purposes, I use the term ‘medical advice’ to encapsulate the asymmetric nature of the relationship between speaker and hearer, in this context.

Medical advice, in the visits in this study, are occasionally presented as bald, on-record as in the example below:

Excerpt 4-8 NP Karen and Mr. Eggers

63. NP: that’s okay so vitamin D three **buy it over the counter** its cheaper two

64. thousand units a day okay

In this example, the advice is given bald, on-record, in the form of an imperative, likely because Karen is distinguishing between medication that is ordered through the VA compared to over-the-counter medication. Here, it has already been established that Mr. Eggers should take vitamin D; the instructions are to clarify how he will get it. In fact, it is rare for medication to be cheaper anywhere outside the VA (which is one of the reasons many patients who have outside providers still seek services through the VA). Therefore, Karen's use of directness can also be understood as highlighting the contrast between this medication and others.

However, examples like this are rare and are often only for minor actions that require little effort for the patient. More commonly, advice takes the form of mitigated on-record or off-record indirect medical advice, even when the cost to the patient is relatively low. The reason for this can be understood as a move toward rapport management, specifically what Spencer-Oatey (2002) refers to equity rights: the right to not be imposed on too much (what Brown and Levinson, 1987, refer to as 'negative face') and as a way of achieving interactional goals (Spencer-Oatey, 2005).

4.2. Defining Indirectness

Indirect speech can include a wide variety of types, depending on the definition and scope one chooses to apply (see Haugh, 2015 for a comprehensive account of definitions of indirect speech). Following Searle (1975), an indirect speech act is a "sentence that contains the illocutionary force indicators for one kind of illocutionary act" but performs, "*in addition*, another type of illocutionary act" (p. 268). Applying this definition would include conventionalized indirect forms, such as 'can you X,' which most speakers of American English would not consider indirect precisely because it has become so conventionalized as a request rather than the literal meaning of a question regarding ability.

More recent definitions have moved away from the analysis of indirectness as being a mismatch between the locutionary act and the illocutionary act and the focus being placed on *what* is said to a broader understanding that also encompasses *how* a proposition is stated. Lempert (2012) uses the term ‘indirect addressivity’ which departs from Searle’s focus on the linguistic form to include a kind of indirectness in which the addressee may not be directly addressed but instead the message is funneled through another person or a medium.

Similarly, Kiesling and Johnson use the term “interactional indirection” and define it as when “the intention or interpretation of utterances (or both) does not match the unmarked norms for a speech community” (2010: 295). One of the advantages of this formulation is that it excludes conventionalized expressions since these are often the unmarked ways of expressing a particular proposition. This definition is also helpful in that it divorces indirectness from individual utterances, something that was taken for granted in traditional Speech Act Theory (SAT), and views it as something that can be constructed over many turns and/or not necessarily identifiable within a single utterance. Haugh (2015: 32) makes a similar argument, illustrating that, “indirectness is not simply a property of individual utterances, but rather can be attributed more holistically to a sequence of utterances.” Excerpt 4-9, below, illustrates how the act of advice-giving occurs over several turn units and across several utterances, where the full perlocutionary effect seems to come from the cumulative effect rather than any individual turn.

One seemingly problematic aspect of Kiesling and Johnson’s (2010) representation of indirectness is in determining the ways in which a speech community may share an understanding of what is ‘unmarked.’ In the case of medical visits, a certain amount of familiarity with the setting, I believe, can be taken for granted, as CA researchers have shown, medical visits follow a fairly consistent organizational sequence (c.f. Heritage & Clayman,

2010), they address specific topics that both participants are oriented to, and, patients know ‘how to be patients’ (c.f. Waitzkin, 1991). The degree of familiarity between the provider and patient can be quite variable, however, making this aspect a bit indeterminate. Nevertheless, in the case of the data presented in this dissertation, the NPs and patients are both speakers of American English and have, at least to some extent, familiarity with the genre of the medical visit, providing a certain level of shared understanding for what would be considered marked and unmarked.

A second, important way to think about indirectness is in the use of mitigation strategies. Thaler describes mitigation as “closely connected to the reduction of responsibility and obligations” (2012: 909) where responsibility and obligations may loosely correspond to Leech’s ‘cost.’ Caffi, similarly argues that mitigation can reduce the “intensity” of an implicature and “thereby further(ing) the achievement of interactional goals” (1999: 882). Caffi divides mitigation into three main components: bushes, hedges and shields. Bushes mitigate the propositional content, often through lack of specificity in verb choice (i.e. ‘give’ rather than ‘prescribe’ medication) or minimization of the intensity or severity of a proposition. Hedges mitigate the illocutionary force, for example, through minimization of the hearer’s role or obligation or through the claim the speaker makes in asserting his/her position to require something of the hearer. Finally, shields background or silence the speaker or the hearer’s role altogether, often through syntactic features such as passive voice. These linguistic choices have often been associated with a more colloquial understanding of indirectness but should be taken into account in a theoretical account as well.

4.3. Mitigated Advice

One of the ways in which medical advice is given in the corpora is through the use of mitigation. Mitigation, as Caffi (1999) shows, is an important part of providers' discourse likely because it works to achieve an interactional goal. In the case of the data here, mitigated advice aligns the NPs in this study with the figure of the 'caring provider' by 1) minimizing the extent to which she positions herself as a figure of authority who is endowed with the power to give instructions or advice and 2) by minimizing the 'cost' of the advice to the patient. One of the most salient examples of mitigation occurs in a visit between Laura and Mr. Vaughn. The excerpt (4-9) starts while Laura is in the process of communicating Mr. Vaughn's recent test results and discovers that he has stopped going to see a urologist. In this excerpt, she uses a number of turns along with mitigating devices to give him the medical advice that he should go back to seeing the urologist annually. Her advice can be understood as on-record indirectness in that the action (e.g. going see a urologist) is referenced in many, although not all, turns but the advice is not explicitly stated. This example also illustrates how the indirect advice cumulates over a number of turns.

Excerpt 4-9 NP Laura & Mr. Vaughn

61. NP: [we::ll that's hematuria micro hematuria

62. microscopic blood cells in the urine and I think (.) ((mouse clicking)) did you ah::

63. see a urologist are you still going to see [your urologist?

64. PT: [no I haven't saw him for some time but

65. yeah (.) it (0.5) other words uh kinda like blood in the urine right? [Or not

66. NP: [yeah blood in

67. the urine right
68. PT: yeh well he told me all the time ya know it was probly from scar tissue from my
69. surgery
70. NP: scar tissue from your surgery?=
71. PT: =yeah=
72. NP: =okay
73. PT: cuz I had my prostrate removed
74. NP: okay all [right
75. PT: [yeah that's what he told me all the time
76. NP: okay (.) s- so generally after you have:: (1.0) ya know prostate cancer↑ and
77. surgery::
78. PT: yeah
79. NP: every now and then you have to go see the uro:logist (.) so
80. PT: yeah I should go see him [again probably
81. NP: [yeah yeah because it's surveillance
82. PT: yeah
83. NP: its surveillance to make sure that everything is [okay
84. PT: [yeah yeah
85. NP: and I did make a copy: two more copies of your blood work for your doctors so
86. share that with [them
87. PT: [okay
88. NP: and one for [you
89. PT: [okay

90. NP: but um ya know with a history of prostate cancer you need to have surveillance
91. PT: yeah
92. NP: just to make sure [that everything is okay
93. PT: [well that's what I could never figure out I was going to him all
94. the time going to him after I had the surgery (.) and well he said 'yeah you
95. should come back' you know I guess the cancer ↑could come back or
96. something=
97. NP: =well that's right (.) cuz what needs to happen (.) ya know until ya leave this
98. earth, ya know a PSA needs to be (.) done
99. PT: oh yeah okay
100. NP: ya know blood tests
101. PT: okay
102. NP: now your PSA came back fine::, it's less than zero point zero one which [is
103. PT: [oh
104. that's good yeah
105. NP: good
106. we get concerned once its one point zero
107. PT: oh
108. NP: if it's going ↑up (.)
109. PT: [oh yeah
110. NP: [then something else is going on=
111. PT: =you read articles though where they say that PSA
112. is [yeah

113. NP: [yeah
114. PT: maybe maybe hhh
115. NP: yeah well I-
116. PT: but you still think it's a good idea=
117. NP: =oh I think it's a good idea
118. PT: I'll probly make an appointment with [them
119. NP: [yeah I- I think it's a good idea
120. PT: cuz I haven't been to 'em in probably four or five years time goes by so fast
121. you know
122. NP: well I- just to kinda touch base
123. PT: yeah
124. NP: just to touch base (.) because ya still have blood in the ↑urine
125. PT: yeah
126. NP: just to make sure tha:t ya know nothing else is going on
127. PT: yeah
128. NP: ya know blood in the urine yes could be from scar tissue:: [but it can also be
129. PT: [yeah
130. NP: from bladder cancer
131. PT: okay
132. NP: okay
133. PT: yeah
134. NP: so sometimes if you have microscopic blood in the urine ah: (.) and you've
135. had it for years and you've had it worked up its its just ya know part of your

136. medical history
137. PT: yeah
138. NP: but [because of your-
139. PT: [it's a possibility it could be something else=
140. NP: =well that's right because of your history of (.) prostate cancer [okay?
141. PT: [oh yeah
142. NP: so you want to be sure ah touch base with a urologist [okay?
143. PT: [yeah yeah okay (1.0) I
144. should I should get a copy of and to take to [him?
145. NP: [yeah yeah you're gonna ge- go
146. home with two
147. PT: okay
148. NP: one for him and one for your private doctor
149. PT: oh yeah okay

In this exchange between Laura and Mr. Vaughn, there are a number of turns that can be interpreted as giving medical advice. The excerpt begins around line 63, in which Laura asks Mr. Vaughn if he is still going to see a urologist. Since Laura has Mr. Vaughn's medical history accessible on her computer, it is likely that she already knows the answer to this question. Therefore, this question functions as a pre-sequence (Levinson, 1983), or more specifically as pre-advice, essentially 'testing the waters' to determine whether advice is necessary. After indicating that he previously visited the urologist on a regular basis, Mr. Vaughn then acknowledges that he has not gone 'for some time' (line 64). This opens up the floor for Laura

to offer medical advice, in lines 76-79. Although Laura uses a conventionalized form of advice in 'you have to' (line 79), the advice is prefaced with multiple mitigating devices, lessening the strength of the advice. For example, the use of 'generally' (line 76) (a bush, in Caffi's terms) distances the patient from the advice, making it seem to apply to anyone in this situation rather than just him. 'Generally,' also has the effect of changing the interpretation of 'you' to be inclusive- again referencing 'anyone' rather than the patient alone. Another example of a bush occurs in the lack of specificity implicated in the use of 'every now and then' (line 79) in reference to the frequency of the visits, giving the effect of less frequent than what is actual required, which is annually (<http://metrovanurology.com/content/post-treatment-monitoring>). It also creates a sense of a somewhat low-ranked imposition on the patient, suggesting that the cost to him is minimal.

First appearing in line 76 but recurrent in Laura's advice-giving throughout (lines 90, 97-97, 100, 126, 128 & 135), is the discourse marker 'ya know' which Schiffrin (1987) refers to as a marker of 'meta-knowledge' shared by speaker and hearer or by the general population. These uses of 'ya know' throughout have the effect of mitigating the force of the advice by suggesting that this is knowledge the hearer likely already has but is simply being 'reminded' of. In this respect, it can also be seen as lowering what Leech (2014) refers to as vertical distance (Brown and Levinson, 1987 use the term 'power') by implying that the NP, in this respect, does not have a greater level or access to knowledge than the patient.

Other ways that advice is mitigated throughout this exchange come in a number of lexical and syntactic choices. For example, the use of the term 'surveillance' (lines 81-83) rather than 'annual check-up' or 'annual testing with a urologist' which would be more specific and has a similar effect as 'every now and then' in minimizing the sense of imposition on the patient, is

another example of a bush. Laura's advice also includes a shield, through the use of passive voice in line 98: 'a PSA needs to be done' in which Mr. Vaughn's role in this action is silenced, thereby minimizing his role and any imposition on him that this might involve. Similarly, in lines 117-119, Laura frames the advice with 'I think,' which Leech (2014: 207) refers to as strategy for "hedging advice." Later in the excerpt, Laura uses 'kinda' (line 122) and 'just' (line 124) to minimize the force of the advice which she this time refers to as 'touch(ing) base,' suggesting a brief rather than long, in-depth meeting. Finally, in line 142, where the advice is most direct, it is presented as a desire in the choice of 'you want' rather than an obligation as 'you should' would be. Any one of these mitigating devices has the effect of lessening the intensity of the imposition; however, taken together over the course of a number of turns, the effect is much greater.

4.3.1. Providing Rationale/Support

Another feature of this advice-giving sequence is the explanation Laura gives for her advice. Unlike the urologist that Mr. Vaughn alludes to who did not provide a clear justification for why he should continue to see him (referenced in lines 93-96), Laura provides justification, sometimes fairly vague as in the case of 'surveillance,' sometimes more specific, for example, her explanation in lines 128-140. Justification for the advice is given in lines 81-83, 122-124 and 128-140. Providing a rationale could be interpreted as her educating the patient, similar to the kind of knowledge sharing discussed in Chapter 5, supporting her 'competent' position as one who is in a position to give advice or instructions. Justification would be expected if Laura, as the one giving advice needed to justify or construct her "superior" position as qualified to give advice; however, her position as the medical authority in this interaction means that this is, to a certain extent, unnecessary.

4.3.2. Why Mitigate?

The extent of mitigation and the justification provided cannot easily be accounted for using Brown and Levinson's heuristic for avoidance of fact-threatening acts. For example, what Brown and Levinson (1987) term the 'relative rank of imposition' or what Leech (2014) refers to as the 'cost/benefit' is, overall, fairly low. In the realm of medical advice or instructions, going to see another provider falls somewhere on the low to middle end, in my estimate. For example, it is likely higher than being required to take prescription medication but not as high as a major lifestyle change such as no longer being allowed to eat a certain type of food, or in the case of much of the data from corpus 1, being an insulin-dependent diabetic. Additionally, based on the discussion regarding paperwork being shared with the urologist (lines 85-86 and 144-149), it seems that this visit is not likely not to require additional testing. Therefore, the 'cost' to the patient is somewhat small.

Similarly, neither Brown and Levinson's Distance nor Power and Leech's horizontal/vertical distance provide an adequate explanation for the extent of mitigation. The NP and patient know each other, suggesting a level of familiarity and a lessened sense of 'horizontal distance.' Although I do not have data on how long Mr. Vaughn has been Laura's patient, this is not their first meeting, which might otherwise account for some level of hedging on her part. Laura, as the medical provider, is in higher position than Mr. Vaughn, one that would, in itself, warrant her role of advice-giver, without the addition of justification and explanation for the advice.⁹

⁹ Even if one were to consider the present-day consumerism of medical care, this does not apply to the type of government-funded healthcare offered at the VA. Essentially, VA providers do not view patients as customers that they need to keep happy in order to retain their 'business.'

Instead, this example can best be understood as building rapport with the patient through attending to the interactional goals of the visit and focusing on relationship building. Laura's discursive choices seem to have the effect of highlighting the relational aspects of the visit while putting aside the instrumental functions. She constructs the 'caring provider' through an enactment of the patient-centered approach. Her identity as a provider is one who does not demand or issue imperatives but gives justified, mitigated advice and leaves it up to the patient to take or leave.

4.4. Off-Record Advice

In Excerpt 4-9, it is clear through the uptake that the patient was able to accurately interpret the advice; moreover, it is not surprising since the advice was on-record. Therefore, the use of indirectness did not necessarily jeopardize the message being communicated accurately. However, in Excerpt 4-10, the NP, Julie, takes a greater risk of the implicature not going through by using off-record indirect advice.

Mr. Adams is a first-time patient for Julie and is at this visit to check medications following a cardiac visit. Julie spends most of the visit identifying Mr. Adams' medications and adjusting and/or refilling medications as needed. Early in the visit, Mr. Adams explains that he was told by another provider to stop taking his blood pressure medicine, but after only a couple of days, he started taking it again because his "blood pressure ran up" and he "started feelin' funny in the head." In the following excerpt, Julie indirectly advises Mr. Adams not to continue taking his blood pressure medicine. The advice in this excerpt is off record, with no reference to either the medication or the advice (e.g. don't take the blood pressure medicine because you don't actually need it). Instead, Julie leaves it up to Mr. Adams to get the intended meaning of her utterance, possibly relying on his familiarity with the context to get the implicature.

Excerpt 4-10 NP Julie & Mr. Adams

196.NP: um hang on I'm gonna give you back the ni- nifedipine this is the one you to

197. you resumed this is that brown [one right?

198.PT: [that brown one right there started takin' it

199. [again

200.NP: [ye:ah um so just to let you know blood pressure going up to one thirty-eight or

201. even one forty that's okay (.) I mean when I looked in your book overall there

202. was only a few times it went up that high and sometimes if we're um not feeling

203. well or if we're stressed or um anxious about anything our blood pressure might

204. naturally rise a little bit and that's okay if your blood pressure was consistently

205. staying higher, then we'd want to make sure we gave you something for it but

206. (.) a short spike every now and then is okay (1.0) um let's see...

Similar to the previous example, Julie starts with a question in line 197: 'you resumed the brown one right' which requests clarification identifying the medication Mr. Adams resumed. Since it has already been determined that Mr. Adams resumed taking this medication that another provider told him to stop taking, we cannot interpret this question as 'pre-advice' since presumably Julie would give the advice independent of Mr. Adams' response to the question. She might delay the advice until she identified which colored pill was the blood pressure medication, but as noted, the fact that he resumed the blood pressure medication is, at this point, given information. The advice, then starts at line 200 and comprises Julie's entire turn (lines 200-206). It begins with an elongated 'yeah,' acting as a turn initiator and "pivot" from listener to speaker role (Drummond, & Hopper, 1993: 205) but also seems to function in a similar way as a

turn initial 'so', indicating a shift from the previous topic (Schiffrrin, 1987). This is immediately followed by the hesitation marker 'um,' marking the discourse as either difficult for the speaker or important for the listener (Fox Tree & Clark, 2002). Julie then begins the advice with 'just to let you know,' which has the locutionary effect of prefacing information sharing, a part of 'advice-giving.' She also includes specific blood pressure readings: 138 and 140, which are the readings Mr. Adams previously claimed were too high, causing him to restart the medication. In lines 202-203, as part of the advice-giving, Julie uses the all inclusive 'we,' meaning something akin to 'all humans' as a way to explain how blood pressure may fluctuate and why the numbers he mentioned are not necessarily problematic or cause for concern. The combination of using the numbers he provided earlier with the more general use of 'we' hints at the advice without explicitly stating it. Julie is relying on Mr. Adams to draw the connection between the numbers he mentioned and the more general patterns Julie describes to recognize that he should not worry about a blood pressure reading of 138 or 140 and that it is not a cause for concern or a reason to go against 'doctor's 'orders.' In line 205, she comes close to referencing his medication but uses the non-specific term 'something;' however this is still off record since there is no deictic (i.e. this/that medication) or a reference to the medication he stopped as an utterance such as 'we'd put you back on that that,' for instance, would have.

In this excerpt, there is no clear uptake from the patient. There is a one second pause before Julie moves on to the next topic so it is possible that Mr. Adams provides a non-verbal response or acknowledgement of the advice; however, without visual data it is impossible to confirm this. Overall, Julie does not provide a significant amount of time to allow Mr. Adams to respond nor does she prompt a response from him in any way, something like 'okay?' or 'does that make sense?' both of which may be too direct particularly in combination with the off record

form that the advice takes in this example. It is possible that Julie is relying on the context: the medical setting, her role as medical provider and his role as patient, to disambiguate her turn and recognize it as advice to follow the instructions of his providers.

In this example, Julie also avoids directly criticizing Mr. Adams' decision to go against his physician's advice to stop taking his blood pressure medication. It is not clear from the discourse whether one of the reasons for this is because of possible adverse effects it was having, for example, lowering his potassium levels, something that Julie discusses as a concern with other patients; therefore, the stakes of Mr. Adams decision to take the referenced medication are not entirely clear. It is then difficult to determine how important this decision was for Julie and what was at stake for her in terms of the import placed on instrumental goals and relational goals. However, it does seem surprising that she would choose to be as indirect as she is when giving advice to patients.

4.5. Interim Discussion

Bonnefon, Feeney and DeNeys (2011) argue that medical encounters are high-stakes situations, similar to flying a plane or emergencies, and that in these types of interactions, one would expect directness and clarity to be valued above politeness and avoidance of face-threatening acts. They argue that because indirectness is mentally taxing, it can lead to confusion, which may interfere with successful communication and completion of tasks; however, that has not been shown to be the case in a number of studies (Caffi, 1991; Defibaugh, 2014c; Parry, 2005) as well as in the data I have presented here.

Viewed in light of Nurse Practitioners' adherence to the patient-centered approach, the use of indirectness makes sense. Indirectness in giving medical advice can lower the sense of social hierarchy or vertical distance between NP and patient, thereby creating a more amicable

relationship. NP's can construct the identity of the 'caring provider' by avoidance of bald, on record indirectness in favor of indirect means.

5. Patient Up-Take of the 'Caring Provider'

Although patient impressions of NPs will be discussed more fully in Chapter 7, one particular comment seems fitting to include here. This comment is from an interview with Mr. Eggers, one of Karen's patients. In my interview with Mr. Eggers, I started with the question, "Did your Nurse Practitioner seem knowledgeable?" The following is his answer along with my follow-up, clarification questions for him:

1. PT: oh yes she she's up to date with everything that goes on with me (.) yeah
2. SD: so you feel like she ↑knows you
3. PT: oh yeah I'm very pleased with Karen I mean she takes time to ask you all the
4. questions and pushes you sometimes for things she knows hh like pneumonia
5. shot (.) I'm not ready for my pneumonia shot so she says 'I'll talk you into it next
6. time' hhh
7. SD: oh ↑really so she tries to ↑push you a little bit
8. PT: well you know I mean she knows what's good for you or best but I mean she
9. doesn't twist my arm and say 'you have to have this' it's subtle
10. SD: right right

The interview starts out by me asking about the patient's impression of his NP's knowledge, but quickly shifts to a discussion of her 'caring provider' identity. This is, in part, due to my question in line 2, 'so you feel like she knows you' asking for more information about how well informed

she is of his health, but, arguably vaguely worded so as to elicit a response about their relationship as patient-provider. The patient's response in lines 3-6 illustrates the kind of relationship he has with Karen. He voices Karen as telling him 'I'll talk you into next time' in a joking manner, noted by the laughter both before and after this quoted speech. Not having heard the recording prior to the interview, I wasn't sure how to interpret this comment (which it turns out is exactly what she said in the visit) and pushed for more information, trying to see whether her comment should be taken at face value or as a joking, rapport building kind of way of putting off the topic until a future time. In lines 8-9, Mr. Eggers constructs Karen as both the 'competent' and the 'caring' provider by pointing out her technical skill and knowledge as well as her ability to not be forceful in giving advice. In this turn, he voices the anti-Karen, a provider who gives instructions/advice in the form of directives. He contrasts this alternative provider identity with her ability to be 'subtle' in communicating advice. The 'subtlety' that Mr. Eggers refers to seems in line with the kind of indirectness that both Julie and Laura use in the examples discussed in Section 4. This impression, although not based on the two providers cited in that section, encapsulates the kind of 'caring provider' identity that the NPs in this study are constructing. The patient sees his NP as someone who knows him, who 'takes the time to ask questions,' uses subtlety when giving medical advice, and creates rapport through humor. Karen, and I argue, the other NPs in this study are able to construct the 'caring provider' through focus on creating a positive provider-patient relationship.

6. Discussion

In this chapter, I have outlined some of the ways that the NPs in this study construct the 'caring provider' identity by employing the patient-centered approach through developing long-

term, patient-provider relationships, taking a holistic view of the patient and allowing for negotiation of treatment and disease management.

Through the use of small talk, NPs can convey interest in the patients, helping them to construct their non-patient identities (see Chapter 6 for more on this topic) and creating rapport through shared experiences outside of their institutionally defined roles. Small talk, particularly, the TST examples discussed in this chapter, have the effect of setting aside the instrumental goals of the visit temporarily in order to focus on the relational goals. Typically, this done at the end of the visit, when then instrumental goals have been met, giving the provider a chance to end the visit with rapport enhancing moves.

Indirectness in the delivery of medical advice seems to align the NPs with the ‘caring provider’ who displays a “non-judgmental attitude” (Ong, et al., 1995: 904) toward patient’s non-adherence to past medical advice and minimizes social distance between herself and her patients. Although, as I have noted, NPs are in a “superior position” which warrants their role as advice-giver, the use of mitigated on-record indirectness and off-record indirectness, has the effect of downplaying that asymmetrical role in favor of a more equitable relationship. And, as Mr. Egger’s comments illustrate, patients seem to respond positively to providers who don’t dictate orders with bald imperatives but are more ‘subtle’ in the way they give advice.

Finally, the use of the ‘inclusive we’ creates as sense of “social orientation” to shared common goals by including the patient in the planning and agenda setting of the visit, including the provider in the tasks that the patient must fulfill, and ascribing responsibility to both parties by acknowledging their dual roles in improving the patient’s overall health. As I have mentioned, the use of the ‘inclusive we’ could be viewed as paternalistic and condescending, and, interpreting them as communal, is a somewhat complicated task. One way of thinking about the

use of the ‘inclusive we’ is that they are more likely to be viewed positively because of who the speaker is. Because NPs are engaging in other types of interpersonal talk and highlighting the interpersonal goals of the visit, the use of ‘we’ becomes part of that identity. If ‘we’ were used in the type of visit where providers were not seen as valuing personal relationships, for example, providers who took a more provider-centered approach, then it is more likely that this pronoun choice, as an isolated attempt at constructing common ground, would more likely be seen as insincere or inauthentic of the provider’s identity.

Therefore, it is important to see how the features discussed in this section work together to construct this identity. Focus on small talk alone is just one aspect, just as pronoun choice is. However, similar to the way that mitigated, indirect advice in 4-9 has a cumulative effect so too do the features associated with the patient-centered approach have a cumulative effect of constructing the ‘caring provider.’

CHAPTER 5

ALIGNMENT WITH THE ‘COMPETENT PROVIDER’ IDENTITY

1. Introduction

As the previous chapter discussed, one important aspect of NPs’ identities is aligning with the ‘caring provider.’ An equally important part of what it means to be an NP is the enactment of the ‘competent provider.’ NPs, as well-educated and well-trained medical professionals, seek to highlight their knowledge and provide patients with appropriate information that can aid them in reaching their long-term health goals.

‘Competency’ in medical care is often focused on technical skills (Callahan 1984), but the term itself can take on a range of meanings particularly when viewed across different medical specialties and disciplines. Murakami, Imanaka, Kobuse, Lee & Goto (2010) point out that competence in terms of technical skills are more highly valued by patients in surgical wards compared to pediatric wards, perhaps not surprising since the stakes are much higher in terms of technical competency in surgery settings compared to primary care visits. Whereas, in primary care, patients may place equal value on technical and interpersonal skills. The Accreditation Council for Continuing Medical Education (ACCME) defines competence as “knowing how’ to do something. Knowledge, in the presence of experience and judgment, is translated into ability (competence)” (www.accme.org). Competency can also be understood more broadly as comprising knowledge, skills and abilities, which Kak, Burkhalter and Cooper (2001) define as: knowledge: “understanding facts and procedures;” skill: “the capacity to perform specific actions: a person’s skill is a function of both knowledge and the particular strategies used to apply knowledge;” and abilities: “the attributes that a person has inherited or acquired through

previous experience” (3). Kak and colleagues, when describing competencies of medical providers include, among others, acting in ‘the helping role’ and ‘the teaching-coaching role’ as well as features associated with skills in diagnosing and administering therapeutic interventions and job-related competencies such as ‘organizational and work-role competencies.’

For the purposes of this chapter, I will include the following as part of constructing the ‘competent provider:’ 1) demonstration of knowledge and 2) recognition of organizational work-role responsibilities. Demonstration of knowledge (i.e. understanding facts and procedures) can be seen in the discourse in one of two ways: through performing the ‘teaching/coaching’ role by providing patients with the information they need, essentially through knowledge sharing; and assessing medical problems and providing informed decisions regarding treatment. This second aspect; however, cannot be evaluated by someone outside the medical community. An NP may *sound* very knowledgeable when she/he recommends a certain amount of insulin for diabetes patients or sends a patient for further testing because of abnormalities in kidney function; however, only a trained medical professional can reliably evaluate whether these are medically informed decisions that represent a high level of skill. Therefore, for my purposes, I focus on competency as ‘knowledge sharing’ as related to ‘teaching/coaching.’ NPs’ competency is evaluated on the extent of their ability to provide explanations that patients are likely to understand (such as using lay terms instead of medical jargon). Recognition of organizational/work-role responsibilities is determined based on the extent to which NPs align with their organization and the larger provider community, such as through the use of ‘institutional we’ (Arminen, 2006) or the way they follow ‘the script’ of medical visits and fulfill the role of ‘provider’ in more general terms. This will be discussed in terms of how NPs, despite the great deal of interactional work they do in medical visits (as discussed in Chapter 4) also

follow the same procedure as other providers (as noted in the prior research) and, in the case of the NPs working at the VA, address all of the prompts the VA computer system requires.

The remainder of this chapter will be organized as follows. In section 2, I illustrate how NPs control the talk by following the medical ‘script’ and by controlling topics. Neither of these aspects is new in the literature on medical visits (as described below), but as I show, the ways in which the NPs in this study control the interaction illustrates their level of competency in recognizing what is important for patients’ overall health. Section 3 returns to an analysis of pronouns, this time focusing on the use of ‘I’ and the ‘institutional we,’ both of which have the effect of highlighting the NPs’ knowledge and competency as a medical provider. Section 4 focuses on knowledge sharing, taking the theoretical concept of ‘epistemic responsibility’ (adapted from Stivers, Mondada & Steensig, 2011) as an important aspect of what it means to be a ‘competent provider.’ Patient up-take and co-construction of this identity is discussed in Section 5 followed by a summative discussion of the chapter.

2. Controlling the Talk

The analysis presented in this section illustrates how NPs control the talk both in topic and form while still addressing patient concerns. In the first excerpt, 5-1, the NP follows the designated ‘checklist’ of questions but allows topics to deviate based on patient responses, suggesting an understanding of opportunities beyond the required ‘checklist’ to gain insights into the patient’s health. In the second excerpt, 5-2, the NP carefully controls the topic of high and low blood sugar levels, directing attention to what she feels is most important while still addressing the patient’s concerns.

2.1. Following (and Deviating from) the ‘Checklist’

One way that the Nurse Practitioners in this study enact the role of ‘competent provider’ is by following the script of medical visits. Boyd and Heritage (2007) refer to the act of history taking as engaging in question-answer sequences that take the form of a ‘checklist.’ They point out that “these checklists of questions may arise from record-keeping protocols, or from the routine experience of the doctor, or from explicit guidelines taught during residency” (169). Referring primarily to primary care visits, Boyd and Heritage illustrate that during this phase of the visit, both patients and provider orient to this ‘checklist’ of questions by keeping questions brief, designing them for optimal responses (i.e. showing a preference toward healthy rather than unhealthy habits) and with sensitivity toward the participant (i.e. acknowledging known information), and, in turn, through keeping responses brief and on topic. In the case of the VA corpus, providers are given a ‘checklist’ of questions on their computer screen in which they must enter information so it can become part of the patient’s record. Through the computer system they also reorder prescriptions, schedule consultations with specialists or order additional tests. The computer system then dictates the ‘checklist’ of questions. However, as Boyd and Heritage (2006) also note, the checklist is sometimes departed from. In the case of the VA visits, NP’s both follow the ‘checklist’ script that the computer system provides, but they also allow deviations from the script when a patient shares information that may be pertinent to his/her health. The following example illustrates this point, as Karen asks a series of standard history-taking questions but allows the interaction to shift away from these questions when the patient, Mr. Franklin, provides additional information.

Except 5-1 NP Karen & Mr. Franklin

1. NP: you're not drinking anymore?
2. PT: oh no no I never dranked [does it say that on there [no I don't drink at all
3. NP: [okay good no it [says none it says none
4. PT: [I mean at all
5. NP: [good good is your father still alive
6. PT: yeah
7. NP: how old is he now
8. PT: he's almost eighty seventy-seven but here's he was I think I inherited some of this he
9. was always short (.) [winded
10. NP: [of breath but he was a smoker?
11. PT: no [never smoked a Baptist minister never smoked a day in his life but, (.) forty years
12. NP: [no oh really
13. PT: in the mills
14. NP: oh yeah the mills
15. PT: he worked at Kline's [(.) you know so
16. NP: [okay so what are you doing for your breathing medicines,
17. PT: I got the air (.) oh Doctor Burton gave me the air, I got the air at the house,
18. NP: the what?
19. PT: the air
20. NP: ↑oxygen
21. PT: oxygen I'm sorry
22. NP: you're wearing ↑oxygen

23. PT: well yeah, he thought I don't really need it but he thought I did so I got everything
24. they came by one day in a van and dropped off all kinds of- (.)
25. NP: when are you wearing the oxygen?
26. PT: when I sleep sometimes I forget
27. NP: okay
28. PT: and then it falls down on my nose
29. NP: oh I know
30. PT: how are you supposed [to keep I try but sometimes I wake up
31. NP: [you have to just tighten it around your ear yeah it's hard so and what
32. else are you- you got oxygen what else are you still taking the stomach pill from me
33. PT: yeah
34. NP: have you had any ↑heartburn
35. PT: ah no [no there ###
36. NP: [okay are you still takin' the blood pressure medication,
37. PT: yep
38. NP: a half tablet,
39. PT: yep

In the visit between Karen and Mr. Franklin she seems to be following the 'checklist' through her reliance on short, medical and family-history related questions. For example, in line 1, she asks him, displaying an optimization bias (Boyd & Heritage, 2006) for a negative answer, 'you're not drinking anymore?' The question is framed with negative polarity, indicating a preference for a negative answer, and suggests a change in condition from a previously

dispreferred action of drinking to one of abstinence, evident from the use of ‘anymore.’ This type of question formation is very much in line with the framing of questions by providers in the ‘checklist’ of history taking. There is a brief departure from the ‘checklist’ questioning when Mr. Franklin questions the information in his medical chart: namely whether the chart suggests that he was, formerly, a drinker. After clearing up this confusion in line 3, the NP then returns to the checklist in lines 5 and 7, asking about the patient’s father as a way of confirming family history. The first major departure from the checklist occurs in line 9 when Mr. Franklin then provides more information than what was asked of him, drawing a similarity between his father’s health and his own by explaining that like himself, his father “was always short winded.’ Karen allows this deviation from the ‘checklist’ format, likely interpreting Mr. Franklin’s contribution as relevant to the reasons for his lung problems. Her question regarding whether Mr. Franklin’s father was also a smoker can be viewed as an attempt at drawing a correlation between Mr. Franklin’s habits and his father’s. Although she is not correct in her assumption (noted by the assumption bias in her statement question), and as is revealed in lines 13-15, this health condition is likely caused by his work in the local steel ‘mills,’ this departure has the potential for revealing possible genetic/family history of pulmonary disease.

Following the first departure, Karen then returns to the ‘checklist’ by asking about his ‘breathing medications’ (line 16) which prompts the second major departure. In line 17, Mr. Franklin describes his use of oxygen, referred to it as ‘the air’ (line 17 and 19), which is not a direct response, as the question was specifically about ‘medications;’ however, this is relevant information and new information to Karen. The departure begins by first clearing up the confusion regarding the patient’s use of ‘the air.’ It is then followed by more questions regarding his use of oxygen and adherence to it. This is an important departure and one where

the patient is prompted by a checklist question to introduce new, relevant information. Karen engages in this departure as the use of oxygen is both new to her (i.e. prescribed by another provider) and likely will be included as part of his chart, which will then presumably become one of the questions she asks at the next visit- essentially constructing part of the ‘checklist’ for future visits. Following this departure, Karen then returns to the checklist for the rest of the excerpt, asking specific questions in lines 34, 36 and 38 about specific medications.

Throughout this exchange, Karen aligns with the ‘competent provider’ identity both in the way she addresses the ‘checklist’ questions dictated by the organization she works for and in her allowance of departures from the checklist, which allow her to elicit additional information from the patient that may not be covered in the VA’s question prompts. By following the ‘checklist,’ she is enacting her “organizational and work-role competencies” (Kak, Burkhalter & Cooper, 2001) by updating Mr. Franklin’s chart with information deemed by the organization to be important. In addition, she uses her professional knowledge and understanding that delving deeper into a topic through accessing the patient’s ‘lifeworld’ (Mishler, 1984) may reveal significant health information.

2.2. Controlling Topics as Medical Competency

One of the ways in which the asymmetry of medical visits has been discussed is in terms of topic control (Ainsworth-Vaughn, 2006), primarily discussed in terms of questioning practices (Boyd & Heritage, 2006; Heath, 1992). Topic shifts are often identified, based on West and Garcia’s (1988) definition, as discourse that “lack(s) referential cohesion...with immediately previous discourse” (p. 61). Topic shifts and controlling of topics can also be based on bringing the topic back to the instrumental tasks or the medical purpose of the visit either when participants engage in small talk or when medical topics seem to veer from the ‘checklist,’ as

was discussed in the previous section. Along these lines, we can look at topic control in terms of how medical topics are sanctioned or not sanctioned by NPs. The following example comes from an inpatient visit with June and Ms. Piper. The first part of the excerpt occurs early in the visit, about 2 minutes and 30 seconds in. The topic of low blood sugars causing a diabetic coma comes up at the end of the first part of this excerpt before June changes the topic. Then again, at about the 10-minute mark of the visit, the topic returns to the process of quickly decreasing very high blood sugar levels to a normal range and the feelings and symptoms associated with this. In this section of the excerpt, Ms. Piper, again, introduces the topic of low blood sugar and inquires what the symptoms of this are. Again, June changes the topic away from low blood sugar to the diabetic medicine. Although she doesn't avoid this topic entirely, particularly in the second part of the excerpt, she backgrounds it in favor of the topic that she deems more important: lowering Ms. Piper's blood sugar to a normal range.

Excerpt 5-2 NP June & Ms. Piper

43. NP: so before I get started on those small (.) assignments or what those assignments
 44. need to be: (1.0) what is your most pressing concern angst fears worries freak out
 45. ↑moments (0.5) as you think about being told in the hospital that the blood
 46. sugars are too high and that they are diagnosable for diabetes (3.0)
 47. PT: I guess (.) how to treat it I guess is my biggest concern um (.) both my parents are
 48. diabetics (0.5) my mom actually went into a diabetic coma (.) so (.) [it's a little
 49. NP: [from low
 50. from low blood sugar
 51. PT: scary yeah

52. NP: alright

53. PT: I mean the EMTs said her blood sugar was twelve

54. NP: okay very scary

55. PT: yeah (1.0)

56. NP: and you (.) have a ↑child

...

187.NP: in fact because you've been living with a blood sugar of three hundred even a

188. normal blood sugar (.) might feel crappy (.) and you check a blood sugar see if its

189. ↑low and you'll be a lo:ng way from going into a coma because we're gonna

190. readjust your body from thinking that three hundred is a good number (1.0) to

191. down in those low (.) one hundreds being a good number and that doesn't happen

192. immediately but you can see if you started feeling shaky sweaty symptoms of

193. low blood sugars and you check and you're (.) one eighty (.) or one fifty (1.0)

194. you're a lo::ng way from going into a coma (1.0) and that's that part of time

195. where we have to get your body readjusted to what good numbers are,

196.PT: so in essence the goal is to drop the numbers slowly I don't wanna just shwoot

197.NP: (2.0) not exactly (1.0) no because it is in best interest

198. to get the good numbers as soon as possible because you're in the hospital with

199. chest pains ##### so (.) because you're in an acute setting and because we have an

200. acute need for good blood sugars, we're gonna use the best products and we're

201. gonna get it down (.) we're gonna get it down as quickly as we can get it down=

202.PT: =but i'm gonna feel yucky [in the meantime=

203.NP: [you might =you might (1.0)

204. just sayin' honest [honest very honest with my patients (.) it's in your best
205.PT: [mhm
206.NP: interest to get out of the big numbers and you might not (.) feel great when you
207. do it (1.0) you might feel symptoms of a low blood sugar, before you're really
208. low
209.PT: and symptoms of low blood sugar a:re:?
210.NP: we'll get to that later let me tell you about your medicine now

At first glance, particularly focusing on the topic shifts in line 56 and 210 it seems as though June is controlling the visit by not sanctioning the topics that Ms. Piper introduces. To a certain extent, this is the case. In line 48, in response to June's question, Ms. Piper expresses her biggest concern through a reference to a past event: her mother going into a diabetic coma and her evaluation of her own diagnosis, marked by a shift from the past tense to present tense: 'it's a little scary.' After aligning with Ms. Piper's evaluation of the diagnosis being 'very scary' (line 54), June then shifts the topic entirely by asking about Ms. Piper's family and work life, topics that do not seem particularly relevant to Ms. Piper's concerns about low blood sugar. Similarly, at the end of the excerpt, after June has mentioned feelings that mimic low blood sugar, and with the reference to low blood sugar, Ms. Piper attempts to continue this topic by asking specifically what these symptoms are, noted by the elongated vowel and rising intonation at the end of the utterance. Again, June does not allow this topic to continue and states specifically that she will not address that question at this point and announces what topic she wants to discuss: 'we'll get to that later let me tell you about your medicine now' (202).

Prior research on medical visits have viewed these types of topic shifts and the ways in which providers control topics as evidence of the asymmetry in medical visits and the ways in which providers do not allow patients equal access to the floor. June is seen to do this through her change of topics; however, it is argued here that she does so in an enactment of competency. She uses here prior knowledge and experience of working with diabetic patients to place the greatest emphasis on the information that she, as a trained, knowledgeable, medical provider, recognizes as most important, and in turn backgrounds or minimizes information that may mislead the patient in the future in a way that would be detrimental to the her health. June focuses on the more pressing concern of high blood sugar levels in this visit, as well as others in the corpus, rather than low blood sugar levels, a topic that she views as less relevant to the hospitalized population she interacts with. June, then, enacts the ‘competent provider’ by redirecting the patient’s focus and concern to what she believes to be more important. Once again, Ms. Piper voices a concern that may be related to her fears regarding dangerously low levels in her comment, ‘so the goal is to drop the numbers slowly I don't want to just shwoot’ (line 196), the ‘shwoot’ simulating a drastic decrease and possible shift in physical feeling associated with this decrease. In lines 198-200, June summarizes that Ms. Piper may feel symptoms of low blood sugar- again returning to this topic of concern, without actually having low blood sugar, essentially disentangling sensations from reality.

Additionally, my examining the extended excerpt, particularly the second part of the excerpt, one can see that June is not simply ignoring Ms. Piper’s topic; she addresses it but only within the larger context of relying on empirical data (i.e. testing her blood sugar) and addressing the more important concern of having high blood sugar levels. June does reference Ms. Piper’s concern about low blood sugar and going into a diabetic coma in lines 189 and 194, in which she

explains that despite feeling ‘crappy’ (line 188) and/or ‘shaky sweaty’ (192), she is ‘a long way from going into a coma.’ These symptoms of low blood sugar are backgrounded in the discourse while the process of lowering and getting to an acceptable range as well as reliance on data as opposed to physical sensations are foregrounded.

Redirecting the talk does reflect the asymmetric power dynamic of the visit; however, this does not mean that the patient’s concern and/or best interest is ignored. Her concern is addressed, albeit not directly but within a larger discussion of feelings associated with lowering her blood sugar levels to a safe and acceptable range. In fact, it may be possible to even view June’s avoidance of directly addressing the question in line 209 as working in Ms. Piper’s best interest. If, at this point, June described the symptoms of low blood sugar, it is possible that Ms. Piper would fixate on this, particularly since she has already expressed concern about it. Then, later, feeling these symptoms, she would inaccurately misinterpret them as problematic rather than a normal part of reaching a healthy blood sugar range. June guides the topic of high and low blood sugar levels, foregrounding what she knows to be most important and backgrounding what Ms. Piper seems most concerned about. In doing so, she aligns with the ‘competent provider’ through acknowledgement of the patient’s concerns but re-directing focus to more pressing medical concerns, thereby attempting to provide the best information and medical care possible.

2.3. Interim Discussion

The two examples in this section present different ways in which the NPs control the talk. In the first example, Karen controls the interaction and fulfills her professional responsibility by asking questions that are prompted through the VA computer system. Part of her alignment with the ‘competent provider’ comes in her willingness and ability to follow the requirements of her organization. In addition to that, ‘competency’ can also be seen in her willingness to deviate

from the ‘checklist’ as a way of eliciting additional, medically relevant information. Simply following the ‘checklist’ precisely and not engaging in the ‘voice of the lifeworld’ (Mishler, 1984) could mean missing something that is important to understanding and treating the patient holistically, an important part of the NP approach to healthcare. June draws on her professional knowledge and experience working with diabetic patients to determine what topics to focus on with Ms. Piper. June’s enactment of the ‘competent provider’ can be seen in her recognition and insistence on addressing the more pressing concern of high, rather than low, blood sugar levels.

3. Institutional ‘We’ as Highlighting Professional Competency

Prior research on pronoun choice by providers has focused primarily on the use of an inclusive interpretation of ‘we,’ as discussed in detail in Chapter 4. Beyond this, two studies, in particular, have examined providers’ use of the first personal singular as well as the use of an institutional ‘we’ (Arminen, 2006) or what can also be understood as ‘exclusive we’ since it does not select the audience as part of the referent. Rees & Monrouxe (2008) illustrate how ‘I’ can index individual agency or official roles. In their examination of tutor-student-patient triad medical encounters, they note that students often use ‘I’ to provide ‘online’ commentary, describing their actions to the patient (e.g. “I’m going to look at your eyes”), which they argue has the effect of highlighting their status as an independent provider. Additionally, tutors may use ‘I’ to disambiguate their position of authority over the students in these encounters.

Along similar lines, Skelton, Wearn & Hobbs (2002) conducted a large-scale study of 373 medical visits analyzing doctors’ use of ‘I’ and ‘we.’ They found that doctors use ‘we’ both inclusively and exclusively, signaling both affiliation with the patient and with another group, respectively. They also note that ‘I’ was used more with epistemic verbs such as ‘think’ or ‘believe’ while ‘we’ was used with action verbs. This distinction could be interpreted as ‘I’

signaling the provider's medical authority and competency in making informed decisions and drawing on medical knowledge to do so, whereas, 'we,' in their study could be interpreted as either an ambiguous referent or an inclusive 'we' used to create a sense of patient-centeredness.

Overall, 'we' is primarily discussed in the literature in its inclusive function as a positive politeness move of affiliation with an interlocutor. Because of the affiliation constructed through the use of inclusive 'we' it is possible to then assume that institutional 'we' is a move of disaffiliation; by excluding the audience from the referent, the speaker is creating distance from him/her/them. Conversely, institutional 'we' can have the effect of aligning with a non-present other, which does not necessarily also indicate disaffiliation with an interlocutor. In the case of medical providers, 'we' can group them with the organization they represent or with the larger medical community. Affiliation with the medical community, I argue, is one way that a provider can construct a positive self-image as a 'competent provider' or a competent member of that community. It is expected that a provider has more knowledge than a patient and it is her/his job to share pertinent information with the patient. An NP, therefore, may highlight her own knowledge and experience, but because her institutional role as an NP is categorically different than that of a patient. Highlighting one's own knowledge does not insult the knowledge or lack of knowledge, of the other. Therefore, viewed within the paradigm of 'face,' it could be understood as enhancing one's own positive face but not necessarily at the expense of one's interlocutor.

In this section, I examine the use of 'I' and 'we' as affiliative moves that align the NP with the figure of the 'competent provider.' 'I' has limited reference in that it can only include the speaker. Agha (2007) refers to 'I' as the most selective within a particular speech event for just this reason. When NPs use 'I,' they position themselves as knowledgeable, endowed with

decision-making power and singly competent in their position. Institutional ‘we,’ as it includes as its referent a non-present other, serves to align the NP with the medical organization or community. ‘We’ as representative of the medical organization (e.g. the hospital) indicates a position of authority to speak on behalf of the organization; ‘we’ as representative of the medical community highlights the NP’s position as a member of a well-trained and knowledgeable occupational group. Additionally, in the following excerpt, I illustrate how switches between ‘I’ and ‘we’ can further reinforce the identity of the ‘competent provider’ in a way that using solely ‘I’ or ‘we’ could not do.

In the following excerpt, June and Mr. Johnson, in a first-time meeting, discuss Mr. Johnson’s prior experiences with diabetes, which he acquired through pancreatic surgery, as well as the best approach for treating him. Similar to the conversation with Ms. Piper presented in the previous section, Mr. Johnson and June discuss whether it is better to have blood sugar levels on the higher end of the spectrum or lower end. June positions herself as knowledgeable and capable of providing him with the specialized care that is required of him primarily through her use of first person pronouns.

Excerpt 5-3 NP June & Mr. Johnson

121. PT: but you know uh (2.0) people don’t know how to handle uh a person (0.2)
122. that’s a diabetic and doesn’t have his pancreas and [()]
123. NP: [I] do: understand that I
124. find >that is< a problem but I’m here to make sure that [we get this]
125. PT: [but well]
126. NP: done well

150. PT: [uh huh [yeah
151. NP: one thirtys maybe one twenty because I worry for you, that (2.0) while its not
152. perfect? we've let you go [too far]
153. PT: [yeah]
154. NP: out on the continuum that way and people can get infections in the ho:spital if
155. we let them sit with these two hundred blood [sugars↑]
156. PT: [yeah]
157. NP: and you're still you still have years left to go there could be another (0.5) big
158. vessel problem like stroke (.) stroke or heart [atta:ck.
159. PT: [mhm
160. NP: directly related to lettin' this run too high,
161. PT: yeah
162. NP: so I agree w- I hear your thought↑ (.02) and I wa- don't need you to be so
163. tight and scary?=
 164. PT: =yeah
165. NP: but I need to pull you back, from that other (0.2) end.

June uses first person pronouns 23 times in the two-minute excerpt; 'I' is used 14 times and 'we' a total of eight times. It is important to note that 'we' is often ambiguous in this excerpt both in terms of its exclusivity (i.e. whether Mr. Johnson is included in the referent) and in terms of whether the non-present other includes the medical community more generally, other hospital employees, or both. Table 7, below, presents a deictic map (Wortham, 1996) of the first person pronouns used by June in this excerpt. I have attempted to be as thorough in the possible

interpretations of ‘we’ in each case, considering all possible persons and entities that might be included. The most likely reading is in regular font with other, in my opinion, less probable interpretations, in italics.

Table 7. Use of first person singular and plural pronouns in Excerpt 5-3

| Line | Deictic | Referent | Context |
|------|---------|---|--|
| 123 | I | June | I do understand that |
| 123 | I | June | I find that is a problem |
| 124 | I | June | I am here to make sure that we get this done well |
| 124 | we | June + other hospital employees + <i>Mr. Johnson</i> | I am here to make sure that we get this done well |
| 131 | I | June | I think |
| 134 | I | June | I agree |
| 134 | I | June | I want |
| 139 | we | all people (including June & Mr. Johnson) | the older we get |
| 139 | we | June + other medical providers + <i>all people who have diabetes including Mr. Johnson</i> | the less perfect we have to manage diabetes |
| 142 | I | June | I’d be running her |
| 145 | we | all people (including June & Mr. Johnson) | every decade we get older the less tight or perfect we have to do |

Table 7 (cont.)

| | | | |
|-----|----|---|---|
| 145 | we | June + other medical providers + <i>all people who have diabetes including Mr. Johnson</i> | every decade we get older the less tight or perfect we have to do |
| 147 | we | June + hospital employees + <i>Mr. Johnson</i> + <i>other medical providers</i> | We don't need |
| 147 | I | June | I don't need |
| 147 | I | June | I want |
| 151 | I | June | I worry |
| 152 | we | June + medical providers (likely Mr. Johnson's previous providers) | we've let you go too far |
| 155 | we | Either June + hospital employees or June + medical providers (both equally plausible) | if we let them sit with these two hundred blood sugars |
| 162 | I | June | I hear your thought |
| 162 | I | June | I agree |
| 162 | I | June | I don't agree |
| 165 | I | June | I need to pull you back |

3.1. 'I' as Experienced Authority Figure

The first use of 'I' in this excerpt is in response to Mr. Johnson's claim that other providers ('people') often do not understand how to treat his form of diabetes (one that arose

from the removal of the pancreas). In lines 123 and 124, June disaligns with Mr. Johnson's portrayal of other providers. She indexes her own position of the 'competent provider' through the use of 'I do understand' and 'I find' both of which indicate prior experience with patients like Mr. Johnson who have had their pancreas removed. In doing so, June sets herself apart from other providers who are less knowledgeable and less experienced with atypical diabetic individuals. She then completes this utterance by designating herself, alone, as the one who is 'here to make sure' (line 124) that Mr. Johnson receives the quality and personalized care that he referenced. Although within this turn, June uses 'we' to align with the hospital community (I'm here to make sure we get this done well'), the exclusive 'we' is embedded in a Complementizer Phrase in which 'I' is the head noun of the entire sentence. This syntactic structure places June in the role of authority-figure and expert who will oversee other providers and hospital personnel with regards to Mr. Johnson's diabetes management. Other examples of 'I' will be discussed in section 3.4, below as they contrast with the use of 'we.'

3.2. 'We' as Speaking for the Hospital

The clearest example of 'we' as inclusive of other hospital employees is in line 124, discussed above. In this example, June is speaking as a representative of the hospital and on behalf of other medical providers she works with at the hospital. As indicated in Table 7, it is possible to interpret 'we' in line 124 as also including Mr. Johnson in such a way that June is including him as also playing a role in improving his health, much in the way that the inclusive 'we' was discussed in Chapter 5. I argue that whether Mr. Johnson is included in the referent here is less important than the fact that June is also including the other, non-present hospital providers and speaking on their behalf.

In line 155, June's use of 'we' ('people can get infections if we let them sit...') seems to primarily align her with her organization and suggests she is speaking for other hospital employees. Although it is possible to interpret the use of the institutional 'we' as also including all medical providers (as Table 7 indicates), the fact that she is focusing specifically on blood sugar levels 'in the hospital' implies that she is limiting this piece of medical information/advice to the immediate context rather than more general advice regarding diabetes management. By confining the information to the hospital setting, it is likely that June is referring specifically to what she and other hospital employees need to do to address Mr. Johnson's current, poor health in order to avoid 'infections.'

3.3. 'We' as Member of the Medical Community

In section 3.1, I discussed the way in which June, through the use of 'I,' disaligns with other medical providers, namely those who do not understand atypical diabetes patients such as Mr. Johnson. Later in the this excerpt, at line 152, June makes an interesting move to align with these less effective providers. Here, June uses 'we' to include herself in the referent of providers who have not provided the best care for Mr. Johnson ('we've let you go too far'). The juxtaposition of 'we' and 'you' here seems to exclude Mr. Johnson as a possible referent. Instead, this 'we' indexes medical providers, including Mr. Johnson's medical providers (whether they are associated with the hospital where June works is unknown). In truth, it is not June who has let him 'go to far' since this is the first time the two have met, and she has had no input on his care prior to this meeting. However, rather than placing blame on others, which is what the effect of 'they' in this utterance could have, she includes herself in this group. This may be a way to align both with other providers and with Mr. Johnson. That is, by avoiding blame of

past care, she creates a stance of shared concern and shared responsibility for his care going forward.

The shift to ‘we’ and the implicit alignment with Mr. Johnson’s previous providers seems contradictory to her earlier disalignment with the same group and has the potential to claim a similar lack of competency on her part. However, because this is their first encounter, she cannot factually and literally be including herself in this group; therefore, she cannot be seen as actually accepting the blame for his past care and his high blood sugar levels. June’s competency, then, is not threatened by aligning with these ineffective providers; instead it is strengthened. In this singular move, June both highlights her position as a member of the medical community and singles herself out as someone who can provide better care for the patient going forward.

3.4. Shifting Between ‘I’ and ‘We’

As Table 8 illustrates, June switches between ‘I’ and ‘we’ a number of times, alternating between highlighting her individual knowledge through the use of ‘I’ and her alignment with the medical community and other hospital employees through the use of ‘we.’ In addition to the effect that individual pronoun use has on June’s construction of medical competency, shifting between ‘I’ and ‘we’ further solidifies her position as both individually competent and representative of a larger group.

One such shift occurs in line 147 where June begins with ‘we’ but self-corrects and uses ‘I’ (‘we don’t need I don’t need you to get close to seventy’). June starts by including other hospital employees, possibly even Mr. Johnson in the subject position, but then shifts to ‘I,’ putting control and the knowledge of what an acceptable number for him is, strictly in her own hands. This shift in pronoun use indexes a shift in footing from simply a member of the team to the one who makes decisions and is knowledgeable enough to know what an appropriate blood

sugar level should be. She continues with 'I' in lines 147 as she describes her goals for Mr. Johnson's health. In this brief section of the interaction, she shifts footing again from not just a competent knowledgeable medical provider but to a concerned, caring nurse. This position is supported by the verb choices: "want" and "worry" (lines 147 and 151) that express her emotive stance toward her patient and his health, which is echoed through the use of the first person singular pronoun 'I.' She then, in lines 152 and 153, shifts back to 'we' to align with other medical providers and other hospital employees, as discussed in the previous sections.

3.5. Interim Discussion

As section 3 has illustrated, June enacts the 'competent provider' identity through the use of both singular 'I' and plural 'we.' The use of 'I' highlights her personal knowledge and experience, primarily as it relates to caring for individuals with diabetes as well as her position of authority to prescribe medication and set insulin doses for patients. The use of 'we' aligns June with the larger medical community, positioning herself as a member of a well-trained occupation and as a provider working within a larger institution. Finally, by switching between 'I' and 'we,' June's position as competent provider becomes fortified. Had she used only 'I' throughout this exchange the effect would likely seem too authoritarian and may, through exclusion of other medical providers, be viewed as presenting herself as the *only* 'competent' provider. Similarly, using only 'we' would minimize the knowledge and experience that comes from working with diabetes patients for many years.

4. Attending to the 'Epistemic Responsibility'

One final way that medical competency is enacted by the NPs in this study is through sharing of medical knowledge with patients. As has been well documented in the literature on medical interactions, providers have access to medical knowledge as well as the authority to

prescribe treatments based on that knowledge (Heritage, 2006; Heritage & Robinson, 2006). One way to operationalize this type of knowledge comes from research on knowledge in everyday interactions from Stivers, Mondada and Steensig (2011). They argue that there are three dimensions of knowledge: epistemic access, epistemic primacy, and epistemic responsibility (Stivers, Mondada & Steensig, 2011). Epistemic access can be understood primarily in terms of who has access to knowledge; epistemic primacy focuses on who has the rights to certain information and who may have a right to know that information; epistemic responsibility addresses how conversational participants determine whether information is shared or not, and therefore, make a decision in terms of what to share as well as how to share information. They argue that avoidance of giving already known information is important in everyday talk.

Although Stivers, Mondada and Steensig primarily focus on everyday interactions in their explanation and discussion of these dimensions, within a medical visit the asymmetry of all three dimensions is to a certain extent institutionally constrained. First, in a medical visit, the provider has greater access to knowledge relevant to the instrumental purpose of the interaction thereby creating an uneven distribution of medically relevant knowledge.¹⁰ The role of epistemic responsibility in this setting can also be understood slightly different than what Stivers and colleagues claim. Because of the high stakes nature associated with medical knowledge (i.e. having relevant knowledge can be the difference between behavioral change/improvement of health), and the inherent asymmetry of medical interactions, two basic premises require reanalysis of Stivers and colleagues' definition for the purposes of this data set. The first is that it may be more important for a provider to share relevant knowledge rather than trying to assess

¹⁰ Heath (1992) points out that patients also bring certain information to the visit, namely knowledge of their symptoms that providers rely on to make an accurate diagnosis. However, the patient's knowledge is understood as being limited compared with that of the provider.

whether the patient already has this information. The time limitations on visits as well as the import of certain knowledge may encourage providers to favor assertions over an information-check style of questioning. Secondly, the provider has a responsibility to share information in a way that patients can understand (Kessels, 2003). Studies have found, for example, that even quasi-technical terms like ‘hypertension’ or ‘obese’ are defined differently by medical providers and lay persons (c.f. Hadlow & Pitts, 1991) pointing out the need for clarity in communication of medical terms and sharing of medical knowledge. Therefore, ‘epistemic responsibility,’ in the case of medical visits, should be understood as the provider’s obligation to share information with patients that they believe is integral to their health, regardless of whether they believe the patient may already know this information. Additionally, information should be shared in a way that patients can easily comprehend, thereby allowing patients better access to knowledge.

The Nurse Practitioners in this study align with this concept of the ‘competent provider’ not only in their display of knowledge, illustrating what Stivers, Mondada and Steenig (2010) refer to as epistemic access, but also in how they fulfill their professional responsibility to convey this knowledge to patients through use of lay terminology and ‘translation’ of empirical health data into dietary choices, or what I refer to as epistemic responsibility. The following two excerpts illustrate these points, respectively.

4.1. Using Lay Terminology

The first excerpt comes from the first corpus of inpatient hospital visits. In this visit, June is visiting with a patient, Ms. Piper, for the first time. Not only is June new to Ms. Piper, her diagnosis of diabetes is also new; she was informed by another provider the day before this visit. Ms. Piper, in adjusting to her diagnosis, begins this excerpt by explaining that her rise in blood sugar levels was sudden in her view, and asks what appears to be a rhetorical question in line 4

(‘how does that happen in just two years’) but is taken up by June as an information-seeking question. June then explains how blood sugar levels can change rapidly (lines 5-8), what happens to the body when it stops producing insulin (lines 8-21) and how medical providers are able to accurately diagnose diabetes (22-26).

Except 5-4 June & Ms. Piper

1. NP: because the nurse looked (.) I mean I was in the hospital two years ago my blood
2. sugar was one twenty (3.5) it was over four hundred (1.0) when I got here
3. NP: okay=
4. PT: =how does that happen in just two years,
5. NP: it can happen in two months when the pancreas has had enough and it
6. cannot produce enough insulin in the face of all the (.) challenges and
7. ↑workload (.) it will start to shut itself down it cannot meet the challenge
8. anymore (1.0) the pancreas is an organ over on that side of your ↑belly
9. [it produces several hormones pan- insulin is only one hormone that it produces
10. PT: [mmhmm
11. NP: but it's the only place we get insulin (1.0) insulin is the hormone that goes out
12. and grabs ↑glucose (.) in the blood stream (.) and grabs ahold of it and moves it
13. through the (.) the body and into the cell walls it's the only way glucose gets into
14. the cell when glucose stays in the (.) blood stream (.) in a big number then they
15. suck water from all the rest of the body and the blood stream because it's trying
16. to dilute all those big ↑molecules so where does all that go:? through the kidney
17. (.) and you pee a lot (1.) and because you're peeing a lot your brain says ‘I’m

18. losing water' and it stimulates thirst (1.0) and because glucose doesn't get in the
19. cells where its supposed to fuel your ↑body you (.) pee your food out into the
20. toilet (.) literally (.) you lose weight, (.) so the symptoms that you've been
21. having? are high blood sugar symptoms (0.5) when the blood sugar (.) in the
22. morning is ↑high (.) we can diagnose diabetes, (.) when it's high anytime in a
23. spot check, we can diagnose diabetes or we can use an A1C which is an average
24. blood ↑glucose
25. PT: mhm
26. NP: and your average is three hundred (.) so we can diagnose diabetes off of that (.)
27. any way we cut it we know that you have diabetes, (1.0) and we can fix that

Even though Ms. Piper's question could be interpreted as a rhetorical question, it indicates her lack of knowledge of how someone gets diabetes. Based on June's description, we also see that Ms. Piper's lack of knowledge can explain how she missed the signs of diabetes (i.e. excessive thirst and frequent urination), which she previously acknowledged to have been experiencing for 'a couple years.' June, presumably, views this as part of her responsibility to share what Ms. Piper does not know about her newly diagnosed condition, first, briefly answering her question in lines 5-8, and then, more explicitly in the rest of the excerpt. Understanding her epistemic responsibility to provide Ms. Piper with accessible information, June uses a number of non-technical lexical choices, namely 'belly' (line 8) and 'pee'/'peeing' (lines 17, 19) as well as the verbs 'grabs' (line 12), 'moves' (line 12) and 'suck' (line 15) to describe the role that insulin plays. One could argue that June's use of low-register terms such as 'belly' and 'pee' could be seen as patronizing rather than helpful; however, as she notes in an

interview, individuals' cognitive processing as well as ability to retain information is severely reduced during an inpatient stay or after receiving a stressful or emotional diagnosis (also supported by research, c.f. Kessels, 2003). Therefore, the consistent use of low register and easy to understand terminology can be seen as an attempt at aiding Ms. Piper in both processing and retaining the information. This is further seen in her lack of specificity in terms of the amount of glucose in the blood that can cause damage, referred to as an unspecified 'big number' (line 14) and her description of how the brain sends signals to the body through her use of the quotative: "your brain says 'I'm losing water' (lines 17-18). As Kessels (2003) reports, "statements in simple language will be recalled better than complex formulations" (221). June's explanation follows what many in the medical community recognize as an effective ways of sharing knowledge through 'simple language.'

June's description of the process specifically addresses previously discussed topics such as Ms. Piper's frequent urination and excessive thirst. In doing so, she relates her knowledge directly to Ms. Piper's experience and acknowledges their shared knowledge, which she most directly references in lines 20 and 21. She uses rising intonation on 'having,' possibly further highlighting their shared knowledge of her previous experiences or 'common ground' knowledge (Brazil, 1997). At the end of her explanation of how insulin works, June also introduces a term 'A1C,' which is a test commonly used and commonly referred to in diabetes management. June, drawing on her knowledge of Ms. Piper as newly diagnosed, defines this term as she recognizes an epistemic need for this information. Again, she provides a somewhat simple and non-specific way of defining A1C rather than giving extraneous information that Ms. Piper likely does not need nor would remember at this point. All of these linguistic choices can be seen as enacting a professional 'competency' as a medical provider.

4.2. 'Translating' Health Information

The second example of an NP constructing the identity of 'competent provider' through sharing of knowledge comes from an outpatient visit between Laura and Mr. Barnes, a 46-year old male who is coming in for an annual check-up. In this excerpt, Laura reviews Mr. Barnes' recent blood work with him. Rather than simply reporting the data to him, she presents it along with the expected norms and 'translates' various aspects of his lipid profile (e.g. triglycerides, LDL, HDL and total cholesterol) into common food items and categories. Unlike the previous example, Laura does not explain what happens in the body, when, for example, we consume high levels of cholesterol; instead her approach is to relate the test results to dietary habits.

Excerpt 5-5 Laura & Mr. Barnes

1. NP: your triglycerides are three hundred and thirty-two, (.) they should be below one
2. fifty that's bread pastas sweets that's carbs okay so you need to cut back on that
3. and look at where you were last time you had blood work
4. PT: okay
5. NP: so from one twenty-six you're up to three hundred and thirty-two so you need to
6. watch yer::: yer diet
7. PT: okay back to what I was doin'
8. NP: well that's right try not to be eating a lot of sweets or breads
9. PT: okay
10. NP: all right your LDL which is the bad cholesterol that clogs up the arteries is one
11. seventy-nine, okay it should be below one sixty that's pork products red meats
12. saturated fats [okay::

13. PT: [aw no pork?
14. NP: so you have to eat more turkey chicken fish,
15. PT: fish okay tuna
16. NP: a:nd it is better than it was last time you were two hundred ‘n two (.) now you’re
17. down to one seventy-nine but [you need to be a little lower
18. PT: [need to get it all lower
19. NP: definitely
20. PT: okay
21. NP: your cholesterol is two hundred sixty-six it should be below two hundred,
22. PT: okay [I gotta cut off on my french fries
23. NP: [so:: well that’s right fried foods um: last time you
24. were at two sixty, (.) so you’re a little bit higher
25. PT: okay

In describing each of the components of the lipid panel: triglycerides, HDL, LDL and total cholesterol, Laura tells Mr. Barnes what his test results are as well as what would be considered healthy (lines 1-2, 10-11 and 21-22). This is important information for patients to know, particularly when their readings are far above what is considered acceptable, as is the case with Mr. Barnes’ triglycerides and total cholesterol levels. Although she does not provide specific feedback in how to improve these numbers, she does ‘translate’ each aspect of the lipid panel into the food sources that contribute to each. In line 2, for example, she ‘translates’ triglycerides into ‘breads pastas sweets...carbs’; similarly, LDL is ‘translated’ into avoidance of ‘pork products red meats’ (line 11) and increased consumption of ‘turkey fish chicken’ (line 14). The

patients' uptake of this approach and 'translation' technique seems to be fairly effective, at least in his ability to report back the information: 'no pork?' (line 13) and 'fish tuna okay' (line 15). He also initiates his own 'translation' of health data to food in line 22 where he interprets his high total cholesterol into 'I gotta cut off on my french fries,' which the NP confirms in the following line 'that's right fried foods' (line 23).

There is another example in this excerpt that could be considered to align with the 'competent provider.' This occurs in lines 3-5. In line 3, after discussing Mr. Barnes' triglyceride reading, she draws the patient into the discussion and into her task of reading and interpreting the data through the directive: 'look at where you were last time.' Although I have only the audio recording and cannot confirm that she physically shows the data to Mr. Barnes, the use of the directive here suggests that she does, in fact, show him the data to reinforce the difference between his previous reading ('last time') and his current reading, which indicates a significant increase and one that took him out of the acceptable and healthy range. Here Laura seems to be addressing the dimension of epistemic access, in her awareness of Mr. Barnes' right to direct access to specific information about his health rather than it exclusively being transmitted through her.

4.3. Interim Discussion

The NPs in both of the examples above illustrate their 'epistemic responsibility' as providers to determine what information is important for patients in order to understand their medical condition better, in the case of June and Ms. Piper, or to understand how dietary habits can influence one's health, in the case of Laura and Mr. Barnes. In each example, the NPs allow patients greater 'epistemic access' through avoidance of excessive medical jargon and the use of language and terminology that is easy to understand.

5. Co-Constructing the ‘Competent Provider’

The Nurse Practitioners’ identity as ‘competent provider’ is constructed not only through their talk but is also co-constructed through the patients’ discourse during the visits and supported through their evaluations as presented in post-visit interviews.

One of the clearest examples of the ‘competent provider’ being co-constructed by a patient occurs in a visit between Karen and Mr. Griffin. Mr. Griffin is a recurring patient of Karen’s. They clearly have a positive and long-term relationship, as he starts the visit by jokingly referring to her as ‘the boss’ and brings her a gift of homemade bread that his wife baked. Like many of the VA patients, Mr. Griffin has another primary care provider, Dr. Kimball, who he sees outside of the VA. His visit with Karen is primarily for an annual check-up and medication refill (similar to many of the VA patients in this study). However, as the exchange below illustrates, he clearly views Karen as a medical authority, perhaps even as the ultimate authority compared to other providers with whom he interacts. This is particularly clear in his confirmation-seeking questions: ‘does that make sense’ in lines 2 and 7 and ‘is that correct’ in line 3a.

Excerpt 5-6 NP Karen & Mr. Griffin

1. PT: yeah so then when I did go to that (.) emergency room like I told you with that
2. terrific pain, they said I had shingles does that make sense (.) inside your head
3. and no no-
4. NP: no rash yeah no a small percent less than five percent do have it without rash
5. PT: okay it was in my head
6. NP: interesting

7. PT: but it only bothered me at night [time does that make sense
8. NP: [oh:::
9. it doesn't make the most sense but sometimes you're in tune to what you're
10. feeling in the evening when you're laying down
-
- 1a. NP: okay so Plavix, (.) Flomax, (.) vitamin E you still take?
- 2a. PT: yeah I just started that cuz I heard somewhere it does a little bit of good for
- 3a. you is that correct?
- 4a. NP: I do not believe so hhhhhhh
- 5a. PT: ah they ruled that ↑out one time
- 6a. NP: u:m they did

In the first part of this excerpt, Mr. Griffin asks the question, 'does that make sense?' twice to confirm his own knowledge and/or that of other providers. First, in line 2, he questions the diagnosis of shingles that he received in the emergency room ('they said I had shingles does that make sense?'). He is clearly drawing on his own knowledge of shingles as a something that is external rather than 'inside your head' and is checking the emergency room doctors' diagnosis against Karen's knowledge, perhaps also confirming that he understood the diagnosis correctly. Karen confirms this diagnosis by providing additional data on shingles: 'about five percent do have it without rash.' His reliance on her medical knowledge, seen in the confirmation check, as well as her knowledge of statistics related to shingles aligns her with the figure of the 'competent provider.' Similarly, Mr. Griffin asks again, 'does this make sense?' in line 7 when inquiring about his symptoms being most noticeable at night. This time the confirmation-check seems to

function primarily as checking his own knowledge about his illness, but could also be understood as checking what other providers told him against Karen's evaluation.

In the second part of the excerpt, Mr. Griffin, once again, co-constructs Karen's medical authority by asking for confirmation regarding the efficacy of vitamin E. He begins his questioning by hedging his own knowledge through the use of 'I heard somewhere' (line 2a), which, in and of itself, creates an opportunity for Karen to display knowledge and either confirm or refute the claim. The addition of 'is that correct' (line 3a) more specifically functions as a way of seeking confirmation as to whether this is accurate information. It explicitly acknowledges her knowledge and ability to know whether vitamin E has any health benefits. Karen, does, in fact, refute this claim in line 4a. Rather than a response such as '↑really' (with marked rising intonation) that may be seen to challenge her assertion, Mr. Griffin accepts her assessment outright, noted through the response of 'ah,' showing deference to her authority.

Based on these excerpts, Mr. Griffin co-constructs Karen's medical authority and competence through direct questions that seek confirmation regarding medical information and advice gained from others, including other providers. It is impossible to know whether Mr. Griffin does this with all providers or if it is only with Karen. Either way, he seems to view her as a 'competent provider' and one who can provide reliable medical information. This is supported further in the interview data in which Mr. Griffin identifies Karen as knowledgeable about his own health and perhaps more actively engaged and aware compared to some of the other providers he sees regularly. In response to the question, "Did the Nurse Practitioner seem knowledgeable about your medical condition?" he responded with: "Yeah always is (.) she checks up (1.0) she's got it there on her screen every year (.) cuz I got some new stuff here." His evaluation of Karen is that she is knowledgeable about his medical history and current

conditions. In response to the question about treatment recommendations, Mr. Griffin shared a story about a previous encounter with Karen in which he highlights her competency in comparison with his doctor:

Last year, (.) I had an open shirt on and I had a mole here and she suggested I go see a dermatologist and I did and that was just by sight that she seen it and I had some on my back (.) she didn't see those but my doctor never said anything about it but she just seen one there and said 'go see a dermatologist' and I did and they had all these taken care of.

Mr. Griffin describes an interaction with Karen in which she noticed a mole 'just by sight' and not because he brought the topic up to her. He also compares her proactive approach of referring him to a dermatologist for 'just one' mole while his doctor, who presumably had the opportunity to see additional moles on his back, did not acknowledge them at all. Through this story, Mr. Griffin constructs Karen as more engaged in his health through application of her knowledge and experience with patients in general.

Similar evaluations of the NPs' competence arise in other post-visit patient interviews. For example, Mr. Jones, another one of Karen's patients, when asked whether she was knowledgeable, provided a similar comparison between Karen and other doctors he sees:

"Oh my goodness yes (.) oh I hate to say this well I don't hate to say it (.) she is as knowledgeable if not more so than some of the doctors that I go to and she's ah (.) a lot more understanding and she has the answers she's exceptional I think.

Similar to Mr. Griffin, but even more explicit, Mr. Jones, describes Karen as ‘as knowledgeable if not more so than some of (his) doctors.’ This evaluation clearly places NPs in a different position than doctors, particularly in a lower position in the medical hierarchy, but it reveals that Mr. Jones views Karen as highly competent even when holding her to the same standard he would for doctors.

Mr. Barnes (the patient from Excerpt 5-5) provides similar evaluations of his NP, Laura. In response to the question, “Did the Nurse Practitioner seem knowledgeable about your medical condition?” Mr. Barnes replied, “Oh yes she's very knowledgeable very much so (.) very much so.” His assessment of her role as a knowledgeable provider is seen in the way he intensifies his reply through the use of ‘very’ and ‘very much.’ Additionally, when asked whether Laura answered all his questions, he responded with, “She answered my questions and even made me think about a few (1.5) she added some things to my own thought about cutting back on the coffee take my vitamins more.” Mr. Barnes, again, reveals his impressions of Laura as a competent provider not only in her ability to answer his questions, but also in how she encourages him to think about dietary changes, one of the things she specifically addresses with him in the visit (see Excerpt 5-5). In this, we can see Laura fulfilling the ‘teaching-coaching’ role as described by Kak, Burkhalter and Cooper (2001).

6. Discussion

In this chapter I have outlined the ways in which the NPs in this study construct the ‘competent provider’ identity. Constructing the ‘caring provider,’ as argued in Chapter 4, involves prioritizing relational goals over instrumental goals, but this does not mean that NPs ignore the instrumental goals of the visit altogether. Addressing the instrumental goals of the

visit involves controlling medical visits, aligning with the others in the medical community and recognizing NPs' epistemic responsibility.

One of the ways in which the 'competent provider' is enacted is through controlling the talk, which, as I have shown, can be accomplished in a number of ways. Controlling talk, in its simplest sense, can be understood as following the 'checklist' provided by the institution (in this case the VA) as a fulfillment of the NPs' organizational responsibilities. Simply following the 'checklist' precisely, however, may not be the most effective way of addressing patients' health concerns, as it would not allow for the exploration of new, and possibly, relevant topics. In the case of Karen and Mr. Franklin, Karen balances following the 'checklist' with deviations that may provide medically relevant information about Mr. Franklin's health including genetic predispositions toward particular health problems in the case of the questions about Mr. Franklin's father, as just one example. June, in her interaction with Ms. Piper, similarly controls the talk but not by following a checklist of questions provided by the hospital. Instead, June draws on her medical knowledge and experience working with diabetic patients to recognize that, despite Ms. Piper and others' anxieties about low blood sugar, the more imperative information relates to high blood sugar levels. June prioritizes information regarding high blood sugar levels while backgrounding the discussion of low blood sugar, placing greater focus and attention on what she sees as Ms. Piper's most pressing issue with regards to her health. By controlling the topics, she highlights her professional knowledge and aligns herself with a particular type of provider: the knowledgeable and competent provider.

Pronoun choice, just as it can signal affiliation with the patient, as discussed in Chapter 4, can also serve to highlight the knowledge of the provider. In this chapter, I argue that the use of both 'I' and 'we,' particularly in the combined use of singular 'I' and plural 'we' highlight the

NP's knowledge as a provider. The use of 'I' serves to signal June's individual knowledge and experience with diabetes, in this case, with a particular form of diabetes that is brought on by the removal of the pancreas. The use of institutional 'we' aligns June with the larger medical community, creating affiliation with other providers including those that have not provided the best care for the patient in the past. In doing this, she avoids placing blame on others and creates a stance of shared responsibility for the patient's health.

Finally, NPs in this study enact the 'competent provider' by acknowledging their epistemic responsibility to patients. Both of the examples presented above illustrate how the NPs avoid overly technical medical jargon in favor of lay terminology. In the first of these two examples, June uses terms such as 'belly' and 'pee' rather than more technical, albeit recognizable terms, such as 'stomach' or 'urinate.' As I have argued, the use of these low register, non-technical terms, can be understood as an attempt at decreasing the cognitive processing necessary in understanding the process of insulin secretion so that Ms. Piper may be more likely to retain the information. In the second example, Laura similarly avoids technical terminology by describing components of the lipid panel through translation to dietary choices. In doing so, Laura focuses on education and practical information that may encourage the patient to make more healthful choices in the future.

In this final section of this chapter, I have argued that the NPs' alignment with the 'competent provider' is both co-constructed by patients in medical visits and sanctioned by them in the post-visit interviews. Patients' recognition of the 'competent provider' comes in their assessment of the NPs' general knowledge of medicine, their specific knowledge regarding their patients' health and in their ability to share pertinent knowledge with patients in a way that will, hopefully, have a positive impact on their overall health.

CHAPTER 6 CONSTRUCTION OF PATIENT IDENTITIES

1. Introduction

As previously discussed, the medical visit is an institutional setting where participants fulfill particular institutional identities, namely that of the provider and the patient. The prior two chapters focused on the construction of NPs as both ‘caring’ and ‘competent’ in their role of medical provider. This chapter will focus on the ways that the role of patient gets constructed.

The institutional positioning of the patient is socially constructed; that is, their institutional role, to some extent, is not negotiated in interaction but exists prior to the interaction. Waitzkin (1991) argues that individuals are, in essence, ‘taught’ how to be the patients through processes of interpellation. Individuals then do not construct the role of patient, themselves, ad hoc, but draw on previous experiences and cultural knowledge of how one is to act in this role and how one is addressed in this role by other discourse participants including intake nurses and receptionists. This suggests that even for individuals with little prior experience of medical visits, the processes of making an appointment, which can include describing symptoms and justifying a need for the visit (Heath, 1992), checking in with a receptionist, and the initial ‘in-take’ evaluation with a nurse, can quickly acculturate an individual into the role of ‘patient.’ Frank and colleagues (2010) refer to this process as being “called to act like and to think of [oneself] as a patient, with all the qualifications of that identity” (36). This can, in turn, lead to one also speaking in a particular, socially sanctioned and culturally appropriate way as well (Davies and Harre, 1990). Mishler claims that medical visits often involve “talk in ways that we, as members of the same culture, recognize as contextually appropriate” (1984: 60). He specifically refers to this type of talk as a part of “unremarkable

interviews” (59) or ones in which the socially constructed, or what Prentice refers to as the “expected social role” (2010: 168), of both provider and patient follows the norms of talk. The typical norms of talk in medical visits, specifically the “expected social role” of the patient have been discussed in previous research as being passive recipients of knowledge, as the next section will discuss. However, as this chapter illustrates, the manifestations of the ‘socialization’ of patient-hood varies much more than the prior research suggests. Patients may, and in fact, do, construct their position as patient not only as deferent to authority but also as knowledgeable, not always compliant with prior directives, and even as ‘non-patients,’ foregrounding aspects of their identities that are not determined by their institutional position as a patient.

2. Performing the Role of Patient: Prior Accounts

The institutional role of ‘patient,’ as presented in the majority of the research on medical visits is that patients are passive recipients of information and deferent to doctors’ authority. Heath (1992) and Stivers (2007) note that patients are often silent during the visit, responding only minimally to questions that are asked of them. In fact, Heath (1992) notes that in his data even minimal responses (e.g. ‘oh’, ‘really’) during the diagnosis phase of the visit were quite rare despite his assessment that the doctor was encouraging a response (e.g. through pause, gaze/posture) from the patient. This performance of the role of ‘patient’ also suggests deference to the doctor’s positioning, particularly in the ‘presentation of problems’ phase of the visit (Heath, 1992; Heritage & Clayman, 2010). Patients essentially feel the need to justify the visit, or prove that they are sick enough to warrant a visit, as if it is an imposition on the doctor.

When patients do assert a more active, controlling position, they often do so through indirect means. Patients will sometimes offer possible diagnoses, and even propose their own line of treatment, but rather than doing so directly, they use mitigation devices such as hedging

or ‘suggestions’ of alternatives (Ainsworth Vaughn 1998). Gill and colleagues present multiple case studies in which patients attempt to request a diagnostic test (Gill, 2005) or offer a candidate diagnosis (Gill, Halkowski and Roberts 2001) through indirect means. These positions are very much in line with Frank, Corman, Gish and Lawton’s (2010) analysis that patients play the role of ‘patient’ by performing certain expected actions. That is, it is expected for patients to play the non-expert role in these interactions. Suggesting possible diagnoses or requesting specific tests challenges the roles of ‘expert’ and ‘non-expert,’ which likely explains the patients’ use of indirectness to introduce these topics.

One study that constructs a different picture of patients comes from Reese and Monrouxe (2010) who present a more complex understanding of patients, arguing that both providers and patients construct identities as “witty, intelligent and powerful” (p. 397) through the use of laughter or ‘laughables’ (or referents of laughter). Although not exactly the focus of their article, Reese and Monrouxe allude to the possibility that patients and providers may choose to highlight aspects of their identity that are not defined wholly by their institutionally-defined roles. For providers, ‘laughables’ may align them with a particular figure of personhood, for instance, the ‘witty/funny provider.’ For patients, ‘laughables’ may represent an interactional move away from the ‘voice of the medicine’ to the ‘voice of the lifeworld’ (Mishler, 1984) in which they reveal aspects of their personality or even construct the ‘non-patient’ identity, described in section 3.5. ‘Laughables,’ as understood as departures (even if quite brief) from the instrumental goals, can create moments of intimacy through shared laughter and joking and have the effect of lowering social distance. Although this study focuses on one very specific linguistic feature, it illustrates the ways in which complex identities may emerge in medical visits.

2.1. Defining the Patient: Outside the Medical Visit

Other, similar, studies focus on identity in illness but do so through examination of online forums (migraine sufferers: Marko 2012) and interviews (diabetics: Connor et al., 2012; Hamilton 2003; Saunders 2011). The latter, which rely on researcher-led interviews with individuals with diabetes, do so from the perspective of past experience of non-compliance or ‘what went wrong and why.’ These studies provide insights into patient’s views of their role in chronic illness, but fall short in considering the identity construction within the medical visit.

3. The Complexity of Patient Identit(ies)

The patients in my data set also seem to fulfill the socially constructed role of patient in most aspects of the medical visit in that they do not directly challenge the role of the provider as ‘expert’ nor do they refute a diagnosis when it is presented to them. That is to say, patients in this data set follow the “expected social role” of patient, but they do so in a variety of ways. Patients come to the medical visit with different problems, different agendas, and different medical histories that can also influence how they construct their role as patient. Prior experiences with a given provider as well as experience in the role of ‘patient’ across different settings and with different providers can all influence the particular identity that a patient highlights at any given moment within an interaction. The framing of the medical visit with the provider and the ways in which the provider and patient co-construct the visit can also foreground particular patient identities. It is also important to point out that expectations of patients have shifted in the last two decades, in which patients are expected to take a more active role in their health. This shift in health care also plays an integral role in how patient identities are constructed, as will be discussed in further detail later in this chapter.

In the remainder of Section 3, I outline a number of different identities that emerge in the medical visits studied. The purpose of this section is to analyze the recurring patient identities as they align with particular figures of personhood (Agha, 2007) and to illustrate how varied and complex the role of patient can be. In Section 4, I use an extended excerpt to show how individual patients often shift identities throughout a particular visit, aligning with different figures of personhood depending on the phase of the visit or the topic. Section 5 provides possible accounts for the emergence of these identities particularly in comparison to what has been noted about patients in previous research, drawing primarily on the medical neoliberal ideology that has come to define medicine in recent decades as well as the position of the NP in the ‘middle space’ of medical providers. This chapter ends with a general discussion (Section 6).

3.1. The ‘Deferent Patient’

As noted in Section 2, patients have often been portrayed as passive recipients of information, essentially deferring to the provider as ultimate source of knowledge and authority. This type of patient certainly exists in my corpus of data, and as discussed in Section 4, is often one identity among many that patients align with in medical visits. One of the clearest examples of the ‘deferent patient’ arose from the interview with Mr. Deaver, a patient at the cardiac care clinic. During the post-visit interview, when asked the initial question of “What was your primary reason for your visit today?,” Mr. Deaver responded with the following:

1. I forgot what he [the cardiac physician] told me (.) it was to a visit the Nurse Practitioner
2. (sic) to see how the medicine he had changed I was supposed to have blood drawn but
3. I forgot so I'm gonna do that on the way out and **normally if they tell me I have an**
4. **appointment I always keep it I don't question what the appointment is about or**

5. **why should I have the appointment** ...every time they told me I need an
6. appointment I **don't ask them why** do I have to have one I always keep 'em **I figure**
7. **they know more than I do**... they ask do you want an appointment for such and such
8. a date I say give it to me 'cuz **they know better than I do**"

In his response to the question, the patient both implies that it was not his need or desire to come to the clinic on this day but that he was following 'orders' from a prior visit with the cardiologist who works with this particular NP, and that he is the kind of person who will defer to medical providers' authority without question. This is most salient in the bolded parts, particularly in his claim to "always keep it" and not "question what the appointment is about or why." He also positions himself as the 'deferent patient' more clearly when he says two different times, "They know more than I do." In the following question, when asked if he had other concerns that he wanted to discuss with the NP in this visit, this identity is further constructed when once again Mr. Deaver defers to the provider's authority and higher position: "I was gonna ask her about that [getting blood drawn] I wasn't for sure what day but **I knew she would tell me.**" Although Mr. Deaver here claims that he had planned to ask a question about the blood work, he then somewhat contradicts this claim by saying, "I knew she would tell me," suggesting that he relies on the provider to give him the information he needs. The use of 'but' indicates an oppositional stance from the previous clause, in some ways negating the claim that he would have asked had he needed to; instead, he positions himself as recipient of information and the NP as the provider of information.

This pattern of patient deference can be seen in the medical visit as well. In Excerpt 6-1, below, Julie asks Mr. Deaver a series of questions about his smoking. Mr. Deaver, for the most

part, provides brief answers to Julie's questions, with elaboration at times. The excerpt ends with Julie asking Mr. Deaver if he is interested in smoking cessation gum.

Excerpt 6-1 NP Julie & Mr. Deaver

61. NP: okay well great great um (6.0) do you smoke
62. PT: yes
63. NP: how much do you smoke
64. PT: eh:: since I started back maybe about uh:: fourteen (.) a day
65. NP: so [half a pack half a pack yeah
66. PT: [cigarettes a day not a pack
67. and you said since you started back↑ (.) when did you stop
68. PT: yeah when I had the heart attack (1.0) February twen- twentieth I think it was
69. (1.5) oh it was seventeenth [I'm sorry February seventeenth
70. NP: [okay (2.0)
71. and when did you start back
72. PT: ahh (3.0) mm::: I would say the middle of April
73. NP: really? how come
74. PT: didn't have enough to do was thinkin' about a cigarette and (.) walked around to
75. the gas station and hhh bought a pack of cigarettes hh
76. NP: darn wh- ha- does your girlfriend↑ smoke
77. PT: yes she does
78. NP: um do you have any desire to quit smoking
79. PT: I have had the desire for quite some time but talkin' about quittin' don't seem to

80. help me
81. NP: yes that's right have you ever tried ah the nicotine gum or lozenges↑
82. PT: ah my doctor (.) the doctor I had at (1.5) what is it
83. NP: Y clinic?
84. PT: yeah Dr. Marcus
85. NP: uh uh
86. PT: well she's transferred now she she had me on some throat lozengers but all they
87. were doin' is makin' my mouth dry and once I get some water to wet my throat
88. NP: yeah
89. PT: I was still thinkin' about a cigarette so I tried that for two months and uh give it
90. up (2.0) but the gum↑ I haven't tried the gum because it says chewing gum
91. NP: yeah
92. PT: I have a major (3.5) denture problem,
93. NP: oh okay
94. PT: as far as chewin' gum I barely can chew food-
95. NP: -yeah
96. PT: so chewin' gum I might not be able to do it but if I can suck on the gum to keep
97. from chewin' it I might try that
98. NP: do you wanna try that↑
99. PT: I can try it

Alignment with the 'deferent patient' in this excerpt can be seen in two main ways: 1) minimal responses to questions; and 2) acceptance of the NP's offer of smoking-cessation gum. First, Mr.

Deaver gives minimal responses to the questions in lines 61-77. Julie asks yes/no questions in lines 61 and 76, to which Mr. Deaver gives short responses of ‘yes’ and ‘yes she does,’ respectively. His responses can be understood as orienting to the ‘checklist’ (Boyd & Heritage, 2007) and talking and acting in the way that he believes patients are supposed to act. The other questions, lines 63, 67, 61, and 73 are more open-ended questions where, in theory, the patient has the option to provide as much or as little detail as he likes. In each of these, again, he seems to provide the minimal amount of information asked, never inferring that Julie might be requesting additional information. For example, in response to the question ‘and you said you started back when did you stop’ (line 61), it is possible to infer that this question might be asking for a narrative not only of when he stopped smoking but also when he started back and why he started smoking again after quitting in the past. Rather than interpreting this question as asking more than what is said, Mr. Deaver provides only the information that is asked of him, requiring Julie to ask both of these questions in subsequent turns (lines 71 and 74). Responding only to what is asked of him parallels Mr. Deaver’s interview responses of doing what he is told to do.

The ‘deferent patient’ alignment continues at the end of this excerpt in Mr. Deaver’s response to Julie’s question about wanting to try smoking cessation gum. Although he has been unsuccessful in using the lozenges (lines 86-89) and expresses doubts about his ability to chew gum (92-94), he willingly agrees to Julie’s suggestion in line 99: ‘I can try it.’ This response does not seem to be a strong agreement of his desire (indicated through the use of ‘want’ or ‘would like’) but instead, because of the use of ‘can,’ suggests simply a willingness to follow the advice of the NP. His response of ‘can’ seems to, once again, position Mr. Deaver as a passive recipient of information and deferent to the providers’ medical authority.

The deferent patient is presented here as representative of the way that patients have been depicted in prior literature. It is important to illustrate that this patient type is not unique to doctor-patient visits but is constructed in NP-patient visits as well. I also present it here as a point of departure for the other types of patient identities that are constructed in NP-patient visits.

One might think that providers would actively sanction the deferent patient precisely because they are focused on following medical advice, keeping appointments, and acknowledging providers' medical authority, all of which serve to maintain the power asymmetry and avoid challenges to providers' higher social and interactional position in medical visits. However, there is no evidence of this in either interview or interactional data. Instead, the type of patient that is consistently affirmed by the NPs in this study, which is why I use the term 'good patient,' is of one who is knowledgeable of his/her health and is well prepared for the visit.

3.2. The 'Good Patient'

It is important to note that the 'good patient' is not presented in opposition to the 'deferent patient.' That is, I am not arguing that the 'deferent patient' cannot be equally successful in improving his/her health as the 'good patient' or any other type of patient presented in this section. The term 'good,' as it is used here, is not intended to be a qualitative assessment of which patients are more successful but as representative of the evaluative stance that NPs take toward certain displays of knowledge and actions on the part of patients. Therefore, what it means to be a 'good patient' for the NPs in this study is to be well prepared, often in the form of bringing a list of medications to the visit (Excerpt 6-2) and being knowledgeable about one's medical condition (Excerpt 6-2 and 6-3).

Excerpt 6-2 illustrates both of the qualities of what it means to be a ‘good patient.’ Lines 3-4 reveal Mr. Adams’ knowledge of his medication; lines 5-6 show Mr. Adams’ preparedness for the visit.

Excerpt 6-2 NP Julie & Mr. Adams

1. NP: okay let’s see when you saw Dr. Schultz um last month he went ahead and increased
2. your water pill right?
3. PT: three and two
4. NP: okay good (.) are you familiar with your medicine
5. PT: I brought everything witcha everything all you need to know I got it right here
6. NP: you brought it with you? fabulous

In this example, the NP begins, early in the visit, by asking the patient about a previous encounter with another provider and a change in medication. She draws on information from his chart and then verifies that information with him in lines 1-2. The patient quickly confirms the change in medication in line 3, without pause or hesitation. This information is given in a shortened form, indexing knowledge of ‘provider speak,’ which often refers to milligrams or number of pills in short hand by time of day (e.g. three and two refers to ‘three pills in the morning, two pills at night’). Julie acknowledges Mr. Adams’ knowledge of his medication in line 4 with the response token ‘good,’ suggesting a sanctioning of his identity as a good patient who knows what medication he takes.

In line 4, Julie asks Mr. Adams about other medications, specifically asking if he knows what other medication he takes. This is a common question in primary care visits, particularly

with older patients such as Mr. Adams who often take multiple types of medication and whose dosages often change depending on a variety of factors. Having that information suggests a level of involvement in one's health and implicates a level of adherence, although this may not always be the case, and later examples will illustrate. In this excerpt, Mr. Adams answers this question by providing Julie with a piece of paper in which all of his medications are written out, as explained in line 5, "I brought everything...I got it right here." This action of bringing paperwork indexes a 'well-prepared patient' who either carries a copy of his medication list with him/her in general, or one who knows, from prior experiences in medical visits, that providers will often ask for a medication list and who makes a point of compiling and bringing this information to the visit. This identity is ratified by the NP in the last line both in her echoing of his utterance and in the use of 'fabulous,' indicating an evaluative stance toward the patient and this action. This identity is one that gets ratified by various NPs repeatedly in a number of visits in a similar way which suggests that preparedness for visits is highly valued and recognized as an important component of what it means to be a 'good patient.' In fact, when patients do not come prepared for visits, they are admonished for it, as illustrated in the exchange between Karen and Mr. Franklin.

6-3 NP Karen & Mr. Franklin

1. NP: are you still taking the medication called Effient
2. PT: **that is what ###**
3. NP: a breathing medication you came out of the hospital with it last time we didn't have it so **do you carry a list of the meds that you take**
4. PT: **no**
5. NP: **you [should**

6. PT: [I should

In this excerpt, Mr. Franklin fails to align with either aspect of the ‘good patient’ identity in that he does not recognize the medication name, Effient (line 2) nor does he carry a list of his medications with him (line 4). In line 5 Karen explicitly advises him to do so, a move that can be interpreted as indirectly showing disapproval of his actions, the very opposite of the type of sanctioning seen in response to Mr. Adams’ actions in 6-2.

A second example of the ‘good patient’ can be seen in the way knowledge is presented not solely based on personal experience but in a more general presentation of information. This excerpt comes from an inpatient visit between June and Mr. Johnson, a 76-year-old patient who has been hospitalized with complications from diabetes. Mr. Johnson, when voicing his concerns about the quality of his care or his own ability to manage his diabetes, does so rather indirectly by invoking generic nouns such as “people” and “person” and the generic pronoun ‘you,’ which functions similarly to an indefinite pronoun, ‘anyone’ and suggest a level of knowledge of diabetes beyond his personal experience.

Excerpt 6-4 NP June and Mr. Johnson

121. PT: but you know uh (2.0) people don’t know how to handle uh a person (0.2)

122. that’s a diabetic and doesn’t have his pancreas and [()]

123. NP: [I] do: understand that I

124. find >that is< a problem but I’m here to make sure that [we get this]

125. PT: [but well]

126. NP: done well

127. PT: I’ve got a question

128. NP: yes sir

129. PT: I feel li:ke, that (0.5) you're better than your (0.5) blood sugar is a little little

130. ↑higher than it bein' a little lo:w, (0.2) [because]

In lines 121-122, Mr. Johnson introduces the new topic by claiming, “people don’t know how to handle a person” who “doesn’t have his pancreas.” The first generic referent “people” appears to index medical providers, since it is medical providers who ‘handle’ people with diabetes. In this he invokes a previous history of failed interactions or what he may deem to be poor care by providers who do not understand his particular form of diabetes. By introducing this comment into the interaction, he also indexes his own knowledge of how his form of diabetes is different from others and may require a slightly different approach to the care. The second set of deictics: “person” and “his” seem to point to the same referent: an unidentified person who has the same form of diabetes as Mr. Johnson. Here, he could easily use the first person subject pronoun ‘me’ rather than “a person” since both he and June know that he is like this unnamed, generic person. The fact that he does not seem again to indicate a larger knowledge base beyond just his own unique experience to something that applies to all within the group. By referencing the larger group of “people” rather than speaking only about his own experiences, Mr. Johnson presents this information as if it is a nomic truth, what Agha terms, a “timeless truth” or “universalizing claim” (2007: 44). The use of the gendered third person pronoun ‘his’ could actually represent a shift from the unnamed, un-gendered ‘other’ to more specifically defined person, in this case a male, thus making the connection between ‘person’ and himself closer. However, it is also possible that ‘his’ is being used in the formerly unmarked use of masculine singular pronouns to represent all genders in a similar way as in “Does every student have *his* book?” Either way, it is

clear that Mr. Johnson is careful to distance himself and June from the more general claim he is making with regards to quality of care. It is this act of distancing that aligns Mr. Johnson with the ‘knowledgeable patient’- a characteristic that is particularly valued in diabetic care. Notions of patient knowledge and familiarity with the disease characterize the widely distributed discourse of diabetes. This can be seen in the statements posted on the American Diabetes Association website:

Diabetes is a common disease, yet every individual needs unique care. We encourage people with diabetes and their families to learn as much as possible about the latest medical therapies and approaches, as well as healthy lifestyle choices. Good communication with a team of experts can help you feel in control and respond to changing needs (diabetes.org 2013).

As this excerpt indicates, a strong focus is placed on education regarding both ‘therapies’ and ‘lifestyle choices.’ Therefore, being knowledgeable not only about one’s own experiences but with the current trends and best practices in disease management can be viewed as what it means to enact the ‘good diabetic.’ By presenting his knowledge as general, nomic truths rather than personal experiences, Mr. Johnson constructs this particular identity.

Similarly, in line 129, Mr. Johnson again uses a distancing second person “you” to make a claim about what the appropriate approach to managing blood sugars is. He begins with the first person “I,” making it clear that this is his belief, but then switches to “you” and “your.” Here the use of “you” is clearly not a reference to June, who does not have diabetes and does not have to worry about her blood sugar levels, but instead it is used as the generic ‘you’ meaning ‘anyone.’ The generic ‘you’ suggests that the patient has general knowledge of diabetes beyond his own experiences- as if to say ‘this rule of thumb does not just apply to me but is a rule that all

diabetics should follow.’ It is clear from line 130, in his use of ‘because’, that he intends to explain his reasoning for this position but is interrupted by June. Therefore, it is unclear whether his reasoning is based on his own experiences or on more general medical knowledge, for example safety concerns that arise from extremely low blood sugar levels; however, the use of the generic ‘you’ in the previous line seems to indicate a level of knowledge beyond personal experience.

Through the use of generic nomics, Mr. Johnson positions himself as someone who is knowledgeable of his own disease, and indirectly, as someone who is not a typical diabetic in that his form of diabetes may require a different approach: an approach that not many medical providers are knowledgeable of and one that, perhaps, favors higher rather than lower numbers. His use of the generic nominal aligns him with the figure of ‘good diabetic,’ which may be in opposition to what is typical of individuals who have been hospitalized, or as illustrated by other studies of diabetes narratives (Connor et al. 2012; Hamilton 2003; Saunders 2011), the commonly circulating narrative of non-compliant diabetic. By creating an alignment with this particular figure, Mr. Johnson positions himself within this interactional moment, not as a passive recipient of information but as an actively knowledgeable individual.

3.3. The ‘Knowledgeable but Non-Compliant Patient’

Another common patient identity that emerges from the data is similar to the previous one in that this patient-type is also quite knowledgeable; however he/she does not always adhere to prior medical advice. I have labeled this patient-type as the ‘knowledgeable but non-compliant’ patient, but another way to understand this identity is to view them as partially aligning with the ‘good patient’ in that they know their medication, but also willingly sharing their experiences of non-compliance with the provider, something that is not outwardly

sanctioned by the NPs but not admonished either. Excerpt 6-5 illustrates this identity. In lines 30 and 32, Mr. Newell, like the previous patients, shows his knowledge of his medication; however, in line 32 he also admits non-adherence.¹¹

Excerpt 6-5 NP Sarah & Mr. Newell

29. Let's look at the medicine you're taking right now
30. PT: Glipizide I think is the only thing
31. NP: yep that's it yeah and what's the dose you're takin'
32. PT: one tablet twice a day after meals (.) that doesn't always happen I mean I
33. Always take two ya know the timing ya know after ##
34. NP: what do you mean two
35. PT: ah the two ah Glipizides
36. NP: okay
37. PT: I take the one in the morning absolutely
38. NP: okay

Again, this excerpt occurs early in the visit during the phase where the NP is verifying the patient's current medication list. Here, the NP, Sarah, starts with a statement 'let's look at the medicine you're taking right now,' seemingly as a way of shifting from the previous topic of kidney functions (not included in the excerpt) and as a way to signal that shift to Mr. Newell.

¹¹ Although sometimes understood differently, the terms 'adherence' and 'compliance' are being used interchangeably in this dissertation. My use of these terms as synonyms reflects the way that the medical providers I work with also use them and does not reflect the more current trend in medical care to use 'adherence' rather than 'compliance' nor the distinction that some make between 'compliance' and adherence' (see Aronson, 2007 for a discussion of these terms).

Following this statement, Mr. Newell responds immediately, in line 30, by naming the medication he takes, followed by a hedge ‘I think’ indicating a level of uncertainty about whether this is the only medication. Similar to Excerpt 6-2 in the previous section, Mr. Newell offers the name of the medicine without hesitation, and, unlike in 6-2, he does so without a question even being asked of him. Mr. Newell essentially preempts the question that Sarah might ask (as noted, this is a recurring pattern in the first phase of the outpatient medical visits in this study), offering unsolicited yet pertinent information. This action suggests a familiarity with the genre and the type of question that is typically asked of him. The quick response, with no hesitation, also illustrates his familiarity with his medication, similar to what was discussed in 6-2.

Sarah then seeks to verify the current dosage in line 31 and Mr. Newell responds, again without hesitation, providing the dosage and the instructions, as if reading from the prescription label or repeating back instructions he has been given by providers in the past: ‘one tablet twice a day after meals.’ Again, similar to Mr. Adams in excerpt 6-2, Mr. Newell is clearly familiar with and able to use ‘provider speak’ when referring to his medication, indexing an identity of ‘knowledgeable and experienced patient.’ However, unlike Mr. Adams, Mr. Newell then pauses briefly and juxtaposes his knowledge of what he *should* do with what he *actually* does. This shift represents a claim of noncompliance despite having a clear understanding of the instructions.

This shift is a particularly interesting one, in that we might expect patients to be unwilling to admit noncompliance in medical visits. Research on admittance of noncompliance is limited, likely due to the difficulty in measuring accounts of what is not said. Hamilton (2003) notes that patients are often either not given the chance or unwilling to offer accounts of non-compliance during the medical visit despite willingly sharing this information in post-visit interviews with

researchers. The fact that Mr. Newell so readily offers up his admission of non-adherence is quite interesting and illustrates the complexity of the patient role in the medical visit.

3.4. The ‘Struggling Patient’

The third patient-type is similar to the ‘non-compliant patient’ discussed in the previous section; however, this patient positions him/herself as limited in his/her own agency by external factors. The example of the ‘struggling patient’ presented here is based on an inpatient visit between June and Mr. Tucker, a patient with diabetes. Because diabetes is an illness associated with individual agency (Defibaugh, 2014a), the way in which patients with diabetes, such as Mr. Tucker, construct their position in relation to their illness can be best understood through the construction of an ‘agency of intention’ rather than an ‘agency of power.’ Based on the distinction by Ortner (2001): ‘agency of power’ is the ability to act unimpeded and maintain control over one’s life whereas ‘agency of intention’ is limited by external, cultural constraints. In the following excerpt, Mr. Tucker constructs the identity of the ‘struggling patient’ through an invocation of these two types of agency.

Excerpt 6-6: NP June & Mr. Tucker

1. NP: what goes on at home what goes on when you drive your truck anything’s wide
2. open so you guys go first what’s your angsts concerns worries fears (2.0)
3. PT: that’s my livelihood (.) if I lose my CDL license I lose my insurance I lose my
4. job (1.0) and that- ah that’s somethin’ to be- that’s a major step (2.0) and with the
5. economy right now I’m lucky to have a job and if I screw around and mess it up
6. (1.0) I’m- I won’t have any health insurance for me to go to a doctor let alone

7. even be <able to pay> bills (.) that's one of the reasons I don't go straight to
8. insulin and if I watch my diet and I'm not sick my Glyburide/Metformin takes
9. care of it (.) it keeps it down

In lines 7-9, Mr. Tucker highlights his knowledge of diabetes by referencing the importance of diet, staying healthy, and taking the prescribed medication (e.g., Glyburide/Metformin). He shows his knowledge of proper diabetes management by referring to commonly held understandings of the importance of diet and medication (see excerpt from the American Diabetes Association website, above). This illustrates that Mr. Tucker, like many patients, is knowledgeable about his disease; this knowledge helps him assert a certain type of agency in that if he controls these aspects of his health, he can maintain a relatively low blood sugar level- "it keeps it down." Through his display of knowledge on how to control his disease he acknowledges the role of individual agency, something that is valued in diabetic care. However, despite the ways in which Mr. Tucker seems to be displaying the 'agency of power' that is characteristic of the institutional discourse, it is prefaced by his claim of dependency on his job as a possible barrier to successful disease management. He equates his job to his "livelihood" and his access to care. In lines 3-4, the job is tied into "losing his insurance;" this connection to access to health is repeated in lines 6-7, where he claims he "won't have any health insurance" and will not have money "to go to the doctor let alone pay...bills." His health is then contingent upon his ability to keep his job and, in turn, his insurance.

The minimization of 'agency of power' can be seen not only in the invocation of how his health is directly dependent on his job, and vice-versa, but also in the way he positions himself discursively. In lines 3-4, he puts himself in the semantic role of patient (one who undergoes a

state of change): “If I lose...”, rather than the role of agent. He further takes this position in line 5, in which the economy is introduced as a reason to hold on to a job, despite the repercussions it may have on his health. Again, in line 5, he places himself in the position of experiencer (a position characterized by an absence of volition): one who “is lucky to have a job.” This suggests that he sees himself as lacking in ‘agency of power,’ something that is assumed to be available to all diabetes patients, according to the prevailing discourses (c.f. Defibaugh, 2014a). Rather than taking an agentive role, he places himself in the semantic roles of patient and experiencer. In line 5, this stance changes as he places himself in an agentive role, although it is not clear what he means by ‘if I screw around and mess it up.’ ‘Screwing around’ seems to refer any act that would jeopardize his job, even if that means becoming healthier by taking insulin.

In this particular excerpt, Mr. Tucker creates a position for himself in which he is not endowed with the power to take control of his health entirely (“that’s one of the reasons I don’t go straight to insulin”, line 13) because of factors such as the “economy” and what is inferred regarding losing his CDL (Commercial Driver’s License) if he were to go on insulin. However, he is able to claim an ‘agency of intention,’ drawing on the prevailing institutional discourse of maintaining a healthy diet (“if I watch my diet”), taking medication (“my glyburide/metformin”) and being healthy (“if I don’t get sick”). Therefore, a central distinction between the ‘non-compliant patient’ and the ‘struggling patient’ seems to be volition: the ‘struggling patient’ is constructed through reference to external constraints while the ‘non-compliant’ patient makes no such claims to these limitations.

3.5. The ‘Non-Patient’

In addition to the many patient identities discussed above, individuals often construct identities that are not directly related to their institutional role of patient but instead illustrate

who they are outside of this role. This identity can be some aspect of their physical activity or overall health (Excerpt 6-7), highlighting ways that they are not defined by their illnesses or can be unrelated to their health entirely and focused on who they are in their family, work or home life (Excerpt 6-8).

The first example of the ‘non patient’ is presented in the following excerpt. In line 4 Mr. Eggers introduces the topic of his exercise routine, which is then taken up by Karen in the following lines.

Excerpt 6-7: NP Karen & Mr. Eggers

- 20. NP: right right right well have a seat on my table
- 21. PT: #####
- 22. NP: let me examine you
- 23. PT: I’m ## well I’ve cut back a little bit but I’m in the gym everyday
- 24. NP: Oh you do you exercise everyday
- 25. PT: yeah
- 26. NP: excellent for how many minutes
- 27. PT: well about forty five minutes for the whole workout
- 28. NP: NP: good where do you go
- 29. PT: I got to the Bartlett civic center
- 30. NP: oh nice
- 31. PT: where it costs me forty dollars a year
- 32. NP: forty dollars a year that’s excellent
- 33. PT: hhh yeah

34. NP: good for you cuz
35. PT: and then you know in the summer time I ###
36. NP: yeah but the more you exercise the better you'll feel all the way around in so
37. many different aspects
38. PT: well its like I go in and I do six miles on the stationary bike and then in the
39. summer I'll do another ten twelve on my own bike hhhhh
40. NP: oh yeah that's excellent good good good

Throughout this excerpt, Mr. Eggers describes his typical routine at the gym (lines 4, & 8) and his level of exercise in the summer compared to the current (fall) season (lines 16 & 19-20). Karen sanctions this identity by continuing to engage in the topic and asking follow-up questions; in lines 17 and 21, she explicitly shows her support of this identity through the use of 'excellent' and the repetition of 'good' (line 21). One might argue that Mr. Eggers is presenting an identity of 'the good patient' through his focus on physical aspects of his health; however, the fact that this is introduced by the patient in a way that is seemingly unrelated to prior discourse as well as not as a result of questioning or prompting by the NP, seems to suggest that this is an aspect of his identity that he chooses to reveal and one that seems to identify him as 'healthy' rather than 'ill.' Using Mishler's (1984) distinction between the 'voice of medicine' and the 'voice of the lifeworld,' Mr. Eggers is speaking in the 'voice of the lifeworld' by introducing aspects of his life that may be related to the purpose of the visit or to his overall health. Mr. Eggers' topic introduction in line 4 represents a shift in footing from actively participating and fulfilling the role of patient to constructing a non-patient aspect of his identity.

to the previous discussion because of the use of ‘good’ and because (shortened to ‘cuz’ here). The ‘good’ offers an evaluation of Julie’s previous utterance; it can most clearly be understood as an elided form of ‘that’s good to know’ or ‘that’s good news,’ indicating a positive evaluation of Julie’s comment. Additionally, the ‘cuz’ suggests a continuation of this elided utterance of ‘good’ where the hearer expects an explanation of the speaker’s approval. However, the rest of the utterance and the following turns do not seem to clearly indicate how the length of Mr. Carlson’s marriage helps explain the evaluation of the information Julie provided. From this point, through the rest of the excerpt, Mr. Carlson continues to provide information about his marriage and his wife (lines 166-167, 169-170, 172-173, 175, 178) before changing the topic to the upcoming birth of his great-grandchild, a topic previously introduced earlier in the visit by Mr. Carlson and re-introduced here in lines 179 and 181.

These shifts away from the transactional focus of the visit to more personal topics that are seemingly unrelated to his health are common throughout Mr. Carlson’s visit. These shifts could also be considered an introduction of the ‘voice of the lifeworld’; however, they are distinct from both the previous examples discussed above as well as Mishler’s (1984) examples in that there is no clear relation to the topics introduced by Julie or even of what is expected of the ‘patient role.’ Similar shifts occur four other times in this visit- in the span of just under twenty minutes, with some of the topics lasting more than three minutes each, including the one excerpted above. What these shifts in topic away from medicine and personal health to the patient’s family seem to indicate is either a lack of familiarity with the acceptable topics and construction of the medical visit or a desire to not be defined by one’s health or sickness.

4. Shifting Rather than Static Identities

In the previous section, I showed how patients align with a number of different identities. However, it is also important to note that patients are not necessarily constructing one particular identity throughout an entire visit. This is the case for some, such as Mr. Carlson, who seems to align with the non-patient for the majority of his visit. However, others actively shift between different patient-types for a variety of reasons including the phase of the visit or what type of identity he/she chooses to make salient at any given point. The following extended excerpt comes from a visit previously discussed between Sarah and Mr. Newell. As illustrated above, Mr. Newell enacts the ‘knowledgeable but non-compliant patient’ by displaying knowledge of his medication but also making claims about his lack of adherence in taking the medication as prescribed. However, it is not the case that Mr. Newell continuously makes similar claims of non-adherence throughout the visit nor does it make sense that he would wish to highlight this particular identity throughout different phases of the visit or across different topics. Instead, Mr. Newell, like most patients, aligns with different identities at different points. In lines 179-206, Mr. Newell seems to be aligning with the role of the ‘good patient;’ in lines 213-221, Mr. Newell’s introduction of the topic of his family suggests an enactment of the ‘non-patient’ identity.

Excerpt 6-9 NP Sarah & Mr. Newell

172. NP: I know I knew you were going to do that hhhh but everything else looks great
173. okay↑ (1.0) um::: you’re comin’ up f:- you don’t follow any other doctors
174. do you you just come to va right↑
175. PT: no

176. NP: that's fine I just wanted to be sure cholesterol is great, I mean everything
177. else is wonderful, let's talk about the medicine you're still on the Terazosin
178. and the Finasteride [okay
179. PT: [yeah in fact they jacked up the Tera- Terazosin
180. NP: okay do you get dizzy↑ from that [at all↑
181. PT: [no uh uh not at all
182. NP: wonderful and do you still take the Viagra↑ (2.0)
183. PT: on occasion [yeah
184. NP: [okay just make sure you don't take it within four [hours of
185. PT: [no I don't
186. NP: you know that [right
187. PT: [yeah
188. NP: okay so I'm just [reiterating↑
189. PT: [is that what they call a nitrate, Teraza-
190. NP: they're not specifically ni- no if you were taking a nitrate we wouldn't even be
191. giving↑ you Viagra
192. PT: okay
193. NP: but there is a slight [um
194. PT: [no I don't [uh
195. NP: [risk of decreased [blood pressure
196. PT: [yeah I'm aware of that
197. right
198. NP: Okay we're gonna keep you on the same cholesterol medication we're gonna

199. keep you on Gemfibrozil, we're gonna keep you on your (.) blood pressure
200. medication, (1.0) um (.) and then how 'bout the Allopurinol you are taking it
201. even at the lower dose correct?
- 202. PT: yeah (.) daily right?**
203. NP: wonderful test strips you need those?
204. PT: no I gotta a few of them
205. NP: okay (.) water pill?
- 206. PT: yeah For- For- Formisulpride huh yeah (7.0)**
207. NP: all right (3.0) so right now everything but the fish oil and the aspirin (1.5) I'll
208. order the CAT scan if you want you can go to the desk to schedule it or you
209. can call and schedule it when you look at your calendar at home I'll give you
210. the number (4.0)
211. PT: It'll be better that way then I don't have to recall
212. NP: I know I know
- 213. PT: gonna get- my daughters are coming for Christmas**
214. NP: WONDERFUL
215. PT: every other every other year they come
216. NP: Oh that's great::
217. PT: five daughters (1.0) but only three of them are coming
218. NP: you've been a busy man
219. PT: hhhh
220. NP: so how many grandkids do you have
221. PT: eight

222. NP: eight come on over hear let's listen to you have you had any other issues o

223. other than this whole fall thing

224. PT: nope

Mr. Newell first aligns with the 'good patient' in lines 179-206. In line 177-178, NP Sarah makes reference to Mr. Newell's medication, specifically mentioning two medications: Finasteride and Terazosin. Although she does not ask for confirmation from him that he is, in fact, taking these two medications, Mr. Newell responds in line 179 by pointing out that his dosage of the second medicine, Terazosin has been increased by another provider ('they jacked up the Tera- Terazosin'). This statement can be viewed as performing two main functions: 1) demonstrating to the NP his knowledge of the medication, and 2) ensuring that she has the most up-to-date information regarding his current dose, particularly since she was apparently not the provider who made this adjustment, based on his use of 'they'. Both meta-functions seem to align with the 'good patient' as one who is knowledgeable and one who is helpful (although helpful here is slightly different than what is shown above).

Similarly, lines 185-197 demonstrate knowledge of his own medication, in this case Viagra and the possible negative complications associated with interactions with his other medications. In his responses to Sarah's comments about when he should and should not take the Viagra: in line 185: 'no I don't;' line 187: 'yeah;' and stated more specifically in lines 196-197: 'yeah I'm aware of that.' Sarah even acknowledges his claim to this information in line 188: 'okay so I'm just reiterating.' Also within this excerpt, Mr. Newell also illustrates more general knowledge when he asks in line 189: 'is that what they call a nitrate?' In asking this question, Mr. Newell is demonstrating knowledge beyond his own experience and medication and likely

beyond what he has even been specifically told in prior medical visits (made salient because of Sarah's response disconfirming that Terazosin is not, in fact, a nitrate). This question is likely due to common warnings associated with Viagra that it should not be taken with nitrates (www.viagra.com), information that Mr. Newell received elsewhere and wanted to be more educated in terms of how this might relate to the medications he is taking.

Finally, in lines 202 and 206, Mr. Newell, again, aligns with the 'good patient' through his display of knowledge of his own medication. In line 202, he responds to Sarah's question about another medication, Allopurinol, first by responding to the question in the affirmative ('yeah') but also by checking the frequency ('daily right'). This check of the frequency, again, has the meta-function of the literal question: confirming information, but also of actively demonstrating his knowledge. In line 206, Mr. Newell again shows his knowledge of his medication by providing the name of the medication in response to Sarah's question regarding the type of medication ('water pill?'). Each of these turns demonstrates his knowledge of the name, type, and doses of the medications he is taking, his knowledge of possible interactions and even (although minimal) knowledge of a class of medication and its interactions with his medicine. This type of knowledge and active engagement in this visit creates a clear alignment with the 'good patient.'

Mr. Newell, in addition to aligning with the 'good patient' and the 'knowledgeable but non-compliant' patient, he also aligns with the 'non-patient' at the end of this excerpt. This is exemplified in line 213 when he introduces a topic that is neither related to the prior discourse nor to the more general topic and purpose of the visit. In line 213, Mr. Newell disaligns with the prior discourse about making an appointment for a CAT scan, and introduces the topic of his daughters 'coming for Christmas.' This topic is likely triggered for him in response to Sarah's

reference to ‘look(ing) at his calendar’ in order to schedule the CAT scan; however, as Sarah does not specifically ask him about upcoming events on his calendar, the topic seems disconnected to the prior turn. This topic shift of sharing personal information unprompted by the NP suggests an enactment of the ‘non-patient’ identity, one which seeks to highlight aspects of the patient’s life beyond his/her role within the medical visit. In this excerpt, as in many other similar instances, the NP sanctions this topic, albeit briefly, through the response of ‘wonderful’ (stated emphatically and loudly, as the use of capital letters indicates) as well as asking additional questions about Mr. Newell’s family.

This extended excerpt illustrates how patients may display different identities within a single visit. Shifting to align with different ‘figures of personhood’ is exemplified in the exchange between Sarah and Mr. Newell, particularly when taken cumulatively with the Excerpt 6-4, discussed above. In general, shifting to align with different identities is quite common in the visits analyzed in this dissertation. As with this particular visit, the most salient identities are typically the ‘good patient’ demonstrating active involvement and displays of knowledge and helpfulness or the ‘deferent patient’ acknowledging the asymmetrical power structure of the medical visit, responding to the NP’s questions, and aligning with the topics the NP introduces.

5. Why Do Different Identities Emerge?

Section 3 outlined five distinct types of patient identities. The construction of these identities suggests that patients are actively playing a role in the medical visit including willingly offering information about themselves and voicing the ‘lifeworld’ (Mishler, 1984) in a number of different ways, some of which do not seem to have a direct correlation with the purpose of the visit. The question then, arises, as to why patients construct such varied and active identities in the medical visits in this study; particularly in comparison with the previous accounts discussed

in Section 2. In this section, I will attempt to provide explanations as they relate to specific identities and larger ideologies.

5.1. Medical Neoliberalism and the ‘Knowledgeable’ Patient

As alluded to in the discussion of three of the patient identities, the ‘good patient,’ the ‘knowledgeable but noncompliant patient’ and the ‘struggling patient’ illustrate somewhat overlapping figures of personhood. The ‘good patient’ and the ‘knowledgeable but noncompliant patient’ both actively demonstrate their knowledge of their medication and/or their illness/disease. The difference between the two being that the ‘non-compliant patient’ also reveals his/her lack of adherence with medication, something that is not necessarily sanctioned as part of what it means to be a ‘good patient’ for the NPs. Similarly, the ‘knowledgeable but noncompliant patient’ and the ‘struggling patient’ both acknowledge their shortcomings in terms of following through with treatment or in taking full ownership of his/her health, respectively. Despite their differences, all three have one commonality, which is the patients’ display of knowledge. In each of the examples of these three types of patients, the patient actively demonstrates his knowledge of his health, specifically through reference to medication both in naming the medication and the prescribed dosage and through more general knowledge of his illness. These displays of knowledge can be understood in terms of the neo-liberal ideology of medical care and more recent changes in expectations of the patients’ role in his/her health.

Fisher (2007) argues that “medical neoliberalism” can be understood primarily in terms of the commodification of health, which, in turn, leads to the premise that “consumption is not only a right but also an obligation” (2007: 65). One of the ways the neoliberal ideology can be seen in medicine is what Fisher refers to as the process of transforming patients into consumers.

She argues that this reanalysis of medical roles places a higher value on individual responsibility on the part of the patient (now referred to as the ‘consumer’) and the provider:

Unlike patients, consumers seeking health care bear the responsibility for the choices they make- or fail to make- regarding their health. Because they are positioned as having the right to make choices about health care, consumers also have the obligation to utilize whatever products and services are available to ensure health or to treat illness and disease (2007: 5)

She presents the position of what Frist (2014) and others term the ‘patient-consumer’ as being advantaged in a greater freedom of choice but, at the same time, also obligated to take a more active role in maintaining and or improving his/her own health. It is the neoliberal focus on individual behavior and a patient’s responsibility for his/her health that has led to the implementation, for example, of national programs in both the United States and the United Kingdom that seek to educate and train individuals with chronic diseases. The Expert Patient Programme in the UK (www.nhs.uk) and the Chronic Disease Self-Management Program (www.cdc.gov) in the US both seek to change patients’ behaviors, often cited as the greatest contributing factor to overall health (Frist 2014; Shortell 2010), and to make them more accountable for their own health.

Therefore, it is likely because patients are “implicated as responsible for their illness through discourses of individualism” (Wellard 1998: 54, cited in Frank, Corman, Gish & Lawton, 2014: 46), that these ‘patient-consumer’ identities emerge in the interactions, primarily through displays of knowledge. If patients are expected to take personal initiative for their health, then it is not surprising that they would want to highlight this in the medical visit particularly through the construction of the ‘good patient.’ Patients, then, can be understood as having a

responsibility to prepare for their visit by gathering pertinent documentation such as lists of medications and medical records from other providers and bringing these to the visit. The fact that this action is so often acknowledged and ratified by the NPs suggest that this is likely their expectation of patients and could index patients' acculturation into the role of the new, modern neoliberal patient.

Being knowledgeable about one's own health as well as demonstrating more general knowledge of a particular illness (e.g. Mr. Johnson's knowledge of diabetes) or type of medication (e.g. Mr. Newell's knowledge of Viagra and nitrates) is also a way that patients align with the neoliberal ideology of medicine. Mr. Newell's knowledge regarding the complications of taking nitrates with Viagra, as discussed in Section 4, can most likely be explained not by information provided by a medical provider since he does not, in fact, take a nitrate, but through epistemic access to the Internet and/or direct to consumer pharmaceutical advertising (i.e. television commercials).

The 'knowledgeable' aspect of the 'knowledgeable but noncompliant patient' and the 'struggling patient' can likely be accounted for by the neo-liberal positioning of the patient, what may be understood as the more modern "expected social role" (Prentice 2010: 168) of patients seeking care. These identities reflect changes in larger patterns and expectations of patients. Conversely, the 'deferent patient' represents the older, more paternalistic approach to medical care in which the provider (prototypically a medical doctor) is viewed as the ultimate source of knowledge. The patient's role is to follow 'doctor's orders,' typified by Mr. Deaver's claims of doing what he is told and not "ask(ing) them why." Accounting for why some patients have seemingly embraced the new model of patient-hood while others have not, is a difficult task. The patient's age alone cannot explain this difference as Mr. Adams, age 79, enacts the 'good patient'

while Mr. Franklin, age 52, and Mr. Deaver, age 67, align with the older ‘deferent’ figure. Familiarity with the provider may be a factor, however, the number of times each patient has met with his/her provider was not collected- only if it was a first or repeat visit. More generally, familiarity with the genre of the medical visit, particularly in recent years could explain differences between alignment with the older, deferent figure and the new, neoliberal figure. It is clear, at least in the visit with Mr. Franklin and Karen, where Karen explicitly advises him to carry a list of his medication with him, that providers sometimes encourage patients to take a more active role in their health. It is possible that other patients have similarly been given this advice in the past, but again, there is no data to support this theory. It is also equally possible that these two figures could be based on individual differences and preferences for the patient-centered or the provider-centered model. In sum, what is important to note is that many of the figures of personhood described in this chapter, at least in part, can be explained by the new medical neoliberal ideology that pervades modern healthcare in the US.

5.2. The ‘Middle Space’ as Co-construction of Patient Identities

Beyond the desire to seem knowledgeable and actively engaged in one’s health, a second aspect that seems to apply to many of the patient identities discussed in Section 3 is patients’ willingness to share. In the case of the ‘knowledgeable but noncompliant patient’ and the ‘struggling patient,’ willingness to share comes in the form of admitting non-compliance and inability to prioritize one’s health through ‘agency of power.’ Enactment of the ‘non-patient’ involves sharing of personal information that is often unrelated to his/her health or to the instrumental goals of the encounter.

This willingness to share may be understood, by the ‘middle space’ positioning of the Nurse Practitioner (Defibaugh 2014b). NPs often position themselves as ‘not doctors’ (discussed

in more detail in Chapter 7). As such, the NP's position suggests a lower level of power and medical authority, thereby allowing patients to be more forthcoming with less fear of negative evaluation. Research on patients' perceptions of willingness to share with different provider-types has yet to be addressed; however, a study involving interviews with registered nurses (RNs) in the UK, reports that nurses believe that patients are more likely to share concerns with them compared to physicians. Reasons include, "lay perceptions about nurses being generally sympathetic" and "nurses appear(ing) to be more accessible or have more time than doctors. For example, 'They think they can *talk* to nurses...' and 'A lot of people are embarrassed to tell the doctor what they tell us'" (Crossland & Kai, 1998: 1384). The validity of this claim is limited by the nurses' own understanding of patients' perceptions of them and their roles; however, it does suggest a larger cultural and social understanding of nurses compared to doctors as being more "accessible" and "sympathetic," qualities that can help explain the patients' willingness to proffer identities of non-adherence or limited agency and therefore as enacting a less-than-full agentive positioning and control of their health. The lowered social distance that NPs often create (as discussed in Chapter 4) may also explain why patients choose to highlight aspects of their non-patient identity. If they view the medical visit less as an asymmetrical, institutionally defined space and more similar to everyday social interactions, it is not surprising that patients like Mr. Carlson would share non-medically relevant aspects of their identity as he does.

Although the data collected for this dissertation alone cannot confirm whether the position of the NP does, in fact, allow for a wider variety of patient identities to emerge, it is certainly an avenue worthy of future exploration.

6. Discussion

As noted in the Introduction, previous accounts of patients show them to be somewhat passive (Heath 1992; Stivers 2007). These accounts suggest that the institutional role of patient is essentially determined by their position in relation to the more socially and interactionally powerful position of the medical provider, more specifically, in those studies, the doctor. This certainly seems to be the case for the ‘deferent patient’ but cannot account for the other figures of personhood that are constructed in the NP-patient visits analyzed for this dissertation.

Although patients in this study do sometimes conform to the role of ‘deferent patient’ at times and to varying degrees, this is simply one identity that patients are aligning with in the visits in the two corpora analyzed here. As I argue, other patient identities can likely be accounted for by two factors. The first is the new, contemporary expectations of the role of patient to conform to the medical neoliberal ideology, which encourages patients to take a more active role in their health. This is evident in the discourse in the ways that patients are prepared for their visits (an action that NPs actively encourage and ratify) and are knowledgeable about their medication as well as their illness or disease. The second factor is the position of NPs in the ‘middle space’ of medical providers, a position that involves lowered vertical distance (ala Leech, 2014) placing NPs and patients on more equal footing than that of the socially and culturally recognized position of the medical doctor. As Chapter 4 illustrated, NPs actively construct the figure of the ‘caring provider’ through a focus on rapport enhancement and maintenance (Spencer-Oatey, 2005), which can also aid in the co-construction of patient identities that reflect a willingness to share including sharing of imperfect medical adherence or personal information. The extent to which these identities are unique to NP-patient visits compared to visits with other providers is not clear, but will be discussed in detail in Chapter 8.

CHAPTER 7

PATIENT IMPRESSIONS AND NP SELF-DESCRIBED ROLES

1. Introduction

This final analysis chapter utilizes interview data from both NPs and patients to identify what features of the professional role of the NP are most salient to each group. I first focus on NP data and describe responses to two of the interview questions along with other follow-up questions, which vary depending on answers supplied by each NP. These questions will address the previously posed research questions: 1) How do NPs view the role of NPs within the larger medical system? 2) Why types of identit(ies) do they construct in interview settings? I show how NPs' self-constructed identities align with the 'caring and competent provider' as described in Chapters 4 and 5. Secondly, I discuss, briefly, responses to two of the post-visit patient interview questions which serve to illustrate general impressions of the NPs in this study, addressing the following two research questions: 1) What are patients' impressions of the NPs in this study? 2) Do patient impressions correlate with the types of identities that are constructed in the medical visits analyzed? I'll end with a discussion about how the interview data presented in this chapter may be able to help explain the linguistic choices that are made in medical visits by NPs and patients.

2. The Self-Identified Role of the NP

The four NPs in this study who work at the VA were asked to participate in an interview, which included two questions that gauged their views on the professional position and role of NPs. Both questions were framed in general terms rather than asking about personal experiences. The first question was: How do you view the role of NPs in the medical system today? The

second question asked: Do you think the role of NPs will change in the future? NPs, for the most part, responded to this question with first person (i.e. I/we), clearly understanding the question to include how they view their own role and position. Some responses also differentiated NPs in the VA, where their role is fairly standard and autonomous, to other settings where NPs may have less autonomy. As one NP explained, “In the VA we function equally to physicians. Our role isn’t any different, like at this clinic they [physicians] do the exact same thing we do. There’s no difference in anything.” Two general themes came out of these two questions. The first is that NPs see themselves as playing an important role but are clear to point out that they are not physicians. The second is that they view their approach as patient-centered and their role with patients as an educator and/or mediator of information.

2.1. “I’m Not a Physician”

When asked how they view the role of NPs in the medical system all four NPs used similar terminology, agreeing that NPs are “adjuncts” (Julie), “an asset” (Karen), “needed” (Laura) and that they “have a role to play” (Sarah). Each of these suggests that NPs view their role as important. Both Laura and Karen commented on the possible effect that healthcare reform will have on primary care and that the importance of NPs may increase, but they also seemed hesitant to make claims that they view themselves as equally knowledgeable as physicians and/or in the same position in the medical hierarchy as physicians. For example, Julie’s use of the term ‘adjunct’ positions NPs as supplementary to other providers. She describes some of the roles she plays as just this: “providing a service where it’s needed whether it’s primary care -providing full primary care, um doing tests, some people do stress tests, doing urgent care or doing visits in between, some where you’re continuing to see patients and tighten medications and things like that.” Karen describes how she works with the other physicians at the clinic. She explains that if

there is something she does not know, she will ask them, for example, she explained, “If I get a new AFib patient that I don't know about I'll ask one of the doctors to come in and help me out.” Sarah provided a similar explanation and scenario in which she would acknowledge the limitations of her knowledge and/or degree: “If I don't know an answer I'm gonna find it out for you. I'll figure it out. I have no problem when something is outside of my scope, saying I don't know and asking someone or doing research and finding it out.” Both Karen and Sarah were clear to point out that they are not doctors. Karen explained to me, “I'm not a physician. I don't want to be a physician.” A similar self-designation of ‘not a doctor’ also came up in my interview with Sarah who explained, “If a patient calls me doctor I'll correct him. I'm not a doctor; I'm a Nurse Practitioner.”

This positioning as ‘not a doctor’ or as being supplementary despite practicing almost completely independently and “function(ing) equally” in the VA is an interesting one and one that may be understood in reference to a larger cultural discussion that has been circulating regarding the role of NPs in healthcare. This discussion occurs within the medical community as many doctors are pushing back against the greater autonomy that NPs are gaining in states across the country as well as in more popular publications such as *The Wall Street Journal* and *The New York Times*. For example, a 2011 Medscape article (<http://www.medscape.com/viewarticle/753628>) presents survey findings from MDs with their reactions on whether an NP who has a doctorate in nursing can/should use the title ‘doctor.’ The article reports mixed reactions from extremely negative to fairly neutral, all of which either make reference to the distinction between NPs' level of education or an implied concern of NPs moving in on physicians' territory. In an opinion piece that appeared in *The New York Times* in April of 2014, Dr. Sandeep Jauhar argued that NPs are not qualified to practice without

physician oversight because of their ‘eagerness’ to send patients for extensive testing and refer to them to specialists, likely because they are less qualified to diagnose many illnesses (<http://www.nytimes.com/2014/04/30/opinion/nurses-are-not-doctors.html>). This opinion article received over 800 responses online and sparked two letters to the editor (published online May 2, 2014) from representatives from the American Association of Nurse Practitioners and two professors of nursing (http://www.nytimes.com/2014/05/03/opinion/what-is-the-role-of-nurse-practitioners.html?_r=0) in opposition to Dr. Jauhar’s comments. The circulating discourse of this debate is worthy of exploration in its own right, but is mentioned here, only briefly, to explain the possible reasons for why the NPs in this study so clearly position themselves as “adjuncts,” “facilitators,” and ‘not physicians.’

2.2. “I Try to Educate Them”

In addition to disaligning with the profession of physician, NPs clearly position themselves as educators and mediators of knowledge who employ the patient-centered approach. In my interview with Laura, in response to how she views NPs, she explained: “I think that we try to facilitate ya know proper medication, (.) we talk about diets we talk about how to be healthy ya know just just teaching.” Laura’s response, although not explicitly positioned in opposition to other providers, illustrates that she views her role as an NP essentially as a teacher.

At the end of the interview, this topic of teaching came up again:

1. SD: Is there anything else you want to share?
2. Laura: I enjoy it (.) I enjoy teaching
3. SD: Do you feel like that’s a big part of what you do?
4. Laura: Definitely yes (.) I think that we take more time and explain more things

5. yeah I think when the patients come see ↑us I think the patients have a
6. better understanding of what they need to do ya know exercise eating
7. habits that will impact their overall health

In this exchange, Laura again highlights her perceived role as ‘teacher’ and aligns it with what she ‘enjoys’ about her job. She also positions the NP more clearly in this excerpt as different from other providers through the use of the comparatives ‘more’ and ‘better,’ which suggests that she believes better patient outcomes come from better education. This is clearly in line with the way that she interacts with patients and uses lay language to ‘translate’ health factors into dietary decisions, as discussed in Chapter 5.

Sarah positions herself similarly. Although she does not use the term ‘teaching,’ she explains her role as educator and guide. In one of the follow-up questions, I asked Sarah how she deals with patients who are non-compliant, which was what she saw as the biggest factor in being effective at her job. Her response to this question was:

I just um try to do the best that I can ya know I try to educate them ‘this is what you have to do and I am-’ this is basically what my speech is I mean ‘I am here to guide you I am not you you are your own person you’re going to decide what to do with your own health’ but my job is to say ‘this is what I believe you need to do this is what statistics show this is this is your numbers and then you have to make an informative decision I can help you with that.’

In Sarah's response she describes her role of NP as 'guide' and presents this in the form of a hypothetical conversation with a patient in which she does not push patients but instead presents them with facts ('statistics') to help them make informed decisions.

Julie's response echoes Sarah's description of presenting patients with 'facts' and encouraging them to make the best decisions. She gives the example of patients not getting a flu shot (which is free at the VA): "I try to give them the facts. When they say they don't want to get a flu shot I don't push them. That's their call but I do tell them that 35,000 people die each year from the flu. Sometimes when they hear that then they'll change their mind." Julie, like Sarah, draws on data to help educate patients but ultimately views her role as something like a 'guide' rather than an authoritarian, paternalistic provider.

Although the NPs present their professional roles slightly differently, all three construct the role of NP as educator and guide, which can be understood in terms of the 'competent and caring provider' identity as well. NPs feel that it is important to give patients the information they need to improve their health, whether through focusing on diet and exercise, as Laura describes, or through sharing specific data – statistics regarding specific blood pressure readings and likelihood of having a stroke (as Sarah describes in a longer extract) or the mortality rate associated with the flu. Their position regarding not 'pushing' patients may be partly seen as a way of building relationships with patients by giving them autonomy. Julie also explains it as being related to what they understand to be important for patient compliance. She continues her explanation of why she does not push patients by stating, "But I don't press patients if they say they don't want to take a medication then I say 'okay' because I know that if they say that they won't do it." This viewpoint is very much in line with Sarah's acknowledgement that patients are their own individuals and will ultimately make their own decisions. Forcing a prescription on a

patient will not lead to better outcomes because it does not actually lead them to taking it. Instead, sharing knowledge and giving patients autonomy is viewed by these NPs as the best method.

2.3. Alignment with the ‘Caring and Competent Provider’

The way that the four VA Nurse Practitioners construct their professional role as ‘educator’ and ‘guide’ aligns quite clearly with the identity of the ‘caring and competent provider’ as I have presented in Chapters 4 and 5. In the interviews, NPs downplay their own knowledge compared to medical doctors, particularly salient in the way that both Karen and Sarah describe their willingness to consult with physicians or research a topic in more depth when they feel their knowledge is limited. This does not mean that they view themselves as not competent or not capable of treating patients. They clearly recognize their ability to perform their job well and the amount of knowledge they have regarding particular diseases and medical statistics regarding likelihood of stroke (as Sarah describes in her interview) or the percentage of people who die from the flu each year, as Julie explains. So although they downplay their medical competency, they do so only with respect to the higher position of MD, which as I discussed in the previous section, is likely, at least in part, due to circulating debates regarding the role of NPs and their ability to practice medicine independent of physician oversight.

In addition, the NPs’ perceived role as educator and guide rather than authoritarian is well represented in their linguistic choices in the medical visits analyzed for this dissertation. Laura describes her role as ‘teacher,’ which is exactly what she does when ‘translating’ Mr. Barnes’ lipid panel into food choices. The way that June also takes the time to explain the process of insulin production to Ms. Piper indexes as similar focus on education rather than simply treating the disease itself. Similarly, Laura and Julie’s use of indirectness when giving

advice echo the claims that both Julie and Sarah make with regards to not pushing patients but presenting advice in what Mr. Eggers perceives as more ‘subtle’ ways.

2.4. Interim Discussion

The ways that NPs construct their identity within the ethnographic interview are very much in line with the patient-centered approach and with the ways that they actually interact with patients. The way that NPs view their role as ‘guide’ and ‘educator’ reflects their focus on patient-centered care, particularly in focusing on health education, behavioral modification, and promotion of long-term, disease prevention.

3. Provider Views on Patient Satisfaction

Within the NP interviews, there were two places in which NPs constructed their identity as reflexive of what they believed patients responded to. First, in the interview with Karen, we talked about how the VA gives patients a set time for visits and that NPs are paid a standard rate regardless of the number of patients they see in a day. This is not necessarily unique to the VA, but there are some NPs working in the private sector who do get paid per visit rather than per day (personal communication). Karen’s response to this was:

Yeah I never have to think about rushing patients out quickly if I did they wouldn’t be bringing me pumpkin bread hhh that’s for sure hhh yeah Mr. Griffin you’ll hear on the tape he says ‘how’s your mom how’s all her vitamins being taken’ cuz he knows my mom takes a lot of vitamins we’re very- I’m very close with my patients I wonder if you’ll notice I’m very close with them.

She describes how Mr. Griffin, a patient for about six years, brought her a loaf of pumpkin bread at his visit, clearly a gesture indicating a positive relationship between the two. She thinks that if

she didn't take the time to listen to patients or talk with them, she would not be able to have this kind of 'closeness' with her patients, which she clearly does and values. She also mentions that Mr. Griffin asks about her mom, referencing prior meetings between the two where they discussed the fact that Karen's mother takes a large number of vitamins. She uses his actions of both bringing the bread to her and his initiating the topic and showing concern for her mother as a signal of how he views his relationship with her and how that relationship has been built over the years, which has the effect of indexing her as a caring provider through his eyes/voice.

Similarly, in a more general discussion about the role of NPs, Karen explains: "the patients like 'em (NPs) the patients like em and the quality of care they give is just as good as a physician and probly even more holistic." In hindsight, a follow-up question eliciting how she knows this, could have been helpful, but whether this is from her own experience or based on research, she positions NPs, and indirectly, herself, as liked by patients, again presumably because of their balance of attending to the interactional and instrumental goals.

Sarah presents a similar position of patients as being satisfied with her as an NP and relates this to the value placed on rapport building: "I've had some patients that have had physicians and they want stay with me. I think it's more of a relationship. We build more of a relationship that's what I see." Sarah identifies patients' preference for her over other providers as a desire to have a relationship with their medical provider. Through talking about what NPs do, she includes herself, as an NP, in that reference and identifies what NPs do that is different from other providers and what patients like about this. Both of the comments from Karen and Sarah align them with the 'caring provider' identity but do so through the voicing of patients.

4. Patients' Post-Visit Impressions

Earlier chapters have drawn on the post-visit interviews with patients to illustrate how patients view NPs as 'caring' and 'competent,' but the extent of these perceptions as well as the overall positive impressions and satisfaction rates is best understood by examining the interview data more thoroughly.

Although not all patients participated in the post-visit interview (a total of 20 out of 28), and the 20 interview responses here should not be taken as representative of all NPs, the overall impression of NPs by the patients is quite positive. In response to the question regarding how knowledgeable the patient felt their NP was, all 20 respondents reported positive impressions. Some of this may certainly be due to acquiescence bias (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003), but 14 of the 20 expressed intensified positive agreement of some sort suggesting something more than simply giving me the response they felt I was seeking. Some of these responses included the intensifier "very" as in "oh very very knowledgeable," "oh yes she's very good very good," and "oh yes she's very knowledgeable very much so very much so;" others included "always:" "yes she always has she always has" and "oh she's always top notch." One patient response, discussed in more detail in Chapter 4, but repeated here, positions the NP as 'better' than his doctors in many ways: " oh my goodness yes oh I hate to say this well I don't hate to say it she is as knowledgeable if not more than some of the doctors that I go to and she's ah a lot more understanding and she has the answers she's exceptional I think." Of these 14 who responded very positively, nine were repeat visits and five were first time visits, showing a higher likelihood of a strong positive response with patients who have built a long-term relationship with their NP but not exclusively so. Even some of those who were at their first visit

with the NP responded enthusiastically to this question suggesting a general approval, and sanctioning of the 'competent provider' identity.

The final question asked patients to elicit their overall satisfaction with their provider. This question was worded as "Would you recommend this Nurse Practitioner to a friend or family member?" This question was borrowed from the American Academy on Communication in Healthcare's patient satisfaction survey (aachonline.org). As such, the wording of the question seeks to elicit satisfaction with the provider rather than the possibility of patients responding to other aspects of the visit, such as the amount of time they had to wait to see their provider or their satisfaction regarding the diagnosis and/or treatment. Patients similarly responded quite positively to this question with all 20 patients providing an affirmative response. Eight of these gave intensified answers including "Absolutely," "I certainly would," and "definitely." There were also responses that indicated the extent to which patients felt positively about their provider, for example, "oh yeah I recommend her to my wife or anybody," in which presumably the patient places a high value on his wife's care. A similar response, from Mr. Barnes illustrates the high value he places on his provider, Laura: "Anybody President Obama could see Laura. She's great. She's great." Another comment suggested that the NP is qualified enough to practice on her own, outside the VA: "I wish Sarah had her own office somewhere. She'd be my primary care doctor. I'm not pulling your leg I'm serious." Although the implicature in this response is that the VA has a lower status in the patient's mind, the fact that his NP, Sarah, has higher status is illustrated by the fact that he would prefer to have her as a primary care provider than whomever his current, non-VA provider is.¹² It is true, however, that some responses were less

¹² Although the patient uses the term 'doctor' in reference to Sarah, I believe this is likely due to 'primary care doctor' being a more common collocate than 'primary care provider' which is less

enthusiastic, with patients responding in the affirmative but more neutrally, for example, “oh yeah” or “Sure yeah sure I would yeah I’ve seen her before she’s very nice.” The only response that specifically addressed the NP by the type of provider was by Mr. Rogan, a first-time visitor to the VA. Mr. Rogan prefaced his response by categorizing Sarah as an NP rather than just as a provider in general: “If they had to see a nurse practitioner? yeah she was she was nice.” When I asked him to explain what he meant, he went on: “Ya know nurse practitioners probably some know more than a doctor it’s like my mom had a cardiologist she used to see a nurse practitioner the nurse practitioner she wasn’t a surgeon but she was (1.0) she knew her stuff” In this response, Mr. Rogan positions NPs as ‘not doctors’ similar to what both Sarah and Karen do in their interviews but also points out that the NP his mother previously saw “knew her stuff,” highlighting her knowledge while still acknowledging the lower social position of NPs compared to surgeons and other medical doctors.

Overall, patient impressions suggest that they also view NPs as both caring and competent, further co-constructing this identity. Additionally, the post-visit interviews indicate high satisfaction rates, similar to the findings of other studies (Budzi, et al., 2010; Newhouse et al., 2011; Seale et al., 2005). The extent to which communication style and the linguistic choices of the NPs can account for the higher satisfaction rates will be discussed in Chapter 8.

5. Discussion

Drawing solely on the interview data with both NPs and patients, this chapter contributes to an overall understanding of the identity of the NP as both a ‘caring’ and ‘competent’ provider. As I have illustrated, NPs’ self-defined roles parallel well with the interactional data that shows a balance of addressing both instrumental and interactional goals during medical visits.

common. Therefore, the use of ‘doctor’ does not necessarily equate Sarah to the status of ‘doctor’ in the patient’s mind.

Additionally, patient impressions of the NPs in this study suggest that they view NPs as knowledgeable and competent providers, seen both in the response to the specific question ('Did your NP seem knowledgeable?') as well as their stated willingness to recommend their NP to a friend or family member.

CHAPTER 8

CONCLUSIONS

1. Overview

This chapter provides summative conclusions for the research presented in this dissertation. The first section outlines the main results of the dissertation. I then describe the major implications of this study. The third section presents two remaining hypotheses regarding the extent to which larger claims can be made. The fourth section addresses the limitations of the study and concludes with a proposal for future research.

2. Discussion of Results

This section is divided into two parts. The first section will provide an overview of the results of the analysis and will suggest possible explanations or accounts for the findings. The second section will attempt to position the findings of this study within the larger body of research on patient-provider interactions, specifically addressing why results of this study may not be comparable to other studies.

2.1. Constructing the NP Role

As Chapters 4 and 5 showed, the overarching figure of personhood that is constructed in the visits analyzed for this dissertation is that of the ‘caring and competent provider.’ This identity can be understood in terms of the ways in which Nurse Practitioners practice the patient-centered approach, which involves balancing of attention and concern between disease management and relationship management. For example, the patient-centered approach is understood as attention and concern for patients’ holistic experience with health and illness as well as creating long-term positive patient-provider relationships (Stewart et al., 2000). In

practicing the patient-centered approach, NPs align with the ‘caring provider’ by temporarily setting aside the instrumental goals of the visit in order to build relationships. This has been analyzed in this dissertation as 1) engagement in small talk, 2) use of inclusive first person pronouns, and 3) use of indirect, hedged medical advice. Small talk is analyzed as topic shifts that are not related to the prior discourse, the purpose of the visit, or the patient’s health. The examples of small talk discussed in Chapter 4 illustrate the ways in which NPs may initiate or encourage topics that draw on personal connections between themselves and their patients. Inclusive first person pronouns, when used for various functions and repeatedly throughout a visit, give the effect of sharing in responsibility with the patient and being a shared experiencer of health and wellness. Finally, the use of indirect speech when giving medical advice lowers the sense of imposition on the patient, draws on shared common knowledge, and minimizes the NP’s role as ‘expert’ in the visits.

NPs in this study also enact the ‘competent provider,’ illustrating that they are not solely concerned with building relationships but are equally adept at fulfilling their professional and organizational responsibilities. What it means to enact their professional role is to provide quality care to patients. Results in Chapter 5 showed that the ‘competent provider’ is constructed through: 1) following the ‘checklist’ of medical visits and controlling topics, 2) aligning with the organization and medical community through the use of the ‘institutional we,’ and 3) sharing knowledge and educating patients. Following the ‘checklist’ is both a standard way in which medical visits are conducted (see Boyd & Heritage, 2006), and, in addition, for providers working in the VA system, it is a required aspect of their job, as the computer system provides them with a set of prompts and alerts which dictate topics. NPs not only work within this framework by asking the required questions but also allow deviation from the ‘checklist’ when it

may help them access important health information that would otherwise not be addressed, had they followed the script without deviation. As the extended example of June and Ms. Piper illustrates, NPs may also control the topic of conversation to empirically foreground what they know to be most important and background information that patients seem to be primarily concerned with. NPs also construct the ‘competent provider’ by highlighting their role as an individually qualified and knowledgeable provider as well as a member of the medical community through the alternating use of ‘I’ and the ‘institutional we,’ respectively. Finally, NPs acknowledge their epistemic responsibility as a medical provider to share pertinent information with patients in a relatable way. This is done through the use of common rather than technical terms and ‘translation’ of health into dietary habits.

As noted in the introduction, these two identities are not necessarily separate but represent the two key aspects of how NPs construct their professional identity of a ‘caring and competent’ provider. In many ways, construction of one aspect aids in the construction of the other, showing the multi-layered aspect of identity formation.

What it means to be a ‘competent provider’ at least for the NPs in this study, also involves care and concern for the patients. An example of this is the way in which June focuses the discussion with Ms. Piper on the problems associated with high blood sugar readings while still acknowledging her concerns about low blood sugar levels. June encourages Ms. Piper to share her concerns and even acknowledges that this is a ‘scary’ concern, providing emotional support through affective alignment. She also explains that Ms. Piper will likely not experience low blood sugars as this is rare due to the quality of medication currently available as well as the fact that the human body adjusts to high blood sugar levels so that feelings associated with low levels do not necessarily represent true lows that would lead to a diabetic coma. She does this,

however, while framing the discussion in terms of her own concerns for Ms. Piper, which is to quickly and dramatically lower her blood sugar to an acceptable and healthy range. June, then, balances, her priorities as a knowledgeable and experienced provider with addressing the patients' concerns. Although I have focused the analysis of this excerpt on June's construction of the 'competent provider,' it is clear that she is also enacting the 'caring provider' by showing concern for Ms. Piper's emotional state as well as for her overall health. Therefore, it is almost impossible to separate which interactional turns could be considered 'caring' and which 'competent' as they are so effectively intertwined.

Similarly, the ways in which NPs lower social distance and construct the 'caring provider' can be viewed as an interactional move that represents competency in their profession. NPs often recognize that in order to get patients to comply they should not feel forced into particular actions. As Julie explains, this is why she does not 'push' patients. The importance of the interpersonal aspect of the medical visit, particularly in connection with patient satisfaction and compliance has been shown in a number of studies (Cecil, 1998; Lambert et al., 1997; Thompson, 2003). Roter (2000), for example, found that patient-centered care was associated with positive patient outcomes, both emotionally and physiologically. A focus on patient satisfaction can be seen as a motivation for the time spent engaging in small talk, the ways in which NPs build relationships with patients, and their reluctance to 'push' medical advice on patients, which may very well lead to greater levels of compliance by patients.

The NP identity of 'competent and caring provider' as well as the linguistic resources employed to enact this identity do not seem to involve conscious efforts at acting in a certain way but simply part of what it means to be an NP. One way to understand this is through Bourdieu's concept of habitus or "a set of dispositions which inclines agents to act and react in certain ways.

The dispositions generate practices, perceptions and attitudes which are ‘regular’ without being consciously coordinated or governed by any ‘rule’ (1991: 12). Thinking of the NP’s interactional practices as part of their identity rather than being “consciously coordinated,” helps explain why there is so much consistency across the NPs in this study. Support for this interpretation comes from a comment made by June, who explained to me that she was “birthed into the practice” of patient centered care as a graduate student in nursing and that ways of communicating with patients was not a stand-alone course but that it was part of everything they did as students (personal communication).

It is important to note that despite the similarities, there are some individual differences. For example, Laura uses similar language (i.e. translation to dietary choices) regarding eating habits as explanation to multiple patients; others do not use this exact pattern, if they did it would be quite surprising and would actually suggest training or directives by the organization they work for mandating certain ‘scripts’ (Cameron, 1995; 2000) or what Bourdieu refers to as “rules.” Each individual NP may have their own style and way of educating patients or hedging advice, but the important thing is that they all employ similar practices when interacting with patients. Others do a similar kind of educating, for example, in my interviews with them, both Julie and Sarah refer to the use of statistics to educate and persuade patients. The same is true for patterns of small talk. All of the NPs in this study engage in small talk with patients; however, no one does this in every visit and no one necessarily does it more than others. Providing quantitative data regarding the number of times each NP engages in small talk and for how long would reveal some individual differences, but it would also confirm that this is a common feature of NP talk and a part of their NP habitus, as part of their ‘caring and competent’ identity.

2.2. Constructing the Patient Role

Analysis of patient identities provides two interesting and important conclusions. The first is that what it means to be a patient is more complex than prior research has suggested, which may, in part, be due to differing cultural expectations of patients. Although little research has focused on patients, most of it has shown patients to be passive, acknowledging their lowered-status in the asymmetrical relationship between provider and patient (Heath, 1992; Stivers, 2007). Although this is true, at least according to my data, it is only one part of the picture. Patients in this corpus enact a variety of identities; this finding is independent of whether they are in an inpatient or outpatient setting. Patients may also shift within visits to align with different figures of personhood at differing points, which reflects the fluidity and emergent nature of identity (Bucholtz & Hall, 2005).

I have argued in Chapter 6 that the multitude of patient identities can be understood in terms of the new figure of the patient-consumer and the shift to medical neoliberalism in healthcare as well as the position of the NP as a ‘middle space’ provider. Medical neoliberalism can account for the patients’ displays of knowledge because individuals in the US are expected to take a more active role in their health. Similarly, the most commonly sanctioned identity in the visits analyzed here, which is why I define them as the ‘good patient,’ is one who is well prepared for his/her visit by bringing a list of medications and who knows important details of his/her medication including the amount and frequency in which medication should be taken. A second common aspect of the patient identities discussed in Chapter 6 is a willingness to share aspects of ‘who they are.’ This includes sharing stories of non-compliance, inability to prioritize one’s health over other concerns, and sharing aspects of one’s personal life that may not be related to their institutional position of ‘patient.’ I argue that sharing, in all of its manifestations,

may be a reflection of the lowered social position of the NP compared to MDs. That is, the NPs as ‘nurses’ rather than doctors, may give patients the impression that they can be freer in sharing information, some like Mr. Carlson, may even treat the medical visit more like an everyday conversation rather than a highly structured institutional interaction. Similarly, because NPs balance interactional goals with instrumental goals, patients may also find encouragement in engaging in the development of interpersonal relationships. These claims are only hypotheses, however, as will be discussed more thoroughly in Section 4 of this chapter.

3. Implications and Contributions

One of the clearest conclusions that can be drawn from the data presented in this dissertation is that Nurse Practitioners are extremely skillful in the way that they approach and interact with patients. The construction of the two, complementary aspects of the NP identity is done so in a relatively seamless and consistent way across different medical settings and with different patients. NPs are able to combine technical expertise and rapport-management in a way that provides a high quality of care to patients. The linguistic features discussed in this dissertation as they are mobilized in the enactment of the ‘caring and competent provider’ align with the tenets of NP practice, as outlined by the American Association of Nurse Practitioners (AANP):

What sets NPs apart from other health care providers is their unique emphasis on the health and well being of the whole person. With a focus on health promotion, disease prevention, and health education and counseling, NPs guide patients in making smarter health and lifestyle choices, which in turn can lower patients' out-of-pocket costs (<http://www.aanp.org/all-about-nps/what-is-an-np>).

Although the AANP does not specifically focus on building long-term relationships with patients, it does address the aim of treating the “whole person,” which can involve showing concern for not only the patients’ specific health situation but also their general well-being. Additionally, the focus on education and ‘guiding’ patients to make informed decisions is clear in the data presented. NPs use a variety of linguistic features in order to effectively accomplish their goals. The results from the patient surveys suggest that they are successful- patients respond positively to NPs’ knowledge and technical abilities as well as their displays of concern for the patients’ well being.

Studying NPs from a linguistic perspective, as I have done, has implications for the medical field and general population. As discussed in Chapter 2, NPs are becoming an important figure in healthcare in the US, a trend that is projected to continue. This research, as I have discussed in the previous section, illustrates the effectiveness in which NPs balance instrumental and interactional goals, or in other words, balance technical and interpersonal skills, both of which have been reported as valued by patients (Ong et al., 1995). Similarly, the linguistic features that NPs use could be reinforced through training of both NPs and other providers as a way to improve communication between patients and providers without sacrificing quality of care. That is, what this dissertation shows is that attending to the interactional goals does not necessarily mean a disregard for instrumental goals- both can be accomplished. In fact, I would argue that enacting medical competency entails showing care and concern for patients.

From a theoretical perspective, this study also contributes to research on identity by considering identity in institutional contexts and within institutional roles. Unlike studies which have considered identities to be based on interactional roles, such as speaker roles or listener roles, or even more specific interactional roles of ‘advice giver’ or ‘cultural mediator,’ as Zayts

and Schnurr (2014) present, in this dissertation, I consider the ways in which culturally recognized figures of personhood are enacted. This theoretical perspective allows for a shift away from interactional positions to socially constructed positions, which, in turn, broadens the focus from individually defined moments of talk to larger cultural patterns of discourse. From this perspective, the heuristic that discourse is shaped by and, simultaneously shapes the world (Johnstone, 2008) comes to the forefront. The theoretical model used shows that roles are emergent, these identity formations can be best captured through discourse, which is also emergent in any interactional situation. The constructions of provider and patient, as I present here, draw on culturally understood “emblematic figures” (Agha, 2007: 237), but the enactment of these identities also helps shape what it means to be a provider or a patient in the current healthcare system in the United States.

Positioned within the field of medical discourse, this study takes a wider view of ‘context’ and employs multiple data collection procedures. I focus primarily on the interactional data collected from the provider-patient visits but also include ethnographic observations and interview data to contribute to the analysis. This approach is a departure from the methods of Conversation Analysis (CA), a focus only on ‘talk in interaction,’ which are pervasive in medical discourse studies. Ethnographic observations were used to help explain the interactional data. One example of this, as discussed in Chapter 5, is the way in which NPs working within the VA follow the computer dictated checklist, something that could not be fully understood based on recordings of the medical visits alone. The combination of data from medical visits with interview data added an additional layer of analysis. Inclusion of patient interviews demonstrated the ways in which the identities of ‘caring’ and ‘competent’ provider were reflected in patients’ impressions of their NPs as knowledgeable and caring. Similarly, NPs self-

described identities as ‘educator’ and ‘guide’ mirror the interactional choices made in medical visits. Therefore, by employing multiple methodologies, I am able to provide a more comprehensive account of the contextual factors involved in medical visits and greater insight into the uptake of patients that may not be present in the interactional data alone.

4. Further Questions

The results of this dissertation raise two important questions, in my mind, which cannot be fully answered with the data presented here but are worthy of discussion: 1) can the interactional patterns account for patient satisfaction?; and 2) are the linguistic patterns and the identities that are constructed in these visits particular to NP-patient visits?

4.1. Addressing Patient Satisfaction and Patient Compliance

The first issue relates to the topic of patient satisfaction. As discussed in Chapter 2, a number of studies dating back to the mid 1970s and as recently as this decade have assessed satisfaction rates of patients who see Nurse Practitioners (Anderson, 2002; Budzi, et al., 2010; Levine et al., 1976; Merenstein, 1974; Newhouse et al., 2011; Seale et al., 2005). The importance of patient satisfaction is not only significant in the modern economic incarnation of patients as consumers and healthcare as a commodity, but also in the way that satisfaction may correlate with greater patient adherence and improved health outcomes (Anderson, 2002; Charlton et al., 2008; Roter & Hall, 1992). Nurse Practitioners in all of the studies mentioned above have equal to or greater satisfaction ratings compared with MDs. Budzi and colleagues (2010) working within the Veteran Affairs system, found higher satisfaction rates for NPs compared to both MDs and PAs (Physicians Assistants). The question then arises as to what can account for these high ratings of NPs, particularly considering the lowered social position and perceived level of technical skill, for instance, as Redsell and colleagues (2007) report, patients prefer to see an MD

when they feel their condition in more ‘serious.’ Charlton and colleagues (2008) attempt to correlate the patient-centered approach with higher satisfaction rates but leave vague the linguistic manifestations of the patient centered approach; that is, there is still the question of what exactly are patients actually responding to when they rate NPs highly? The results of this study narrow this gap by identifying particular linguistic features and interactional choices that put the patient centered approach into practice. Although this study stills falls short in providing correlations between linguistic choices and post-visit surveys, the inclusion of both, and the overall positive results of the study, bring us one step closer in understanding the discursive choices that lead to greater patient satisfaction. Additional research with a greater number and variety of provider-types is necessary to address this issue more fully.

4.2. Comparison across Provider-Types

The second remaining question with the results of the analysis presented here is to what extent are the patterns of provider and patient identities specific to NP-patient interactions? This question is much more complex than it would seem. As noted in Chapter 2, there is a wealth of literature on doctor-patient visits. Some of this research addresses many of the same linguistic features that I have discussed. For example, as Chapter 4 notes, Douglas Maynard and Pamela Hudak present a fairly extensive account of small talk in doctor-patient visits. In fact, the way that I chose to limit the examples of small talk in my data comes from their category of ‘topicalized small talk’ (TST); however, the bulk of their analysis of small talk, particularly in Maynard and Hudak (2008), is on how small talk serves a disattentive function- co-occurring with instrumental tasks. It does not consider the social or instrumental work that small talk can accomplish nor the ways that it can index a particular identity or type of provider. Similarly, Ragan’s (2000) study does show that small talk, when the topic is related to the purpose of the

medical visit, can serve an instrumental function. However, my data illustrates that small talk primarily does social, interactional work, which I see as constructing a particular type of provider identity. It does not necessarily index disattentiveness nor does it necessarily need to be ‘co-topical’ with the medical visit in order to be significant and worthy of exploration and analysis. Further, when they do present examples of TST, it is between providers and patients who already have a relationship and clearly, from the transcript, they have a relationship outside their patient-provider roles. This is not the case in the data presented here, which include one example of small talk occurring during a first and only visit and one in which the small talk itself seems to help construct a patient-provider relationship rather than simply being reflective of one. This is just one example of the ways that my data seem to be different than what others have presented.

Another example is the ways that providers follow a ‘checklist.’ Boyd and Heritage (2006) devote a great deal of time outlining the types and forms of ‘checklist’ questions but only briefly mention deviations from the ‘checklist’ and do so only to point out that deviations are recovered from quickly in order to return to the ‘checklist.’ In my analysis, I show that these deviations are just as significant as the ‘checklist’ itself in terms of providers constructing their competency and enacting what it means to be a ‘good’ provider. Although I suspect from their acknowledgement that there are brief departures from the ‘checklist’ that Boyd and Heritage found a similar pattern of talk in their data set as I did, it is difficult to make a comparison regarding the nature and purposes of the deviations. Is this something that NPs are more inclined to do or do all providers look for opportunities to access the patient’s lifeworld in these opening moments? Without a similar methodological and theoretical lens, it is impossible at this point to claim that this is a unique feature to NPs.

Returning to the conclusions regarding the types of patient identities constructed, the same lack of equitable comparison may account for the difference between the variety of patient identities I present and the ‘deferent patient’ that other studies show. I suggested that NPs, in their ‘middle space’ position of providers may ‘allow’ for other types of patient identities to emerge; this certainly fits our understanding of identity as emergent and co-constructed (Bucholtz & Hall, 2005). Discourse is shaped by the setting and the participants with which we are engaging; therefore, having an NP who aligns with the ‘caring provider,’ through other discursive resources, may allow patients to feel more open in sharing aspects of their ‘non-patient’ identity or more willing to admit non-compliance. However, without a comparable data set for comparison, once again, conclusions regarding the extent to which these patterns are confined to the NP-patient dyad, are limited and speculative, at best. It is also important to note that the rise in the medical neoliberal ideology over the past few decades may play a significant role in how the ‘expected role’ of the patient has shifted.

I also want to be clear that I am claiming that these patterns of talk define the NP identity; however, by no means am I arguing that the ‘caring and competent’ provider is uniquely an NP identity. As my discussion of these prior studies indicates, there is simply no way to definitively claim that NPs construct their professional identity differently than other providers or do so through alternative linguistic means. Because other studies have taken different approaches and sought to answer different research questions, there is, to date, no equitable comparison that allows such a claim to be made.

4.2.1. Differing Goals, Differing Results

In her 1997 article “Performing Gender Identity: Young Men’s Talk and the Construction of Heterosexual Masculinity,” Deborah Cameron re-analyzes her student’s data because, as she

argues, “his analysis was not inaccurate, his conclusions were not unwarranted, but his description of the data was partial” (47). Cameron then proceeds to illustrate how a different theoretical lens can present a different analysis of the data. I include this not to draw parallels between Cameron’s novice student and the highly skilled and qualified researchers who have come before me. I do, however, think that the parallel lies in the difference in theoretical, and in my case, methodological perspective. Prior researchers examining doctor-patient interactions are not wrong in their claims about providers or patients. As my data illustrate, sometimes patients are deferent and sometimes providers do control the interaction. But I believe that this is not the full picture. Patients are complex and how individuals construct this role is, therefore, also complex and varied. It may depend greatly on who their provider is, but it also depends on what kind of person and/or patient they are outside the medical visit. Similarly, research has shown that doctors assert their power and authority over patients through language (c.f. Heritage & Clayman, 2010). The NPs in this study are not so different in this. They also control the interaction in a number of the same ways, but this is just one aspect of who they are and how they construct their professional identity. Additionally, looking more deeply at what it means to control topics and control talk, from an ethnographic discourse analytic perspective, we see, for instance, that controlling the topics may actually be in the best interest of the patients and does not inherently mean that patients’ voices are silenced.

In Chapter 2, I discussed how CA has been the predominant theoretical and methodological framework in medical discourse. The goals of CA researchers are quite different than my goals. As Arminen (2006) explains, CA researchers are interested in using the language (and I might add, *only* the language) to understand how the institution is constructed. Using CA is an appropriate methodology for this aim as it starts with no preconceptions about what the

institution is. The results of these studies have contributed greatly to what is known about institutional discourse and medical visits, without which, this dissertation may have taken a different direction. However, since I view the institutional setting as a site for identity construction and take a different theoretical and methodological approach, the findings here are different from those in prior research. One example how different research questions and different frameworks lead to different results can be seen in Candace West's (2006) analysis of medical closings. West examines the ways doctors signal the end of the medical visit and how patients may attempt to extend the visit by presenting new concerns. She notes, in her discussion of one particular example, that following the closing sequence, the transcript continues for "three more pages" (2006: 412). What happens in those three pages of transcript is not West's concern, likely because it is outside of the purview of her study. As I note in my analysis of small talk, it often occurs at the end of the visit, even after the closing sequence has been initiated. Is this an example of extended small talk that West does not include in her analysis? If so, does it function similarly to the small talk in my data? Differences in research goals lead to differences in the data that are presented. Because of this, it is, in general, quite difficult to compare data collected and presented for differing purposes and difficult to make cross-provider comparisons based on the existing research.

5. Limitations

Although this study makes clear contributions to the field of linguistics particularly in understanding how identities are constructed in medical visits and provides some general findings concerning the ways that particular linguistic resources are mobilized in the patient centered approach, there are a number of limitations, which this section will address.

The first limitation concerns the number of NPs who participated in the research. In total,

over 800 minutes of interactional data were collected for this dissertation, comprising a rather large corpus of NP-patient visits. However, only five providers were involved in the research. In order to make stronger claims regarding the NP interactional style, a larger number of NPs is necessary.

On a similar note, by combining the two corpora, I was able to examine patterns across multiple settings including both inpatient and outpatient visits as well as two different types of outpatient visits: a cardiac care clinic and a primary care clinic. NPs work in a number of different settings, the most common being private outpatient offices, which are not included here. The outpatient data from the VA, particularly the three NPs working in primary care (Laura, Karen & Sarah), follows the general pattern of primary care visits as outlined in prior research, but because a majority of the visits dealt with annual, preventative medicine rather than acute care, the ways in which NPs interact with patients in that setting would be important to include in future research.

The demographics of patients and providers are also somewhat skewed. In the case of the patients, a larger percentage of them are male because data for the second corpus were collected in the VA setting. Almost all of the data collected at the VA involve older male patients; this is not surprising considering the fact that data were collected in the men's health clinic. Also, the average age of the veteran population is 58 years old (http://www.va.gov/vetdata/veteran_population.asp). I have not accounted for demographic factors of age, gender or socio-economic status of patients, which, while outside the purview of this study, would contribute to a larger, more comprehensive sociolinguistic analysis of NP-patient visits.

Finally, the NPs in this study are all females, which, therefore, does not account for male

NPs who may draw on different linguistic resources. This is less of a concern in terms of identifying general linguistic patterns for NPs since most NPs are female. Reports indicate that only 6-7% of NPs are male (US Department of Health and Human Services, 2014; Skilman, Kaplan, Fordyce, McMnamin & Doescher, 2012). Therefore, using females only is fairly representative of the field. Nevertheless, the study would have benefited from at least one male NP in order to examine the extent to which the interactional patterns are representative across genders within this occupational field.

6. Future Research

As Section 4 discussed, one of the most important questions that arises from this dissertation concerns the extent to which the findings are specific to NPs. I have made tentative conclusions, suggesting that NPs, because of their consistent focus on the patient centered approach, and the extent to which it has become part of their professional habitus, construct the ‘caring and competent provider’ in a way that is unique to their occupation. In order to test the validity of this claim, however, additional research that applies the same theoretical and methodological approach but with other provider types is necessary. In the future, I hope to work with NPs, PAs and MDs working in outpatient, private practice settings in order to compare the ways that these three providers each construct their professional identities and the ways in which patients, similarly, construct identities with different providers. This dissertation opens a line of research using methodological innovations to successfully achieve a wider picture of medical discourse, which must be applied to interactions with other providers in order to more fully understand the complexities of this institutional setting and the roles that individuals enact within it.

7. Discussion

In summary this dissertation has presented an analysis of NP-patient visits, focusing on the identities that both provider and patient construct in these visits. I have shown that within the institutional space of medical visits, participants construct identities that align with socially and culturally recognized figures of personhood through their use of “emblematic” (Agha, 2007: 237) linguistic resources. However, this dissertation has also highlighted the need for more work, primarily, in terms of understanding the extent to which similar resources are employed in other types of provider-patient visits.

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APPENDIX

Transcription Conventions

| | |
|------------------|--|
| [| overlapping speech |
| = | latching, or no gap between utterances |
| - | cut-off speech |
| ? | rising intonation |
| , | continuing intonation |
| . | falling intonation |
| : | elongated sound |
| CAPS | loud speech |
| > < | fast speech |
| °okay° | quiet speech |
| <u>underline</u> | marked stress |
| ### | unintelligible speech |
| <i>italics</i> | analysts' descriptions of non-verbal communication |
| Bold | focus of analysis |