

Discourse and Professional Identities in Healthcare Communication

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Abstract:

This study examines how professional identities are enacted in discourse; how clinicians convey their professional expertise and navigate the asymmetries that occur between expert and lay speakers in healthcare dyads. Utilising an innovative mixed-methods approach that combines corpus linguistics and discursive pragmatics with ethnography, two distinct healthcare corpora are analysed: The simulated consultations of a pedagogic training programme for general practice trainees, and the real-life consultations of primary care-based clinical pharmacists – a novel professional role that has not yet seen examination of its communicative practices.

Analysis of the two datasets identifies that the GP trainees enact a performative certainty characterised by a disposition to state what ‘is’ within consultations, through realis moods, epistemic stances and commentary over contemporaneous states of affairs. Asymmetry is navigated by the trainees via recurrent strategies such as implicatures and *wh*-interrogative constructions previously identified as ‘invitations to input’ (Emerson et al. 2020).

Examination of the clinical pharmacy data illustrates the clinical pharmacists’ utilisation of transactional irrealis constructions (characterised as ‘emphatic front staging’) to provide discursive evidence of work being concurrently undertaken, and to be undertaken in the future, for patient-centric purposes. The analysis argues that these formulations also operationalise a significant identity component, by dialogizing the remit of the new CP role and its alignment to the wider healthcare institution.

Analysis of both datasets also considers how the meso-level, contextual detail apparent in each corpus effects the individual clinician’s identity performance. In line with the commitment to the collaborative, applied linguistics methodology taken, the thesis makes a number of recommendations for applied professional practice based upon the findings.

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1. Introduction

1.1 Impetus for the research

The delivery of primary care in the U.K is in a period of critical change. The impact of a number of contextual and demographic factors, such as the significant increase in the number of over 65s within the population, a subsequent growth in chronic, complex or long-term conditions within the population, as well as a staffing deficit associated with recruitment shortfalls and generational retirement patterns (BMA 2017) have created unprecedented demands on the service. In order to address these challenges, a number of large-scale governmental appraisals have been launched. In 2013 NHS England launched 'Improving General Practice – A Call to Action', a project designed to engage both healthcare professionals and the public in a dialogue to develop a modern framework for primary care provision. Alongside this initiative, the Department of Health issued the 'Transforming Primary Care' report specifically addressing the evolving care required for the over-75 demographic in April 2014. At the same time, the then-British Prime Minister David Cameron announced plans for expanded general practice delivery nationwide; including the potential for seven day working for practitioners and extended opening times for surgeries.

In this climate of reflective evaluation of frontline healthcare delivery, the Primary Care Foundation's 2015 report, 'Making Time in General Practice' suggested that up to 27% of GP appointments were avoidable, with a large number of these able to be redirected to the wider primary care team such as pharmacists, nurse practitioners or wellbeing workers. The report's recommendations proposed that the increasing workload of GPs could be potentially spread throughout enhanced roles for both pharmacists and physician assistants. These sentiments were also echoed in NHS England's 2016 the 'General Practice Forward View' report which foregrounded increased GP numbers, extended primary care access and expanded multidisciplinary primary care teams – including doubling the number of clinical pharmacists – as top priority areas.

Despite the focus of these policy advances however, there has been notable turbulence within the GP profession during this period. Figures for 2017 suggested that a deficit of 1300 full-time equivalent general practitioners had arisen (NHS 2017), with causal factors such as an increase in working abroad, career breaks and early retirement identified (Dale et al. 2017). Additionally, recruitment to GP training programmes has fallen below government targets persistently (Marchand and Peckham 2017), with fewer medical students choosing general practice as their first-choice specialty (Svirko et al. 2013). Factors such as increased workload, lack of recognition and low morale are all thought to contribute towards the perception of primary care as an undesirable specialty (Marchand and Peckham 2017, Owen et al. 2019). Furthermore, since 2010 a number of controversies have arisen around the veracity and validity of the RCGP's Clinical Skills Assessment (CSA) examination – a series of assessed simulated consultations – with the main contention surrounding the CSA's potential cultural bias (see for example, Roberts et al. 2014).

British primary care is therefore, in a period of crucial transformation as it struggles to adapt to a number of contemporary, demographic and professional challenges. Accordingly, this presents applied linguistics a unique opportunity to investigate how the role of language within healthcare provision may also be undergoing transformational change. This thesis, therefore, examines the linguistic data of two distinct professional sites positioned on the front line of this continuing service transformation: Firstly, a cohort of general practice specialty trainees undertaking simulated consultations as part of an educational intervention programme designed to enhance their consulting skills. And secondly, the real-life consultations of a group of clinical pharmacists in the East Midlands, approximately eighteen months into their deployment within an initial pilot scheme to introduce clinical pharmacists to primary care.

1.2 Applied linguistics and healthcare

A rich tradition of research examining the language of doctor-patient dyads exists within the social sciences. From the classic medical-sociological research of Parsons (1951) and Freidson (1970), early discourse research (e.g., Mishler 1984, Thomas 1985) sought to establish how authority codified in specialist knowledge or social standing subordinated the patient's position to that of the doctor, engendering a paternalistic relationship. Later work in conversation analysis proposed that the asymmetrical relationship between doctors and their patients as achieved interactionally within the dyad (Maynard 1991, ten Have 1991), and also established the primary sequential components that constitute clinical dyads (e.g., Heritage and Maynard 2006). Whilst work around the turn of the millennium focused on analysing the clinical dyad in consultation with practitioners in the field – offering the findings of discourse analysis to address real-life language problems highlighted by professional collaborators (e.g., Candlin and Candlin 2003, Roberts and Sarangi 2003).

The enaction of professional identity in clinical dyads, however, has not been so widely studied, with Atkinson (1995, 1999) in particular, critiquing the research focus on patient experience and the claims that professional modes of communication are harmful or alienating to the patient. This study, therefore, seeks to address this gap in light of the professional changes outlined. Performative, discursive identity as a linguistic phenomenon has been covered by a myriad of research; both as a general concept (e.g., Meyerhoff and Niedzielski 1994, Benwell and Stokoe 2006) as well specifically in a workplace (e.g., Holmes and Marra 2005). The upshot of this research presents a broad consensus that professional identity is emergent from interaction, arrived at transactionally and contextually dependant – whilst also being influenced by wider societal practices. Thus, indicating that the performance of professional identity is neither stable nor immutable within any professional practice.

Within this thesis, I examine how professional identities are discursively enacted in two datasets that epitomise the changing nature of UK primary care provision. Perfect Day is a pedagogic programme designed by medical educators to enhance consultation skills in

postgraduate general practice trainees via the application of Self-Regulation Theory (Bandura 1991) – its name is derived from a focus on maximising ‘on the day’ performance in the CSA exam. The GP trainees participating in Perfect Day are a cohort of nascent professionals engaged in workplace-based learning in order to become fully fledged specialists. As such they are apprentices of a long-established and highly codified profession. The clinical pharmacists of the Clinical Pharmacists in General Practice (CPiGP) pilot study, however, are a group of independent practitioners with differing levels of experience and qualification. They represent a brand-new role for pharmacists that is largely without precedent, or a formally instantiated training programme. Both of these datasets therefore, present areas of the oft-researched clinical dyad in which discursive professional identity is emergent.

From the overarching theme of professional identity and its enactment, the data is also interrogated to examine how the clinicians in these consultations formulate their identity as professional experts. The notion of expertise itself has also faced recent socio-political scrutiny, in which the (albeit decontextualized) quote that “people in this country have had enough of experts” by the then-justice secretary Michael Gove, was taken as an indicative sentiment of a population increasingly rejecting institutional voices. This phenomena was also noted internationally in Nichol’s 2017 book ‘The Death of Expertise’. In healthcare, challenges to institutional expertise are concordant with the increased availability of medical knowledge online – often known by the epithet ‘the democratisation of knowledge’ – leading to more informed, so-called ‘expert patients’ (Shaw and Baker 2004). The performative, discursive construal of expertise, therefore, is another area of the clinical dyad which is potentially impacted by recent cultural change.

Finally, the enduring notion of interactional asymmetry in medical dyads is investigated in order to ascertain whether this is still a relevant area of clinical interaction. Or, whether this lay-expert relationship has metamorphosed in line with the socio-cultural and political changes I have outlined in this chapter – especially those by which expert knowledge has become more accessible.

Despite being presented as discreet areas here, a fundamental assumption of this research is that the discursive enactment of these three areas – identity, expertise and asymmetry – are inextricably linked in the undertaking of dyadic medical work. For example, a socio-cultural change such as the democratisation of knowledge impacts the perceived status of professional experts primarily, and as secondary effect, this potentially influences how asymmetry and the performance of professional identity is accomplished contemporaneously in the dyad.

This thesis also takes a reflexive approach to the research endeavour itself, as both a collaborative enterprise with the educators of Perfect Day and the organisations of the CPiGP project, and as a product of *Linguistic Profiling for Professionals* and the European Regional Development Fund. A component of this reflection is my own status as a researcher who previously worked in postgraduate medical education – therefore affording me an element of prior contextual understanding of delivery of medical pedagogy and the challenges faced within.

1.3 Research aims

In considering the three central threads – professional identity, expertise and asymmetry – of linguistic concern within these two datasets, this thesis therefore considers the following research questions:

1. How do language-based professional identities manifest in these two distinct datasets?
2. How do the clinicians discursively evidence their professional expertise in the consultations?
3. To what extent does interactional asymmetry manifest within the data – does it play a significant role in these particular consultations ?
4. Can a useful, practicable methodology be developed for external collaborators that combines corpus and discourse analysis with aspects of ethnography?

1.4 Thesis structure

This study is comprised of eight chapters; Chapter 2 provides a contextual background to the research forming the basis of this thesis. Existing literature pertaining to professional discourse, discursive identity, expertise, doctor-patient asymmetry and medical simulations is reviewed. Because research into healthcare dyads is so extensive – spanning both linguistic and clinical-based research – I have attempted to synthesise the main areas of the debate relevant to this thesis in this chapter. The methodology in Chapter 3 is comprised of two distinct areas; firstly, a critical overview of the history of external collaboration within applied linguistics, in which the datasets and contextual underpinning of this research as a product of both the *Linguistic Profiling for Professionals* (LiPP) business unit and the European Regional Development Fund (ERDF) is outlined. The second half of Chapter 3 documents the corpus linguistic, discursive pragmatic and ethnographic methodologies taken within this research, discussing both the benefits and limitations of this approach. This area of Chapter 3 also delineates the approach taken to building corpora from the Perfect Day and CPiGP datasets.

Chapter 4 is the first of three analysis chapters. In the initial analysis chapter, I present the findings of the corpus analysis of both datasets; detailing trends yielded from a keyword analyses, investigating the frequent collocations of those keyness areas and offering a preliminary interpretation of how the areas of linguistic significance function in context. Chapter 4 concludes with the application of these findings to a working model of discursive identity. Chapters 5 and 6 present an extensive discursive pragmatic analysis of extracts from both the Perfect Day and clinical pharmacy corpora – the extracts themselves, arrived via a method proposed by Louw et al. (2014) targeting areas of typical keyness distribution within the data. In this discursive pragmatic analysis, I examine how the linguistic components of identity resultant from Chapter 4 operate in extended areas of the data. The analysis within these chapters is also augmented by ethnographic detail generated from the data collection.

The discussion in Chapter 7 then synthesises the primary elements of discursive identity for each corpora gleaned from the analysis chapters. In this chapter, I argue that the Perfect Day candidates orient towards a discursive identity that foregrounds a performative professionalism, whilst I also consider their recurrent use of a particular linguistic strategy in navigating perceived lay-expert asymmetry. For the Clinical Pharmacy Corpus, I make a case that the CPs enact the consultations in a transactional mode not dissimilar from traditional pharmacy encounters, dialogically emphasising the ongoing work taking place in the dyad. Within the penultimate chapter, I also discuss how the findings of this research has practical ramifications for practitioners and evaluate the contributions this thesis makes to applied linguistics as a discipline. The final chapter takes stock of the overall findings and makes suggestions for further research.

2. Literature Review

In order to contextualise the present study, this chapter initially discusses the broad areas of professional discourse and health communication research, charting the directions taken so far in each domain. From there, I examine how the current literature specifically informs the three areas of research enquiry within this thesis – professional identity, expertise and asymmetry. This chapter then concludes with a discussion of healthcare contexts especially pertinent to the thesis – expert patients, patient-centric care and medical simulations.

2.1 Professional discourse

2.1.1 Defining professional discourse

This thesis is primarily an examination of professional communication and how identity is enacted within discourse. How professional clinicians speak and present themselves as experts in the dialogic context of their work, and how they navigate encounters with non-professional patients. In this section I will broadly define professional discourse as it relates to this study.

The term *discourse* itself requires some initial clarification in regard to its adoption within this thesis given that it has been variously applied across a number of research domains and disciplines. Baker (2006: 3) for example, observes that its use in research often exists in 'inter-related yet different ways'; either language above the sentence or clause, language in use, or a descriptor for a particular genre of use – for example healthcare discourse. Arguably the most prominent taxonomy of *discourse* at this point is Gee's (1999: 6-8) conception of 'big D Discourses' and 'little d discourses', in which the macro 'Discourses' pertain to societal and ideological conventions that allow identities and undertakings to be manifested in both language and social practice, whilst 'discourses' are more aligned to the traditional sense of language use beyond the sentence, or, in context. Sunderland's (2004:6) own conception is similar, in which socio-cultural big D discourses are similar characterised as 'discourses' plural, whereas language in use, or 'little d' discourses,

is assigned as 'discourse' singular. It is worth noting that both 'big D' and 'discourses' in these definitions share a common ancestry in Foucault's (1972: 193) own notion of discourse and discursive practice as a 'certain way of speaking' about a subject, derived from the societal and historical values attached to it.

Although identity plays a central concern within this thesis, my use of *discourse* here is more akin to 'small d' discourse as language use in-context, above the sentence level. This analytic choice to focus on language in use – opposed to a macro-level analysis – reflects the primacy of the contextual and interactional mechanics of identity construction in the undertaking of a professional role to this study. The discursive approach alongside the levels of analysis taken within this research are discussed further in Chapter 3.

The study of what could be broadly considered professional discourse has an extensive history under guises such as business discourse, workplace communication and institutional talk to name just a few variations. As Sarangi and Candlin (2011: 3) note, it is a body of research that 'straddles two domains of study: applied linguistics and studies in professional and organisational communication'. And although a number of studies have examined the professional workplace from a communication perspective previously (for example, Labov and Fanshel 1977), Bargiela-Chiappini (2009: 2) outlines the 1990s as the consolidation period for research into professionally situated discourse; demarcating Drew and Heritage (1992) in particular as a conspicuous starting point.

A variety of topics and themes have been investigated under the broad banner of professional discourse research; for example, leadership and power (Baxter 2009), intercultural business communication (Spencer-Oatey 2004), how gendered stereotypes inflect the workplace (Mullany 2007), whether the discourse of business meetings can be typified as a speech genre (Handford 2010) to name just a few. In the late 1990s the *Language in the Workplace* project provided a significant contribution to this field of work, investigating a large corpus of real-world workplace interactions to investigate a multitude of topics such as small talk (Holmes 1998, 2000), miscommunication (Stubbe 2000),

leadership (Holmes 2004), humour (Holmes and Marra 2002) as well as a number of other language-based research areas. Latterly, work by Iedema and colleagues has investigated professional discourse in light of the 'new work order' (Gee et al. 1996), increased technologization and textualization of work practices. In particular, how these contemporary changes affect the identity of the worker, their roles within an organisation and how this in turn effects the work of the academic researcher (Iedema and Scheeres 2003, 2009). The increased role of technology in the workplace has also been taken up by studies investigating the applicability of politeness norms to relatively new modalities such as email (Van Mulken and van der Meer 2005).

The central concern throughout all these research threads remains a focus on the language used by professionals 'in order to get their work done' (Bargiela-Chiappini, Nickerson and Planken 2013: 3). But as the more recent research demonstrates, the impact of societal and technological changes upon the workplace render it a site that is constantly evolving, and accordingly, the study of professional discourse remains a highly fertile area of research enquiry.

Whilst arguably the terms professional, business, and institutional discourse have been used somewhat interchangeably within the literature I have highlighted, the adoption of the epithet 'professional' in the context of this study does infer a certain direction in the research. As Sarangi and Roberts (1999a: 15-17) highlight, whilst an expression such as *institutional discourse* would implicate speech activities that are promulgated, defined and enforced by the institution itself, *professional discourse* on the other hand is the dialogic enaction of the 'duties and responsibilities' of the professional.

The institutional-professional distinction, then, approximates the distinction between Gee's (1999) 'big D / little d' discourses, with the focus on *professional discourse* in this study demonstrating the primacy of the discursive work being undertaken in context by clinicians, rather than, necessarily, the genres imposed by the wider institution. Indeed, I argue that the term *business discourse* would also bring with it a distinct set of connotations surrounding the discursive activity under analysis; for example, negotiating, goal setting,

task completion and the enactment of explicit hierarchical power. In order to address *professional discourse* beyond this initial conception, this study incorporates a varied mixed-methods framework – this is outlined fully in Chapter 3.

2.1.2 Professional healthcare discourse

In this section I present a brief overview of the research history into health communication in order to further situate the present study and its aims and intended contributions; also illustrating where the dominant research themes in this field originate. Due to the breadth of the body of research into healthcare consultations – both from a social science and clinical background – this section is purely to provide an outline of the main topics and approaches to the clinical dyad. In sections 2.2-2.5 forthcoming, I discuss how areas of the healthcare communication literature specifically apply to themes present within this research. The focus of this particular section is specifically on the archetypical doctor-patient interview, and therefore necessarily omits developments in other areas of healthcare communication such as written, online or experiential studies of health.

The extensive social science research into doctor-patient dyads over the past sixty years can be traced back to Parsons' (1951) early medical sociology. Despite a patient-focus (contending that patients aligned to a commonly known, societal 'sick role', which subsequently impacted on how they were perceived within society and the responsibilities they held), in Parson's view the clinician was a 'technically competent' individual (463) whose authority could not be questioned by the layman, and who was ultimately a constituent part of what became a mechanism of social control (477). In *Asylums* however, Goffman (1962) challenged Parson's notion of orderly agreement in the adoption of super and sub-ordinate roles in the dyad, instead arguing that social order was negotiated in the process of care and that it could also be subverted by patients.

Another major piece of sociological work endorsing the authoritative role of the clinician was Freidson's (1970) examination of how the medical profession achieved and maintained its claims to specialist knowledge. Freidson in particular highlighted the self-

regulating autonomy of medicine inherent in its societal, professional status, and how this manifested in a gatekeeping role over both medical knowledge and the identification of conditions that ultimately meant that medicine held a 'first claim to jurisdiction over the label of illness' (251).

Beyond these early medical sociological studies, the explicit inquiry into doctor-patient communication began with what Pilnick and Dingwall (2011: 1375) call the interactional, 'code-and-count' tradition in the 1970s. Studies such as Korsch et al. (1968) identified disparate cultural and value systems between clinicians and their patients as evidence for a communication 'gap', whilst Korsch and Negrete (1972) offered a critique of didactic consultations laden with technical 'jargon' and in which patients were reticent to speak. The methodology behind these studies, as Pilnick and Dingwall's (2011) designation would suggest, was the coding of behaviours using 'interaction process analysis' originally developed by Bales (1951). This system was subsequently refined by Roter and colleagues into the Roter Interaction Analysis System (RIAS) utilised by Roter 1977, Ong et al. 1998, Roter and Larson 2002, which – much like the Bales system – classified the various discursive activities evident in medical dyads for the purposes of 'examining the dynamics of resource exchange' between clinician and patient (Roter and Larson 2002: 243). Nonetheless, as Heritage and Maynard (2006: 4) note, these systems of coding have been critiqued for their disregarding of 'content, context and meaning in medical interaction'.

In a similar manner, Byrne and Long (1976) typified the medical consultation into six action components such as greetings, reasons for attendance, examinations etcetera. Whilst they noted that a broad range of patient participation existed, Byrne and Long highlighted that clinicians had a number of linguistic (and non-linguistic) means at their professional disposal with which to dictate the patient through the various components of the consultation. Notably, this body of research (along with its studies such as; Roter 1977, Stott and Davies 1979) has also had a significant impact on medical training as both Brown et al. (2006) and Tate (2010) observe; with pedagogic measures taken to address the perceived communicative gaps or doctor-centrism within the dyad. This reinforcement of the notion that

medical interviews were inherently 'paternal', in turn had implications for the development of patient-centred-care – discussed in Section 2.5.2.

Around the same time as the interactional studies, Foucault (1973) proposed the 'clinic' (a synonym understood as the institution of 'medicine') as an organisation in which medical knowledge is processed and disseminated, and accordingly produces a distinctive, modern 'regard' – or gaze – by which clinicians observe and assess patients. Power within this medical paradigm is characterised by its imposition of a particular frame of understanding upon patients, influencing how they may understand, control and experience their bodies and illness (Foucault 1973: xv-xix, 110-122). For Foucault (1973: xix), the clinic was not merely a reorganisation of medical discourse, but instead a disavowal 'of the very possibility of a discourse about disease' in a particular epoch.

Foucault's concept of the medical gaze was later developed by critical theorists such as Waitzkin (1991) in regard to medical consultations, explicitly introducing political and economic concerns into the analysis of the doctor-patient dyad. For Waitzkin, the clinician's role-restricted 'drive to diagnosis' excluded patients expressing a number of personal and familial background details, instead rendering these issues homogeneously as social problems. The dominant economic and professional concerns producing medical discourses that engendered a bureaucratic and dehumanising clinical role – clearly echoing Foucault's (1973) point that the discourse of the clinic constricts the 'possibility' of a patient speaking about illness.

These themes were also picked up in other critical studies such as Mishler (1984), West (1984) and Wodak (1996). From Mishler (1984) the oft-cited dichotomy of opposing voices in the dyad was proposed – the clinician's voice of medicine and the patient's voice of the lifeworld. These conceptualisations not only encompassed the literal voices of the interlocutors, but also the underlying value structure inherent in each role – echoing much of the interactional work preceding. Mishler argued that these incompatible sets of values resulted in the patient's experiential domain not being addressed and accordingly, that clinicians turned the patient's 'practical interests into technical ones' (127). This notion of an

interactional 'asymmetry' between the interlocutors was also critically underscored from a gender perspective in West's (1984a, 1984b) findings that doctors interrupt more and ask more questions of their patients, and that the nature (and inherent success of) their advisory utterances demonstrated notable differences in application and efficacy between genders (1990).

Following this abundance of critical theory-based enquiry, researchers in conversation analysis (CA) began to address the doctor-patient dyad from a micro-analytic, turn-by-turn perspective. As Harvey and Koteyko (2013: 35) note, the CA approach to the medical interview does not presuppose inherent asymmetry within the roles, but rather that any notion of power differential must be accounted for in the mechanics of talk itself. Studies such as Maynard (1991) and Gill (1998) suggested that, rather than asymmetry being socio-culturally instantiated by the clinician as a dominant locutor, that both participants within the dyad orientated towards roles that were asymmetrical in order to achieve various goals; thus, demonstrating that perceived professional power was not absolute. Stivers (2002) meanwhile, outlines how parents can explicitly work against the perceived authority of the physician in the dyad in order to achieve their own goals. The micro-level focus of CA analysis also allowed for further explication of Byrne and Long's (1976) taxonomy of the various sequences of the consultation – see for example Heritage and Maynard (2006).

An appreciation of the broader context in which the medical interview sits was re-established with the uptake of work that could broadly be said to take an applied discourse analytic approach. Much of this research (for example, Roberts and Sarangi 1996, Roberts et al. 2014) involved 'external' professional collaborators and was orientated around specific problems encountered in the real-life enaction of medical dyads and contemporaneous issues in healthcare. As will be outlined in Chapter 3, a recurrent theme throughout this research was also a reappraisal of the efficacy of an 'applied' approach, especially in healthcare sites (Candlin and Candlin 2003) alongside the idea that disciplinary reflexivity should be adopted (Roberts 2003, Sarangi and Candlin 2003).

Arguably, these studies also shifted the focus back onto the clinician as a professional practitioner, rather than the structural inequalities that manifest at the site of the medical interview. Indeed, this applied approach fulfilled Atkinson's (1995: 34) plea that healthcare research should chart a future beyond the typical doctor-patient dyad, into neglected backstage and pedagogical areas. In this respect, therefore, the applied, collaborative approach to healthcare interactions more closely aligns with the professional discourse concerns of examining language by which work is practically undertaken.

In this section I have outlined a condensed overview of the research approaches to (dyadic) health communication in the social sciences over the past fifty years in order to contextualise the present study. Two themes are apparent from the literature; that interactional asymmetry is an intrinsic part of the dyad, either by dint of incompatible lay-expert value systems, the ubiquitous influence of western capitalist healthcare discourses that ignore the experience and agency of the patient, or, as a joint achievement between the participants in order to fulfil transactional goals. This in turn produces the second theme from the literature – a pedagogical focus that seeks to correct a paternal, asymmetrical relationship from arising in the dyad via communication reforms and the instantiation of patient-centrism.

From this existing research I contend that a number of questions can be raised in the undertaking of the present study. Firstly, to whether medicine, or 'the clinic' in Foucault's (1973) conception, still has an exclusive institutional hold on medical knowledge and authority. Secondly, if this societal epistemological power still exists, can the asymmetry it produces in the consultation be characterised as alienating, or productive and jointly achieved. And finally, given the social and technological advancements of the twenty years since the prevalence applied discourse approach, have technological and workplace developments – similar to that identified by Iedema and Scheeres (2009) – changed the context and modalities of the dyad in a significant manner.

As a professional discourse study of clinical interaction (or 'applied linguistics of professions' Sarangi 2005) this thesis is primarily interested in the discursive undertaking of

medical activity – how clinicians present themselves in discourse as an expert locutor. As Chapter 3 will present, this research focus has clear methodological implications. Following the contextualisation of the present study, I now examine the literature pertaining to the three distinct research questions for this thesis.

2.2 Identity in professional discourse

2.2.1 Why identity?

Identity has been conceptualised as a ‘means of referring to and making inferences about the self and other’ (Zimmerman 1998: 87) that may reside ‘in the mind or in concrete social behaviour...anchored to the individual or group’ (De Fina 2011: 265). Though the question may be asked why, in a study so closely associated to specific professional occupations, is identity an important analytic abstraction. Indeed, Sarangi (2010c: 27) notes that identity as a concept is often used interchangeably by researchers in professional communication alongside, or in place of, the epithets ‘status’ or ‘role’.

The rationale behind the examination of identity – as opposed to a conceptualisation such as ‘role’ (for example, Goffman 1959, 1961, Foucault 1972) – within this research is twofold; firstly, the nascency of both professional positions within the dataset. The candidates of the Perfect Day programme are trainee professionals undertaking a pedagogical training programme in order to enhance their undertaking of a professional vocation. Similarly, clinical pharmacy in general practice is a new primary care role in the NHS, that is, so far, without national standardisation. Therefore, to analyse the discursive undertaking of ‘role’ within this data, might be to presuppose a stable understanding of what role *is*, or intended to be, within these contexts.

Secondly, I believe that the analytic supposition of ‘role’ would provide an insufficient account of the multiplicity of discursive activity taking place in each dataset. For example, whilst the candidates in Perfect Day are enacting and practicing a professional occupation, they are also postgraduate learners undertaking a simulation scrutinised by a senior educator team, thus adding contextual considerations beyond just the performance of a

professional role. Accordingly, I adopt the approach taken by Ochs (1993: 288) in which identity is utilised as a term to account for the various discursive endeavours undertaken by the speaker in the dyad in the realisation of their 'statuses, roles, positions, relationships, and other relevant community identities'.

2.2.2 Conceptualising discursive identity

The examination of language-based identity has seen extensive attention over the past thirty years, with perhaps the most comprehensive summation of discursive identity in context – in opposition to identity construction by category – discussed by Benwell and Stokoe (2006). As Benwell and Stokoe observe, a discursive approach to identity has been viewed in two distinct manners; as a linguistic performance construed within interaction, or as a set of structures that enact power upon identity (29). Work such as Foucault (1972) and Fairclough (1992) is primarily concerned with the latter of these categories, in which identity is a production influenced by dominant discourses and social practices. In *The Archaeology of Knowledge* Foucault (1972) proposes identities – or 'subjects' – are constituted of prevailing societal discourses, in so far that any identity is inevitably a composition of available discourses.

Drawing on the work of Halliday (1978), Fairclough (1992) explicitly distinguishes 'identity' from 'relational' functions of language, with each function contributing to the way in which 'social identities are set up in discourse' and ultimately how these identities are navigated. Crucially, for Fairclough the discursive, interactional construction of personal and social identities becomes a 'fundamental aspect' of how societies work and impose notions of power on their members (168).

As Benwell and Stokoe (2006: 31) argue however, this is seemingly a 'one sided' model of identity in which subjects appear without agency, and instead are merely enacted upon by wider discourses and ideologies. In the model of communicative identity proposed by Meyerhoff and Niedzielski (1994) the dynamic nature of speaker identity is emphasised, with the authors claiming that a multiplicity of identity components can be 'called on'

depending on the context in which the speaker finds themselves (319). This dynamism expands upon Fairclough's (1992) notion of a social construction of identity, suggesting that communicative identity can be modified upon receipt of the feedback the speaker may glean from their interlocutor (Meyerhoff and Niedzielski 1994: 321). For Meyerhoff and Niedzielski, the ability for a speaker to 'spin' their identity becomes largely automated and is an essential aspect of moving between personal identities and those that are based in wider social groups for the subject (ibid). And whilst this model yields an increased emphasis on speaker agency in enacting identity, it is stressed that this process of negotiation is neither positive nor equal for all speakers (317) and is instead fraught with imbalances of power which inflect the roles of sub/superordinate (318).

The notion of dynamic adjustments in speaker identity is also taken up by Zimmerman (1998: 90) who focuses on the aforementioned individual identity components, categorising micro-level conversational roles as 'discourse identities'. Zimmerman contends that emergent, discourse identities – such as listener, storyteller, questioner – perform an integral role in the organisation of interaction, as locutors gravitate to, and adjust towards these temporary roles. And whilst discourse identities are the smallest locutionary identity function for Zimmerman, they are augmented by larger, contextual, 'situated' identities, in which there is alignment to identity traits associated with particular jobs or societal roles; such as, for example, doctor and patient. As well as 'transportable identities' which are the latent identities that reside with individuals associated to their 'physical or culturally based insignia' (ibid). These final two categories according with a broader social constructionist view of identity composition.

Whilst both Meyerhoff and Niedzielski (1994) and Zimmerman (1998) amongst others (see for example, Antaki and Widdicombe 1998, Aronsson 1998) yields the broad understanding that discursive identities are emergent in local contexts, transactionally applied but yet vulnerable to wider social forces, (providing a general ontological picture of discursive identity) they do not outline the precise linguistic mechanisms by which identity is enacted. The work of Ochs, however, illustrates how both stances (1993) and indexing

(1996) can be utilised by speakers to contribute towards identity. Ochs (1993: 288) outlines that stances – a ‘display of a socially recognised point of view’ – can index either knowledge certainty (epistemic qualities) of the locutor, or emotional affective concern. The efficacy of stances, Ochs notes, is dependent on shared conventions and expectations of the community and context in which they exist. The conception of the ‘indexicality principle’ (Ochs 1996: 410) meanwhile, demonstrates how grammatical moods, verb voices and pronominal systems are used by speakers to index particular aspects of identity such as relative status.

The numerous analytic threads viewing discursive identity as a dynamically achieved entity is arguably most comprehensively summarised in the model proposed by Bucholtz and Hall (2005). The core tenet of the Bucholtz and Hall model is that ‘identity does not emerge at a single analytic level’, instead operating at ‘multiple levels simultaneously’ (386) to yield a ‘discursive construct that emerges in interaction’ (387). This assertion, therefore, would challenge – in the case of this research, for example – the idea that the clinicians’ identity is merely described via the a priori role assignment of general practitioner or clinical pharmacist as the critical theorist or interactionist view may attest. The Bucholtz and Hall model revolves around five principles that are ‘fundamental’ to the examination of discursive identity; *emergence*, *positionality*, *indexicality*, *relationality* and *partialness*. These principles are summarised in Table 2.1 below:

Emergence	That identity emerges from specific instances of linguistic interaction. Identity is not merely psychological self-classification but constituted through social action.
Positionality	The speaker’s orientation to local temporary categories and roles: evaluator, joke-teller, listener.
Indexicality	Overt mentions of identity categories, implicatures around the speakers own and their interlocutor’s identity positions, evaluative and epistemic

	stances towards the interaction, use of language systems associated with particular groups or personas: The link between linguistic form and its social meaning.
Relationality	The intersubjective construction of identities and how they acquire meaning in relation to others and other identity positions.
Partialness	Any performance of identity is partial and contextually situated

Table 2.1: *The five principles of discursive identity – as adapted from Bucholtz and Hall (2005)*

Many of the features of the Bucholtz and Hall principles are recurrent from the ongoing discussion, synthesised from identity research that I have mentioned so far in this section. For example, positionality echoes the components of identity noted by Meyerhoff and Niedzielski (1994) and Zimmerman (1998), whilst the indexicality principle builds upon the same notion proposed by Ochs (1996). Because this model comprehensively encompasses much of the contemporary discursive work into identity, I adopt it in this thesis to provide the research with a framework with which to understand the findings in terms of identity features.

2.2.3 Professional identity

Whilst the preceding debate provides an overall approach towards discursive identity, the following section examines how identity has been investigated within workplace and professional discourse generally, and then within healthcare contexts specifically.

In their examination of institutional identities, Benwell and Stokoe (2006: 87) foreground the methodological dilemma faced by researchers in terms of adopting a micro analytic (Conversation Analysis) approach versus macro analysis (Critical Discourse Analysis) in attempting to locate how institutional identities exist linguistically – a consideration that also resonates within this research as I outlined at the conclusion of Section 2.1.2. Benwell and Stokoe distil ‘institutional talk’ and ‘ordinary talk’ into distinct registers within workplace discourse, demonstrating how institutional talk is not confined to

jargon or specialised lexis, but can hold dedicated pragmatic functions, the alignment to which, can endorse an expression of institutional identity (94-5). Accordingly, institutional talk and the identities it creates, are not 'omnirelevant' within the workplace but are deployed strategically and produced dialogically (96-7).

Drew and Sorjonen (2011) demonstrate how speakers can index their membership of professions or institutions via pronominal alterations. The most prevalent forms of this 'person reference' (227) is in the use of collective pronouns such as *we* and *us* – an example with clear applicability to the Bucholtz and Hall (2005) notion of overt indexicality. Drew and Sorjonen (2011: 228-9) demonstrate that this collective pronoun use can be utilised in medical dyads in order to convey a sense of joint agency or to navigate sensitive areas in which the clinician must ascribe agency to the patient. Again, discursive work such as this would appear to fall under the rubric of Bucholtz and Hall's (2005) pragmatic aspect of indexical identity formation.

Both Holmes and Marra (2005) and Holmes (2006) meanwhile, have demonstrated how narratives and anecdotes can aid the interactional formation of a workplace identity. In a similar manner to Benwell and Stokoe (2006), they delineate business talk from relational talk in the workplace, and contend that anecdotes can allow an individual to navigate between various facets of their identity; even at times functioning to reconcile potentially contradictory aspects of a locutors social identity within the workplace (Holmes and Marra 2005: 193). Utilising managers as a specific example, Holmes and Marra highlight how personal narratives can 'humanise' an otherwise authoritarian professional identity, democratising the discourse at hand and relieving tension (210).

In a study looking at the relatively new role of professional coaching, Graf (2011) examined how this emergent professional identity was being construed discursively. Graf observes that overt discursive identity work was highly prevalent within the coaches' role, concluding that a lack of shared understanding regarding the role engendered more metacommunicative work in order to mitigate 'the global insecurity that surrounds coaching as a professional interaction' (144). Graf opines that once professional coaching is

established and codified leading to a common understanding between practitioner and client, the metacommunicative approach to 'methodological and conceptual issues' will cease their frontstage positioning (146).

As I outlined in Section 2.1.2, the departure point for a sense of professional clinical identity within social science research begins with Parson's (1951) 'sick role' in which the role of the clinician was seen as a 'technically competent' (463) individual whose authority could not be questioned by the layman, and who was ultimately a constituent part of what became a mechanism of social control (477). However, a number of challenges have been made to Parsonian conceptions of doctor-patient identity; most prominently by Goffman's (1962) avocation of an interactionist, experiential perspective – in which identities are emergent through experience of illness – as Brown et al. (2006: 6) state. In concluding the review of professional health communication in Section 2.1.2, I questioned whether the authoritative conception of the medical profession was still entirely relevant.

In a contemporary healthcare context, Hall, Sarangi and Slembrouck (1999) demonstrate how the discursive production of identity in social work can reinforce the agency and authority associated with the profession. Explicitly delineating notions of identity from those of role, and situating identity as a product of interaction, Hall et al. employ a diverse framework to detect the multiplicity of identities and their interplay within social work; including Goffman's (1955) notions of 'face' management, modes of talk and type-token reasoning (294-7). Their findings suggest that layers of identity are dialogically created within the social work interactions to differentiate the roles of professional and client (298). Critically, this process of role demarcation also underscores notions of power for the healthcare professional; by invoking elements of reported speech from 'the client's and professionals' worlds' (306), Hall et al. argue that the identity of the social worker is ultimately legitimised over that of the client, leaving the client with a restricted choice to either 'tak[e] up or go along with' any proposed interventions (305).

As Roberts and Sarangi (1999a: 228) emphasise, within Hall et al. (1999), the characterising element of discursive identity is not just that it exists as a process, but that it is intrinsically active in its agency, echoing the ideas found in the Meyerhoff and Niedzielski (1994) model, as well those of Aronsson (1998) and Bucholtz and Hall (2005).

Erickson (1999) meanwhile, charts the communicative trajectory of 'residency' level junior clinicians, demonstrating how performative, discursive identity is changeable and procedurally learned within a specific community as a member is socialised into the professional environment. Erickson's work foregrounds the transitional state of identity of the residency-level doctors, in which their discursive performance is moving beyond the formal register expected of medical students to one which encompasses traits of informality and lay terminology – hallmarks, Erickson argues, of more experienced clinicians (122-3).

Erickson aligns this process with Lave and Wenger's (1991) conception of dialogic apprenticeship within a community of practice, but also notes that senior clinicians play a critical pedagogical role in endorsing the emerging identity of the residency doctors by emphasising 'co-membership ... of uncertainty together' (Erickson 1999: 121). According to Erickson, this process demonstrates the epistemic architecture of this particular professional community, by which learning is modelled by the senior clinician, to be then taken on board actively by the junior clinician who ultimately comes to progressively 'own the voice' of an expert (137-8), subsuming it within their professional identity.

In the view of Sarangi and Roberts (1999b: 66), the split Erickson (1999) highlights between the formal register of medical students and the fusion of formal-informal register utilised by the senior clinicians is a discursive index of the distinction between student and professional communities. Accordingly, 'hybridity' appears to be an important constituent of the discursive activity of medical practice (Sarangi and Roberts 1999b: 62). A sense of hybridity within professional discourse also evokes Iedema and Scheeres' (2003) notion of a workplace identity that is reflexive, inventive and mediates between discursive activity both inside and outside the professional role. Indeed, although the focus of the present study is not on register nor genre, the mediation between overt and subtle identity work may be an

important component of discursive professional identity – particularly in the pedagogical arena of Perfect Day.

2.3 Professional expertise

2.3.1 Conceptualising professional expertise in discourse

As the overview of literature into professional healthcare discourse I presented in Section 2.1.2 attests, the notion of expertise is considered to be a primary constituent of professional clinical identity. With the establishment of a 'knowledge gap' (Grimen 2009) between professional and lay interlocutors in clinical consultations generating a 'paternalist' model of care highlighted and critiqued by much of the research into clinical dyads in the 1970s and 1980s. An important distinction should be made at this point, however; what is examined in both this section and in study in general, isn't the quality or veracity of professional expertise itself, but rather the discursive enaction of an interpersonal expert identity. Indeed, as Nguyen (2006: 147) observes 'having expertise...does not automatically entail the ability to use this knowledge in discourse'.

Billig et al. (1988) express the contentious nature of expertise, and the positioning of a speaker as 'an authority' within western societies that are fundamentally democratic in principle. Using teaching staff by way of illustration, Billig et al. argue that whilst an identity of the authoritarian, expert figurehead is primarily out-dated, modern expertise instead shapes itself as a 'hunch-shouldered authority'; in which the expertise can manifest as 'non-authoritarian authoritarianism' (67). Discursively, these modes of 'unequal egalitarianism' (Wetherell et al. 1987) are achieved by distinct registers of specialised talk that are entwined with politeness maxims and an overall observance of Gricean cooperative principles that imply a shared democratic underpinning by which expertise is enacted (Billig et al. 1988: 68). For expertise and its associated authority to operate at this level, it is, in effect, a flux state of on-going negotiation of the limits of expertise between the interlocutors (70). A negotiation of equality and authority, that for Billig et al. is never fully resolved (71).

Tracy and Robles (2013: 278) discuss this dilemma for the professional in terms of identity, noting that those conversational strategies considered more democratic may ultimately undermine perceived levels of expertise, because the establishment of expertise in language is inherently undemocratic. In this respect, Nowotny (2003: 152) characterises the dissemination of expertise as 'transgressive' as it primarily addresses a lay audience and must accordingly be 'sensitive to a wide range of demands and expectations'. Benwell and Stokoe (2002: 441) have shown how academic tutors may favour a more tentative discursive approach to hierarchical roles, by utilizing politeness strategies, humour and 'novice' registers to democratise interactions. Benwell and Stokoe (2002: 442) suggest that this shift towards more egalitarian roles may itself reflect a macro-level change in the ideology of higher education and student-centred approaches. And indeed, in Section 2.5 forthcoming, I consider how notions of democratisation of interactions may also apply to medical interactions given modern socio-cultural changes around the profession.

Controlled knowledge and its association to language use is also underscored by Cicourel's (1995:364) assertion that the relationship between experts and non-experts is one of 'knowledge representation and language use in a specific task'. The ability to use and display knowledge structures are a mark of the symbolic power of the expert for Cicourel (367). In later work Cicourel (2000: 143) highlights that although the language of the expert is often seen as 'specialised' in its register, the lexis borrowed from 'natural' language and re-semotised for explicit use. Accordingly, the subsequent navigation of such polysemic language can become a hallmark of professional expertise in practice (144). This once again reiterates that expertise does not reside in a particular register and is instead a 'hybrid' (Sarangi and Roberts 1999b) construed within significant stretches of discourse.

2.3.2 Professional expertise in healthcare

In the dichotomy of voices brought forward by Mishler's (1984) characterisation of the patients' 'lifeworld' voice and the doctors' paternalistic 'voice of medicine', however, it may be tempting to locate expertise as a distinct register. As Billig et al. (1988: 81) note, studies

have shown that in the domain of clinical expertise, practitioners have attempted to impose their own linguistic schemata on the lay public without success.

Atkinson (2004: 15) however, contends that clinician competence is fundamentally grounded in the intra-professional 'mundane' descriptions, diagnoses and discussions of patients and illness. In this instance, the performative professional identity associated with expertise is comprised of a number of discursive devices, which function in combination with one another: *Contrasts*, that construct implicit evaluations of the work of colleagues, *evidential marking*, which differentiates the credibility of accounts and findings and, finally, the *assertions* of senior clinicians (ibid). Atkinson's view accords with the previously discussed work of Erickson (1999), in highlighting that commonplace language plays a key pedagogical and transactional role in regard to medical expertise. This notion of expertise residing in inconspicuous discourse is also echoed by Sarangi (1998), as well as MacDonald's (2016) research on nursing: Whilst Sarangi (1998: 310) illustrates that silence, or the absence of reporting, can be construed as a token of expertise, MacDonald's (2016: 7) findings demonstrate that in nursing, utilisation of small talk can be a 'highly developed clinical skill'.

Cicourel's (1995) accounts of medical pedagogy and the uptake of linguistic markers demonstrating expertise, reinforces Atkinson's (2004) view of the discursive socialisation of clinical knowledge, whilst also bringing about important methodological concerns to how the researcher may identify elements of knowledge in what may be an unfamiliar environment: As Cicourel (1995: 378) notes, the talk under analysis by the researcher may not always provide the researcher with 'clear markers about expertise'. Accordingly, a means to achieve a greater sense of ecological validity and accuracy in the analysis can be sought in the co-operation of 'native experts' (ibid). The creation of a professional 'habitus' (Bourdieu 1977) in which expertise is conveyed in a polysemic discourse – rooted in natural language, but also inflected with specialised lexis (Cicourel 2000: 143) – may require an analytic mode that takes account of the wider organisational structure, and pushes beyond the narrow constraints of, for example, a conversational analysis focus.

Cicourel's (1995: 365) work also accounts for the patient themselves as a domain of experiential expertise within the dyad – especially those patients who are recurrent visitors to the clinic. And there is evidence (for example, see Maynard 1991 and Gill 1998) that clinicians incorporate discursive strategies that account for patients' entitlement to experiential-based knowledge – this is explored further in Section 2.4.2.

In an extensive discussion of medical risk and expertise Candlin and Candlin (2002: 117) examine the 'synergy' between professional expertise and discourse, noting that it is often the 'strategic deployment of discursive resources' that is a marker of expertise in professional environments. They reiterate Cicourel's (1995) concern regarding the local, contextual understanding of discursive expertise, and highlight that it is 'orientation to specific features of interaction' in context within a particular specialty that is crucial (Candlin and Candlin 2002: 122). They identify three important factors in appraising how expertise may manifest within discourse; firstly, the aforementioned point that any analysis must be site and context specific, secondly, that not all professional talk within an interaction is an instance of expert talk, and finally, that a categorisation of expertise in discourse should not fall into simple taxonomies (125). These are areas that are integrated into the methodological approach of this thesis as the following chapter will attest.

Looking specifically at pharmacists' discursive construction of expertise, Nguyen (2006: 157) discovered that a nascent professional pharmacist was able to increase their ability to 'present expert information contextually' over the relatively short period of an internship. Nguyen's findings once again underscore the distinction I outlined at the beginning of this section between cognitive, knowledge-based expertise and the discursive performance of expertise in interaction – a trait that Nguyen calls 'expertness'. This discursive performance of 'expertness' demonstrates the importance of the interactional competence required in order to 'construct oneself as an expert in social interaction' (ibid). Notably, in her conclusion Nguyen also observes the inefficacy of ridged and prescriptive health communication training in the establishment of the emergence of 'expertness' – noting that it did not account for the interactional dynamism inherent within the role (158).

As the foregoing discussion attests, a recurrent theme throughout is that ostensibly unremarkable talk can yield remarkable expertise equally as much as the use of technical lexis or registers. As I noted previously in Section 2.1.4, Sarangi and Roberts (1999b: 62) characterise the move between a number of registers for professionals as ‘discursive hybridity’ – a shifting between ‘multiple modalities’ in order to navigate the ‘complex and multi-layered nature of medical work’. The importance of such hybridity in expertise has been demonstrated in Roberts et al.’s (2014) consultation with the Royal College of General Practitioners, critically appraising the Clinical Skills Assessment (CSA) taken by trainee general practitioners. In their findings, Roberts et al. characterised the CSA – as well as UK GP consultations more broadly – as a ‘casual conversation / institutional hybrid’ (41), that meant candidates more familiar with this hybrid mode were more likely to project the requisite appearance of a credible expert (58).

Sarangi and Roberts (1999b: 70) also extend the ethos of hybridity to the methodological approach concerning studies in which analysis of ‘complex and multi-layered...medical work’ takes place, advocating Atkinson’s (1999) suggestion that researchers adopt extended methodologies – incorporating, for example, ethnographic field work with language data – in order to fully account for the thematic richness of the data.

Later work by Sarangi (2010a: 167) typifies healthcare interaction as an ‘expert system’, with ‘complex variations’ that reflect the various specialties in which it exists. Similar to Candlin and Candlin (2002), Sarangi (2010a: 169) also highlights the increasing ‘democratisation of knowledge’ as a potential factor affecting the perception of modern expert identities, alongside the influence of ‘socio-political, organisational and technological changes in healthcare delivery’ (176).

Looking particularly at genetic counselling, Sarangi proposes that the multiplicity of discursive functions within professional clinical interactions are ‘not necessarily a skill, but a knowledge system laminated with expertise and authority’ (192). In essence, providing an abstraction of clinical communication that covers identity, expertise and knowledge asymmetries. Sarangi notes that ‘new expert systems are continually emerging’ (169) – a

notion that has clear applicability to the clinical pharmacy dataset in this thesis, and its status as an emergent part of UK primary care. Furthermore – from a research collaboration perspective – Sarangi advises that professionals under analysis may value ‘theoretical and analytic insights’ over explicitly prescriptive advice (192), which also holds practical ramifications for the approach taken within this thesis.

2.4 Professional-lay asymmetry

2.4.1 Conceptualising power and asymmetry

If indeed professional expertise is a component by which a power discrepancy, or interactional asymmetry, is conceived of in medical consultations, it is worth defining what exactly both of those terms mean dyadically – especially given that asymmetry and power are often used interchangeably within the healthcare communication literature.

Arguably, as a concept, the use of power in studies of healthcare communication is perhaps best understood from French and Raven’s (1959) classic taxonomy of social power. Within their model, French and Raven define social power as the potential for behavioural, attitudinal or belief-based influence from one person to another (152). Particularly applicable to professional clinical contexts are French and Raven’s conceptions of ‘legitimate power’ – where the target of influence is accepting of the influencing agent’s authority to require change or obligation – and ‘expert power’; in which the targeted person surmises that the influencing agent holds a level knowledge or insight that they do not, and therefore, is potentially willing to accept judgements without fully understanding them (Raven 2008: 3). This echoes Thomas’ (1995: 126) evocation of Spencer-Oatey’s (1992) own ‘expert power’, in which one person holds a providence of knowledge/expertise that another requires; also highlighting that this type of power is characteristically transient as it may pertain to only a certain workplace context (128). This conceptualisation of power in terms of potential knowledge, expertise and legitimacy of the interlocutors aligns with the notion of an interactive ‘expert system’ (Sarangi 2010) that I detailed in the conclusion of the previous section, in which professional expertise is interwoven with modes of authority.

Fairclough (1989: 61) characterises the typical dyadic doctor-patient interaction as one in which the discourse type is an imposition upon the patient – functioning to control and constrain their responses as the less-powerful interlocutor (see also Bourdieu 1991 on ‘legitimate language’). Rendering the dyad an ‘unequal encounter’ (Fairclough 1986: 44), in which those without direct access to specialist knowledge are reliant on the mediation of this knowledge by a professional. This discursive inequality also reiterates Meyerhoff and Niedzielski’s (1994: 317) idea that the negotiation of speaker identity, is not always ‘shared equally by all participants’, and that the process of negotiation itself is not one that is inherently positive.

Fairclough (1989: 61) situates this interactional disparity within the hierarchical and ideological organisation of the medical discipline itself, in which individual practitioners enact and embody a superordinate role as a default organisational discourse type. Reiterating a similar point, Wodak (1996: 61) highlights that a pervasive set of linguistic norms within dyadic medical encounters can alienate and confuse patients, characterising the inequality of the interlocation as fundamentally a lack of knowledge and information (60).

The early work of Thomas (1985) also views the linguistic realisation of power as a binary of subordinate and superordinate interlocutors enmeshed within established institutional roles. Identifying a number of meta-pragmatic strategies by which medical professionals exert modes of power over patients, Thomas contends that a recurrent theme of a more powerful locutor is the removal of ‘pragmatic ambivalence’ and indirectness from the interaction; contrary to the politeness norms found in conventional interaction (767-8). As I identified in Section 2.1.2, Mishler (1984) contributed the idea that the clinician and patient represented two distinct and contrasting ‘voices’ (the voice of medicine and the voice of the lifeworld) encompassing both what was said by either interlocutor as well as the values underpinning it. As such, Mishler characterises the medical consultation as a site in which incongruent conceptions of illness and experience of illness collide; conceptions which, once again, stem from the restrictions in access to biomedical expertise.

Later work by Landmark et al. (2015) has re-characterised this traditional emphasis on the knowledge gap between clinicians and patients as a divide between the clinician's 'epistemic status' countenancing a higher degree of 'deontic rights' within the interaction – i.e., the right to determine a patient's future treatment. Thus, providing a more explicit notion of how the 'legitimate' or 'expert' power (French and Raven 1959) manifests in discursive action. To briefly summarise then, the research I have highlighted so far in this section proposes that the conferral of expertise alongside the societal position of the professional medical role create a relationship of unequal power in medical dyads, which is then conveyed in language as an asymmetrical interaction.

Such is the consistency with which disparity has been observed in dyadic doctor-patient interactions that Harvey and Koteyko (2013: 34) argue that these locutionary roles have become 'naturalised' in their asymmetry, being thought of as common sense whilst also hiding the interactional mechanics of power at work within the consultation. This presumptive mode of operation within healthcare encounters accords with Iedema's (2003: 47) use of Habermas's (1987) concept of 'delinguistification' in the workplace; in which emergent, delinguistified 'meaning making' creates presupposed ways of 'knowing, saying, doing and being' within interaction, ways that are fundamentally routed in the broader context of the organisation in which they exist (46-47).

Nonetheless, I argue that Iedema's (2003: 43) contention that power and identity are more complex than current analysis has acknowledged, also requires consideration – especially against the backdrop of changing socio-political and technological contexts. Iedema states that insights of micro-level performativity within the workplace be coupled with accounts of organisational environments and conventions (ibid); whilst a concern for the broader organisational context in which power dynamics can originate has also been expressed by Harvey and Koteyko (2013: 36) and fulfils Sarangi and Roberts's (1999a: 1) advocacy of Geertz's (1973) 'thick description' approach, as well as Sarangi's (2006) later proposal of 'thick participation'. These considerations will be adopted into the methodology in Chapter 3.

2.4.2 Beyond traditional asymmetry

The research discussed so far has viewed discursive power within healthcare interactions somewhat homogenously – imbuing the professional identity of the clinician with an inextricable organisational power as the superordinate locutor and has accordingly viewed this dyadic dynamic as inherently negative. Atkinson (1999: 75) critiques this traditional view of healthcare interactions for its emphasis on the language and experiences of patients, which leads to the dismissal of professional voices. For Atkinson, clinicians within the dyad have been monolithically characterised as purveyors of language that is ‘bureaucratic...dehumanising or disempowering’ which accordingly provides only a partial exploration of the language forms and functions on offer (ibid).

Similarly, Barbour (2011: 23) has highlighted that research within medical sociology has a tendency towards embracing macro, structural processes of dominance at the expense of professional agency. Whilst Pilnick (1998: 30) forewarns that often communication is viewed only as a product of macro-level power structures, neglecting the possibility of an interactional explanation. Conversely, work such as that by Holmes, Stubbe and Vine (1999: 378) suggests that the enactment of power should not be generalised as a standardised concept, because interlocutors may dynamically align with a number of different identities or goals within an interaction. In terms of social power, Raven (2008: 5) makes a similar point, highlighting that an influencing agent may adopt differing power strategies depending on their attitude towards their interlocutor.

The idea of power as dynamic and interactionally mediated has been advocated by Maynard (1991: 449), who states that focus within the dyad should not be on a sense of professional ‘abstract power’, but instead should emphasise how elements of potential asymmetry are interactionally achieved by both participants. Maynard’s approach foregrounds that, whilst doctor-patient dialogue favours the biomedical model over the patient’s experiential view, talk is fundamentally rooted in sequences that are similar to those used within ‘mundane conversational situations’ (ibid) – echoing the sentiment of Section 2.3.2. Within these sequences, restrictive discourse for the lay identity is not ‘comprehensive

or totalistic' but is instead asymmetrical in specific and predictable ways (485). This more nuanced view of power positions the consultation as an 'indigenous orderliness' in which the thematic key is discursive and interactive problem solving – akin to modes found in ordinary talk – whereby the institutional context is secondary to the interactional pragmatics found in the attempts to gain understanding and compliance between interlocutors (486).

Gill (1998: 349) echoes a similar point to Maynard, characterising the dyadic interaction of doctor and patient as an asymmetry that is jointly constructed, productive and not absolute in its power dynamic. Taking a detailed CA approach, Gill positions patients as experts of their experiences in an emergent sequence of explanations and responses that jointly achieves an unequal balance of knowledge and authority, as the clinician responds to, and gathers data from these explanations (343). At the same time, the frame of asymmetry is not 'imposed unilaterally' by the doctor on the patient, because evidence suggests that patients' contributions are often acknowledged as important within the consultation (349). For Gill, the principle of the dyad itself is that each participant has distinct 'cognitive states of knowing'; that of experience of illness and that which demonstrates states of knowledge. And these distinct areas construe 'social productions that come about through organised patterns of interaction' (357).

2.5 Contemporary healthcare contexts

2.5.1 The expert patient and medicalisation

Against these challenges to a traditional sense of asymmetry, consideration should also be given to whether the view of a passive, subordinate patient identity (Fairclough 1989, Wodak 1996) is still fully relevant in a modern healthcare context. 'Medicalisation' processes within western societies (Armstrong 1983, Conrad 1992, Metzl and Herzig 2007), through which the biomedical framework has become progressively pervasive in everyday life, has resulted in the phenomenon of the 'expert patient' (Shaw and Baker 2004). Empowered by increased access to medical knowledge online (Barker 2008: 20-21), it is argued that patients no longer view expertise to be strictly the domain of the medical professional (Sarangi and

Clarke 2002: 140), and accordingly the modern patient can approach clinicians with an informed conceptualisation of their illness (Barker 2008: 22). As such, Metzl and Herzig (2007: 697) view patients with access to pluralised knowledge as potentially 'active...as advocates, consumers, or even agents of change'.

Similarly, Ariss (2009: 909) highlights that both the type of patient and consultation may also effect how asymmetrical the consultation actually is; noting that patients suffering from chronic conditions have prolonged exposure to healthcare professionals and therefore hold 'considerable knowledge and opinions' about their condition and its accordant treatment. Ariss contends that patients that attend the clinic frequently may, therefore, hold inherently more symmetrical discursive relations with clinicians (ibid).

Nonetheless, the ability and willingness of a patient to convey their experiential knowledge 'legitimately' remains a challenge as Martin (2014: 496) notes. Grimen (2009: 30) meanwhile, refutes the notion of a 'democratisation of knowledge' in healthcare entirely, instead arguing that the knowledge gap between clinicians and patients is in fact increasing rather than decreasing. Whilst Grimen concedes that the populace has become more informed, he believes that 'the "informed patient" is informed, but not much more than that' and therefore, that a more expert patient does not impinge on the autonomy of doctors in providing a professional service. Rather, it is other professional services to which medicine has 'lost control' of medical knowledge – constituting 'a new division of epistemic labour' (ibid).

2.5.2 Patient-centric care

Alongside the increased influence of biomedical modes has been the move in the latter half of the 20th century towards 'patient-centred care' (Dwamena et al. 2012: 3). As the name suggests, this approach towards clinical practice is characterised by seeing 'illness through the patient's eyes' (McWhinney 1986: 876) and being steered by the patient's knowledge and experience (Dwamena et al. 2012: 3). Both Sarangi and Roberts (1999a: 10) and Gwyn (2002: 63) note that the prevalence of patient-centric care is also congruent with the 'new

capitalism' and the added importance of empowerment concepts, as well as the notion of shared decision-making within professional practice generally.

The trend towards patient-centrism was initially noted in the medical literature under various guises – for example 'humanising' healthcare, person-centred care – in the mid 1970s by work such as Howard (1976) and Howard et al. (1977), and by the late 1980s the concept of patient-centred care was being widely introduced to healthcare institutions (Greene et al. 2012). As I noted in Section 2.1.2, many of the healthcare communication studies in the Bales (1951) and RIAS coding tradition have been said to have contributed – at least in part – towards the pedagogical focus on patient-centric care (Pilnick and Dingwall 2011: 1375).

The initial aims of patient-centric care were for the patient to become an 'ally' in their own healthcare (Howard 1976: 353) and as Mead and Bower (2000: 1089) note, this developed into an egalitarian move towards sharing power and responsibility, with a focus on negotiation and empowerment that appears antithetical to foregoing notions of organisational power oppression. In their avocation of a patient-centric framework, Greene et al. (2012) highlight the abundant evidence that this type of care plan has positive effects for patients, going as far to say that it is difficult to imagine that non patient-centric care could have ever been justified (50). Notably, the interpersonal domain is a key area of patient-centric focus, with Stewart et al. (2000) reporting that verbal patient-centred practice allowed clinicians and patients to find 'common ground' within the dyad, producing 'positive health outcomes' in the process.

As Pilnick and Dingwall (2011: 1375) demonstrate however, this process of patient empowerment has met with mixed results when it comes to levels of patient satisfaction and treatment adherence. Consequently, they critically evaluate the role that interactional and language-based research has had in proliferating an inherently negative idea of asymmetry within the consultation, the upshot of which, they argue, has been a blanket move towards patient-centric care in order to address perceived communicative deficiencies in clinicians (1376). Pilnick and Dingwall instead posit that evidence of on-going interactional asymmetry

in the face of patient-centred reforms may intimate that asymmetry is not only a resilient interactional mode in this context but could also 'lie at the heart of the medical enterprise' itself (1374). Alternatively, they suggest that the focus of research should shift towards identifying what constitutes functional and dysfunctional asymmetry within the dyad (ibid).

2.5.3 Medical simulation

This section explicitly addresses a means by which expertise, knowledge and arguably identity are learnt and performed within medical pedagogy. The discussion of medical simulation dyads is undertaken separately within this chapter, because – as the forgoing discussion will attest – there are a number of interactional and contextual considerations that are potentially distinct from 'real life' consultations.

The modern era of medical simulation began in the early 1960s (Jones et al. 2015: 57) however, the use of simulated patients and clinical environments has only become commonplace in the past twenty years and is predominantly focused towards developing skills often perceived as neglected within medical education, such as communication skills (Bradley 2006: 256-258). As many of the existing language-based studies of medical simulation illustrate, it is an area that has seen a relative paucity of attention within applied linguistics in comparison to the traditional doctor-patient dyad; perhaps due to concerns around the scripted nature of the language and artifice of the simulation itself as Seale et al. (2007: 177) propose. Subsequently, the following section will examine the existing language research in medical simulation and how these pertain to primary themes of identity, expertise and asymmetry within this thesis.

Taking an interactional sociolinguistics approach to the analysis of undergraduate Objective Structured Clinical Examinations (OSCE) Roberts et al. (2003), sought to uncover the key elements of communication contributing to success and failure within simulations. Their findings suggested that whilst successful candidates used communicative styles that were empathetic and characterised by attentiveness, shared problem solving and contextualising, poorer candidates were characterised by inappropriateness, the labelling of

patients, ridged adherence to a medical agenda and a lack of patient understanding (195-197). From a pedagogical perspective, they note that the manner in which stronger candidates manoeuvred their turns in context-sensitive ways would prove difficult to teach, and that the application of standard phrases and 'trained empathy' was only 'counterproductive' (200). Significantly, as the cohort consisted of junior members of a broad learning community, Roberts et al. also discovered that performance in the OSCE was underscored by pre-existing values and assumptions in regard to the status of medical expertise and authority, as well as attitudinal approach to patient-centrism.

Moving beyond candidate performance, Seale et al. (2007) investigated how the actual frame of role-playing is established in simulations, and how candidates can manipulate the purported realism within the dyad. Operationalizing Goffman's (1974) notion of frame switching alongside contextualisation cues (Gumperz 1982) and metacommunication, Seale et al. (2007: 184) typify the medical simulation as a hybrid discourse mode, in which the clinician must deftly manage 'frame ambiguity' as they alternate between professional mimicry and 'out of frame' metacommentary on this mimicry. They suggest that their findings may indicate that observance to strict notions of realism may in fact occlude the pedagogical aim of the simulations themselves, and that 'out of frame' activity may in fact contribute towards the establishment of a 'safe' learning environment where new skills can be practiced (185).

The question of reality within simulated medical encounters, its validity and the subsequent relation to the uptake of medical expertise is recurrent throughout the literature on medical simulation. Hanna and Fins (2006: 266) view the inversion of asymmetry within the dyad as the primary source of medical simulation's lack of validity: They contend that the junior clinicians' nascent identity as a professional, the removal of medical consequences, and – in the case of assessed simulations – the presence of a third-party assessor, all contribute to an environment that cannot replicate the correct 'interactional dynamics' of a real consultation (267). As such, and as Seale et al. (2007) also noted, Hanna and Fins (2006: 267-8) suggest that the simulation becomes an exercise in imitation; and ultimately

this is imitation of unrealistic ideal, leading to medics who are able to only 'act out' synthetic relationships with patients.

De la Croix and Skelton (2009) similarly emphasise the inversion of power relationships within simulated encounters, and from a specifically linguistic perspective, they highlight that the simulated patients talk and interrupt significantly more than medical student within the dyad. Taking Hanna and Fins (2006) findings a step further, de la Croix and Skelton (2009:701) suggest that not only is the asymmetry reversed within simulations, but that the simulator is instead imbued with institutional power on behalf of the regulatory assessment process. Thusly, the central concern within the simulation becomes 'the language game of teaching' as 'the game of teaching...overrides the game of medicine' within the consultations to allow the simulator a more assertive and dynamic locutionary role (ibid). Albeit, one that de la Croix and Skelton note, can also function to help the junior clinician 'suspend enough disbelief to function adequately' (ibid).

These studies appear to demonstrate that alongside notions of reality and validity, that performativity is a central concern within medical simulation. Atkins et al. (2016: 7) identify that what is likely assessed is not the real communication of a clinician, but instead the ability to craft 'a credible appearance of such communication'. Subsequently it is those candidates that are able to 'play the game' the best – by modifying otherwise formulaic language to authenticate empathy and concern – who are the most successful (ibid). However, as Atkins et al. emphasise, questions of performativity are not restricted to the clinical role within the simulation; they suggest that despite simulated cases being standardised, the simulator is a hybrid of 'acting behaviour and their own, individual interactional resources' (6). And as such, the actor can respond with real emotions to the performance of the candidate, whilst the examiner also adjudicates this hybrid performance by utilising their own personal and professional expectations (ibid).

In linking simulation to the acquisition of knowledge within a community, Hodges (2012: 26) defines the language of simulation as 'performance discourse' – which is demonstrative, but not necessarily centred around the same lexis associated with

'knowledge discourse'. Hodges reports that critics have stated that an overemphasis on decontextualized, performativity within pedagogy may lead to a level of incompetence 'characterised by poorly integrated knowledge' and inauthentic performance (27).

2.6 Literature summary

This chapter has firstly outlined and contextualised the present research in regard to both studies of wider professional discourse and healthcare discourse. It then reviewed relevant literature from the three primary areas of concern within this thesis – discursive identity, expertise and medical asymmetries – and provided background to several contemporaneous healthcare contexts, including literature pertaining to medical simulations. Resultant from this literature is a number of open debates that have potential methodological implications for this research as I have noted throughout the chapter.

The deliberation over macro-societal and micro-interactional approaches permeate questions of both discursive identity and dyadic asymmetry. I argued that for discursive identity, the Bucholtz and Hall (2005) model provided the most comprehensive framework by which facets of identity might be understood in this study – delivering a matrix by which identity is composed of both turn-by-turn utterances, preconceived roles and interaction with another interlocutor. Stemming from my discussion of power and asymmetry, I contend that dyadic asymmetry in terms of access to restricted professional knowledge is the most practicable and tangible means by to conceive of an imbalance between interlocutors. But that as Iedema (2003) notes, the navigation of this asymmetry is likely to be complex and highly context dependant.

For discursive performances of expertise, the literature presents a question over the extent to which expertise is engendered in specialist language forms and technical lexis (indicating the presence of a professional register or genre), or indeed, resides more prosaically in speech we might consider commonplace. On this point I believe that Sarangi and Roberts (1999b) notion of discursive 'hybridity' bears the most relevance for this study – especially given the dual healthcare contexts under examination. For both notions of

asymmetry and expertise however, there are also a number of contemporary healthcare considerations to reflect upon – outlined in Section 2.5 – that may have bearing on how these areas are dialogically approached in the data.

The literature on medical simulations adds an extra dimension to existing debates on medical dyads; giving rise to potential reversals of asymmetries, a modified role for institutional influences, as well as aspects of pedagogical identity generally not accounted for in the main body of health communication research.

3. Methodology

3.1 Introduction

This chapter introduces the methodology and analytic methods used within this study, the dual datasets, and the broader organisational contexts in which the research is placed.

Section 3.2 establishes the approach taken to research in this study; discussing the contribution of applied linguistics as a discipline with practical relevance and collaborative value for organisations external to academia. This section also takes a reflective view, discussing applied linguistics research as a collaborative enterprise with external stakeholders and/or clients, what this means for the identity of the researcher and ultimately, what the limits, ramifications and consequences are for this type of research collaboration. Throughout this area of methodological discussion explicit reference will be made to how these theoretical principles translated to the data-gathering activity for the clinical pharmacy dataset, and the ongoing research relationship LiPP held with the educator team of Perfect Day.

Section 3.3 provides contextual background to place this research within the wider remit of the *Linguistic Profiling for Professionals* (LiPP) business unit and the ERDF *Enabling Innovation* project as a whole. From there, Section 3.4 will outline the two healthcare datasets under investigation within this study, how they were obtained and the constitution of each corpus. Finally, in Section 3.5 I will discuss the adoption of an innovative mixed-methods approach to the data; starting from a corpus-assisted analysis of the datasets to locate specific areas of discursive identity, to the detailed discursive pragmatic analysis of these areas, in which aspects of ethnography are also integrated.

3.2 Applied linguistics in the workplace

3.2.1 The application of applied linguistics

By its very name, applied linguistics as a research discipline connotes tangible application to 'real world' problems (Brumfit 1991, 1997, Schmitt and Celce-Murcia 2002, Teubert 2010). Accordingly, the chronology of applied linguistics research has seen diverse topical foci in areas such as second language acquisition, psycholinguistic processing, and sociolinguistic practices, to name just a few. Thematic cohesion of these research areas can be characterised by what Davies and Elder (2004: 1) term 'a central interest in language problems', the engagement with which highlights the 'socially accountable role' of the discipline. A central aim for this thesis is to follow the path taken by Roberts (1997, 2003) and Sarangi and Candlin (2003) in moving toward an approach that focuses on practical relevance and reflexivity within applied linguistics in an attempt to situate research as part of a collaborative negotiation addressing social or professional problems. In their own use of the notion of reflexivity, Sarangi and Candlin (2003: 271) invoke Bourdieu and Wacquant's (1992) conceptualisation of a process by which a particular group contextualises and evaluates its intellectual practices. This study, therefore, adopts this definition of reflexivity, and recognises the maxim 'relevance and reflexivity' to mean an active process of researcher and research-based awareness for context and action, that is mediated by an inclination for practical relevance within workplace practice.

The debate over how extensively applied linguistics research can be practically applied has received considerable attention around the turn of the 21st century, with a selection of prominent papers (see: Rampton 1997, Roberts 1997, 2003, Scheeres and Solomon 2002, Candlin 2003, Candlin and Candlin 2003, Roberts and Sarangi 2003, Sarangi et al. 2003, Sarangi and Candlin 2003) informing the core of this methodological debate. Rampton (1997) highlights a disposition for the central tenets of applied linguistics research to be a concern with 'discovery' and 'usefulness'; a conceptual view of the field which Roberts and Sarangi (2003: 340) explicate upon, noting that this orientation towards research often means that 'practical application or 'usefulness' becomes an afterthought.

Approaching research in this manner yields what Roberts (1997: 68) portrays as a detached model, in which the role of researcher and research subject are distinct, a division that consequently maintains the separation of theory and application. Whilst the role of the researcher within applied linguistic research and their mediatory value will be investigated fully within Section 3.2.4, it is worth noting at this point that for Candlin and Sarangi (2004) the mediator role played by the researcher is also integral to this potential separation of theory and practical application. Moving beyond Rampton's (1997) identification of 'discovery' and 'usefulness', Sarangi (2012) provides a critical outline of four major categories of applied linguistics research and their practical relevance:

- 1) Pure research
- 2) Applied research driven by practical concerns
- 3) Consultancy, or problem solving within the workplace from prior research knowledge.
- 4) Consultative research, which is demarcated by collaboration between researchers and participant.

(Adapted from Sarangi 2012: 3)

The institutional context of LiPP in which this thesis sits and its associated processes of data collection render categories three and four here especially relevant: The research endeavours that account for half of the data collection for this thesis were initially conceived as part of a joint project with the University of Nottingham's School of Pharmacy to examine the intra and inter-professional communication of pharmacists within GP practices. It was anticipated that this joint consultation project would have a triumvirate of practical outputs; in providing practicable health communication feedback for the medical professionals themselves, as resource for the Pharmacy School's teaching and module development, and as a resource of raw language data for LiPP – to be utilised for future corpus-building and

research purposes. As Section 3.4.2 will attest however, as is common with projects of this nature, the focus was modified significantly from its initial conception.

Whilst research activities such as these may echo Sarangi's (2012: 3) characterisation of consultancy as a 'problem-solving mentality', or evocation of the 'jobbing linguist' (Crystal and Brumfit 2004), it was the aim of the study to develop relationships into long-term research collaborations in line with the ideas of Morse (1997) and the precedent of Holmes and Stubbe (2003). And indeed, further work has subsequently taken place beyond this initial partnership, with LiPP collaborating with the School of Pharmacy to investigate undergraduate simulated consultations during Spring 2019. The interpersonal role played by the researcher in developing and maintaining these collaborative relationships will be explored in the following sections.

3.2.2 Problems with an applied approach

Whilst the move towards consultative, negotiated and practical research relationships in applied linguistics appears to be a positive step in avoiding Clarke's (2003: 383) depiction of research subjects as 'feeling cheated' by short-term involvement with no practical application and McCarthy and Handford's (2004: 171) 'no reciprocal gain', this methodology still comes with its own limitations. For instance, Candlin and Sarangi (2004) warn against a potential disciplinary overreliance on consultancy and service provision, noting that applied linguistics cannot sustain itself by these means alone, and requires an essential commitment to theoretical and analytical discoveries alongside practical application. The synthesis of academic epistemology and workplace practicality has also faced critique; Crystal and Brumfit (2004: 397) highlight that any research involving socially-occurring phenomena has a tendency to view that phenomena in a decontextualized and isolated manner. Sarangi (2012: 8) adds that this process of decontextualisation can potentially mean any intention towards practical relevance becomes a 'pretence'. The manner by which practical relevance for the applied linguist exists has also been questioned; Roberts and Sarangi (1999b: 498) stress that practical solutions based on research findings are not in a 'one to one

relationship', whilst later work by Sarangi and Candlin (2003) notes the fundamental differences in knowledge that yield intellectual rather than practical solutions. Notably, Sarangi (2010b: 413) has also highlighted that the clinicians and contributors themselves are ultimately the arbiters of relevancy of any findings – so whilst outcomes in their 'raw', academic form cannot be applied directly by practitioners, this should engender reflexivity in research practices.

This argumentation indicates that any reciprocal research collaboration needs to undergo a process of recontextualization – or adaption from the conventions of academic research – by the professional practitioners, in line with the conclusions of Roberts and Sarangi (1999b). Accordingly, Sections 3.5.2 and 3.5.4 will outline how the methodology of this thesis was explicitly developed with these concerns – and the mediation between an academic and professional audience – in mind.

3.2.3 Research as collaboration

The move towards a collaborative research framework by which to engage external stakeholders, advocated by Roberts (1997), Clarke (2003) and Roberts and Sarangi (2003), can seemingly be traced back to the work of Cameron et al. (1992), and their exploration of interactive and dialogic methodologies, culminating in the maxim; 'research on and for' social subjects. Whilst noting that social science research has historically tended to focus on less powerful groups within society, Cameron et al. argue that power relations between researcher and research subject can be multi-dimensional, fluid and dependant on local context (16).

The data collection for the clinical pharmacy area of this thesis was a collaborative, consultative endeavour with the School of Pharmacy and, ultimately, a number of GP practices within the East Midlands. As will be explicitly detailed in Section 3.4.2, the nature of this collaboration developed and adapted over a number of years, with the School of Pharmacy serving as mediatory body between LiPP and the external healthcare organisations. In this respect, the relationship between the research team and the

researched organisation constituted an on-going balance between the 'on' and 'for' (Cameron et al. 1992). In terms of practical applicability, this integrated, collaborative approach reflects the edict set out by Bloor (1997: 410), as an association centred around the 'coalface' and practitioners themselves, rather than an attempt to influence policy-makers or 'managers of practice'.

As Clarke (2003) attests, the insight offered by collaborating participants can be an integral part of the research. Candlin and Sarangi (2004: 4) underline that, whilst the applied linguistics researcher may focus solely on language within the workplace, participants can draw attention to other 'semiotic modalities' in which significant facets of data may be encoded. The relationship between researcher and the participants is also integral to moving the research activity within this study beyond problem-solving or the negative notion of the 'jobbing linguist' (Crystal and Brumfit 2004): Roberts and Sarangi (1999b: 473) frame their own collaboration with the Royal College of General Practitioners as 'joint problematisation', a conception they achieved through interim discussions of findings with the participating body. This sentiment is further echoed by Clarke (2003) and the importance he places on 'hot feedback' for professionals who are collaborating with linguists in the workplace, alongside Holmes and Stubbe's (2003: 20) strategic 'short-term outcomes' / 'long term results' approach to presenting their findings. I have already briefly touched on how the emergent methodology described above manifested on a macro scale throughout the clinical pharmacy-based research process. However, it is also worth stating that during the data collection itself, iterative developments or suggestions towards areas of importance were made through discussion of the research with the clinical pharmacists themselves.

Clarke (2003) also demonstrates however, that conversations with an academic researcher can draw attention to facets within practice that the professional may have neglected, offering a reciprocal relationship to the one noted by Candlin and Sarangi (2004). Clarke (2003: 382) also offers a reflective 'outsider' perspective of a medical professional engaged in linguistic research, emphasising the need for both sides of the research partnership to 'becom[e] engaged with each other's perspectives' in order for the potential of

any research collaboration to be fully realised. For the Perfect Day dataset, this process was already in place within LiPP, with the educator team collaborating with LiPP on a number of research projects.

If an immersive and reciprocal approach towards research is the hallmark of achieving a worthwhile collaboration, it is also worth noting where consideration and trepidation should be given to this type of research relationship. As previously detailed, Roberts and Sarangi (1999) argue that a process of 'recontextualisation' must always occur between the academic findings of research and any professional / practical use they may have. However, the idea of a dialogic, transformative interaction between academia and professional workspaces has been critically evaluated by Scheeres and Solomon (2002), who forewarn of an unstable and tension-filled 'hybrid' space, in which the identity of academia and academics remains ambiguous in the face of an increased cross-pollination with the practices of professional workplaces and governmental agendas. For Scheeres and Solomon, the nature of modern collaborations between professionals and academics is one that produces not only 'new knowledge in new ways', but also 'new kinds of academics' (182-3). Work such as that undertaken by du Gay (1996) also foregrounds that the increasing requirements of workplace communicative competence – later highlighted by Iedema and Scheeres (2003) and Iedema et al. (2005) – can have a significantly destabilising effect on professional and employee identity, which must be accounted for by the collaborating researcher.

Whilst the potential for a 'new kind of academic' will be discussed in Section 3.2.4 below, the idea of conflicting agendas within the collaborative intersection of academia and the workplace has also been addressed by Sarangi and van Leeuwen (2003: 4) who contend that applied linguists forfeit an element of research autonomy through close collaboration with external bodies. Whilst for Sarangi and van Leeuwen this loss of autonomy within the discipline is offset by a renegotiation of the applied linguist's identity within a professional community of practice, Knapp and Antos (2008: xi) argue that professional alignment entails research being driven by the specific professional community

of practice, rather than academics within the discipline itself – a stance which echoes Candlin and Sarangi's (2004) idea that applied linguistics cannot be sustained on practical collaboration alone.

3.2.4 The role of the researcher

The move towards participatory and cooperative research arguably demonstrates the growing importance of interpersonal skills and identity management for the applied linguistics researcher that go beyond the idea of Labov's (1972: 209) systematic observer. A comprehensive categorisation and analysis of interactional concerns is provided by Sarangi and Candlin's (2003) citation of an unpublished paper by Sarangi and Hall (1997), and the idea of a researcher identity being fluid, malleable and context-dependant has been previously picked up in the work of Cicourel (1987) and Mullany (2007). In this particular study, the role and identity of the researcher is initially preceded and contextualised to collaborators by the wider context and work in which the research sits – namely the LiPP business unit and the ERDF project as a whole. However, beyond this preliminary contextualisation of the research to participants, the personal role of the researcher held differing levels of involvement as Sections 3.4 and 3.5.4.4 will detail.

This institutional, collaborative framing of the research activity – mutually beneficial for both researcher and researched – arguably led to the lessening of problematic aspects of approach or access foregrounded by previous work (Bargiela-Chiappini and Harris 1997, Holmes and Stubbe 2003, Schnurr 2009). As the discussion surrounding the theoretical identity of the researcher below will attest, this study sought to minimise the enduring division of researcher-researched identified by Roberts (1997), whilst also acknowledging that, in line with Duranti's (1997: 101) view of linguistic anthropology, this is to some degree an unavoidable aspect of social research.

The reflections of Clarke (2003) as a medical professional who has been the subject of applied linguistic research are especially pertinent to facilitate a research identity that is as unobtrusive as possible: Clarke's observations highlight the increased tendency for

professions to be familiar with modes of observation, auditing and reflective practice and the critical advantage this gives to the contemporary researcher (374). In terms of the individual clinicians in this research, this was certainly the case for the clinical pharmacists who raised no objections to their observation and in many cases were familiar with being observed for either assessment or mentorship purposes.

Practically, Clarke (2003) also offers guidance to the researcher in terms of appropriate appearance and mannerisms whilst conducting research in the workplace (381), and crucially emphasises that, whilst researchers should be engaged with their participants at a 'low intensity level' (ibid), the hallmark of a successful collaboration is one where the researcher does not become an unnatural 'fly on the wall' observer. This is an important distinction to make regarding researcher-researched engagement and agency and was especially pertinent within the methodology of this study, where data was gathered at close proximity to on-going workplace activity.

Clarke also reiterates points made by Roberts and Sarangi (2003) and Sarangi and Candlin (2003) in foregrounding how the temporal immediacy to the approach and dissemination of feedback is a key facet within the role of the embedded workplace researcher, and one that can delineate workplace research from other areas of social research. As previously discussed in Section 3.4.2, so-called 'hot feedback' can be an area in which the researcher is able to contribute an outsider viewpoint which elucidates areas that the professional has not considered, contributing positively to the reflective practice of the workplace and helping the researcher's process of ingratiation into the workplace context. However, work such as Cicourel (1987) and Hall, Sarangi and Slembrouck (1997) demonstrates that caution should be taken when negotiating this element of researcher identity, as the researcher may find themselves unreasonably framed as an 'expert', potentially losing credibility when aspects of linguistic 'expertise' cannot be delivered in a work context contemporaneously. In addition, Sarangi and Candlin (2003: 280) note that notions of the expert voice for the researcher are further complicated when they are required to deliver expertise, yet gather basic contextual knowledge of workplace environments simultaneously.

For Sarangi and van Leeuwen (2003: 5), integration into workplace environments and practices for the researcher constitute 'learning of new ways of acting and seeing', however, this uptake of new research contexts and methods should not be seen as a passive process of adaption, as Iedema and Scheeres (2003: 334) demonstrate: In their view, embracing this new research identity fundamentally implicates the researcher into workplace activity – with both positive and negative ramifications – creating research findings that may not be in keeping with traditional ideas of academic convention (ibid.), whilst also contributing to the conception of 'new knowledge' and a 'new kind of academic' (Scheeres and Solomon 2002).

The collaborative endeavours between LiPP and both sets of healthcare professionals situates both the researcher, and the LiPP collaboration as a whole, within the professional and epistemic functions of the workplace, echoing Iedema and Scheeres (2003) sense of 'implication'. Accordingly, the methodology of this study attempts to locate the role of the researcher beyond Candlin and Sarangi's (2004: 3) idea of the applied linguist as a mediator between two distinct worlds, to their advocacy of a 'mediation model' (ibid) whereby the researcher is an immersive and active participant within the production of workplace insights of practical relevance. This positioning of the researcher is in itself methodologically significant, as it yields comprehensive contextual detail to the production of the data corpus in line with the suggestions of Cicourel (1987). The detail of this level of involvement and the ethnographic elements it provides will be fully discussed in Section 3.5.4.4.

3.3 Contextual background: LiPP & ERDF

3.3.1 Linguistic Profiling for Professionals

The research forming the basis of this thesis is situated in the wider context of the public-facing work of the *Linguistic Profiling for Professionals* (LiPP) business unit. Founded in August 2015, LiPP is positioned in the University of Nottingham's School of English and offers a range of communicative resources to both public and private organisations through linguistic methodologies such as corpus, conversational, discourse, and pragmatic analysis undertaken by a team of academics operating as research consultants. As part of its resource portfolio, LiPP has offered a number of workshops around topics such as gender, leadership, miscommunication and team dynamics in the workplace, along with specialist eye-tracking for websites, online learning packages for CPD and personalised linguistic consultancy packages based the particular need of a business or organisation. This public-facing activity can be viewed in light of the increasing importance of higher education institutions to evidence 'impact' – the identifiable benefit of academic research to society as a whole.

The research underpinning this thesis was initially part of a consultancy package designed by LiPP in collaboration with the School of Pharmacy at the University of Nottingham to provide areas of service improvement and reflective practice for dispensing pharmacists based in GP practices in the Nottingham area, specifically targeted on areas of inter-professional communication. However, as Section 3.4.1 will detail, this initial collaboration changed due to a number of contextual factors. As part of the methodology adopted within this study, the procedural and theoretical implications of this doctoral research existing within the wider context of LiPP activity will be discussed throughout this thesis wherever relevant.

3.3.2 European Regional Development Fund

The European Regional Development Fund (ERDF) is a regional fund allocated by the European Union as part of its cohesion policy, with a particular attention on business

investment in order to create economic growth and minimise 'intra and inter regional economic disparities within the EU' (Dept. for Communities and Local Government 2015: 1). Strategic delivery and oversight of ERDF funding throughout the UK is led by thirty-nine Local Enterprise Partnerships constituted of local businesses, government, universities and community partners (3). A specific focus for ERDF funding within the UK has been on the promotion of research and innovation within business, as well as a redressing of the 'innovation gap' between small-scale businesses (SMEs – small and medium enterprises) and large companies (7). In the East Midlands region this wide-scale strategy has been realised in the form of *Enabling Innovation*; a three-year collaboration between the University of Nottingham, Nottingham Trent University and the University of Derby (2016-2019), with the aim of offering support and development to two thousand SMEs in the local area through workshops, teaching and access to university materials (Enabling Innovation 2016: para.1). As part of *Enabling Innovation*, LiPP received a large funding grant to deliver twelve hours of development contact time to over fifty individual businesses and organisations in the East Midlands – either in the form of workshop attendances, bespoke consultancy packages or a combination of the two. The ERDF funding received by LiPP also financed the research for this doctoral project.

3.4 Contextual background: data sites

3.4.1 Perfect Day

The Perfect Day project is a targeted educational support programme external to LiPP, established for postgraduate General Practice specialty training and funded by the East Midlands division of Health Education England (HEE). Perfect Day was developed by a medical educator team as an interventional strategy to introduce GP registrars to the application of self-regulation theory (Bandura 1991) and meta-cognitive strategies within their consultations. This interventional programme was specifically for those GP trainees identified as potentially 'at risk' due to at least one failed attempt at the Clinical Skills Assessment (CSA) examination, or an 'unsatisfactory progress' rating at their Annual

Review of Competency Progression (ARCP) panel. Ultimately, Perfect Day would aid the trainees in their preparation for the CSA – an examination of thirteen simulated consultations required to practice independently as a GP in the UK.

In summer 2017 LiPP received access to two cohorts of candidate data from Perfect Day, yielded from workshops in autumn 2016 and spring 2017. The data comprised of thirty registrars from the East Midlands locale undertaking two separate simulated consultations, equating to a total corpus of sixty simulated doctor-patient interactions. Each of these dyadic interactions is accompanied by a GP educator delivering a pre-exercise interview with the candidate to establish potential strategies and confidence levels for the consultation and followed by a post-hoc debrief to reflect on the levels of success achieved by the candidate in the exercise. The two distinct exercises within Perfect Day are henceforth designated Scenario A and Scenario B for practical consideration within the present study.

Scenario A involves a patient attending the surgery to receive the results of neurological tests, ostensibly unaware that the results of the tests may have serious implications. Accordingly, the candidate must navigate the patient's perceived lack of insight to ultimately deliver the news that they have Multiple Sclerosis. In Scenario B the simulated patient is also attending to receive the results of tests; undertaken due to reported recurrent bouts of sickness. In this scenario the patient believes a stomach ulcer is causing the symptoms and is unaware that the tests undertaken by the hospital have included a liver function test. Sensitivity around the unmentioned liver test in this scenario stems from the patient having an undisclosed alcohol problem which they are not comfortable discussing. In both scenarios, the candidate is contextually grounded as a locum-style doctor who has no prior knowledge or experience of the patient other than the notes they receive. The characterised patient in Scenario A is female, whilst in Scenario B they are male .

The Perfect Day Corpus (henceforth known as PDC) under investigation within this thesis is a 32,000-word sample of the larger Perfect Day dataset held jointly by LiPP and the School of Medicine and Health Sciences. The data analysed for this thesis focuses on the candidates undertaking the two consultation exercises and was achieved via a random

sampling of the 2016 and 2017 intakes. Within this sample, four candidates are male and two are female – this 67 / 33% split in favour of males in the sample approximates the demographic profile of the entire Perfect Day dataset itself which is weighted 63 / 37% male. Whilst the scenarios remained the same for both the 2016 and 2017 cohorts, the scenarios were delivered from a group of four simulated patients, the distribution of which is illustrated in Table 3.1, below.

Although for the educator team, Perfect Day has a specific intent in regard to the development of self-regarded action in the consultation, within this thesis they will be discussed generally as pedagogic-simulated consultations.

CANDIDATE:	SEX:	SCENARIO A			SCENARIO B		
		CAN WORDS:	SIM:	SIM WORDS:	CAN WORDS:	SIM:	SIM WORDS:
1	M	903	1	1383	1533	2	1368
2	M	1191	1	1162	1893	2	962
3	M	1789	1	1745	2253	2	1608
4	M	1219	1	939	2242	2	1021
5	F	1358	3	861	1758	4	946
6	F	1125	3	509	1531	2	1320
TOTALS:		7585		6599	11210		7225

Table 3.1 – Word totals and simulator allocation in the PDC

3.4.2 Clinical Pharmacists in General Practice

The initial LiPP collaboration with the School of Pharmacy was conceived as a series of ERDF-based consultations with both community pharmacies and GP practices, delivering linguistic insights into professional communication for the practices, whilst also affording LiPP the chance to gather data for corpus-building and further research. However, the professional contact groups and local professional networks of the Pharmacy School, and later LiPP’s own promotional effort, yielded only one sign up for the consultations – a Clinical Commissioning Group: an organisation falling outside of the ERDF’s SME parameters.

Upon reflection, the lack of uptake for the project could be attributed to the difficulty of promoting the tangible benefits of extensive (and potentially time-consuming)

consultations to public-sector organisations. From my own work experience within Health Education England (HEE) I am aware that often factors such as overriding political mandates, staffing issues, regulations around external providers and, of course, the immediate concerns around service provision all take precedence in an organisation's direction. This is in stark contrast to the appetite and positive feedback reported by private SME businesses in receipt of academic resources as part of the ERDF remit. The research partnership between LiPP and the Pharmacy School did however, open up an opportunity for LiPP to contribute language analysis to the ongoing national Clinical Pharmacists in General Practice (CPiGP) project facilitated in the East Midlands by the School of Pharmacy.

The CPiGP project was a yearlong pilot study funded by NHS England that sought to introduce 470 clinical pharmacists (CP) into over 700 GP practices in order to address the stresses placed on General Practice (Mann et al. 2018: 6). As part of the ERDF *Enabling Innovation* strategy, in summer 2018, LiPP was assigned to follow up the CPiGP pilot project with a series of linguistic analyses of data yielded from the initial study. This involved providing a linguistic profile for each of the five original sites examined by the School of Pharmacy in 2017, as well as a final overall report for Primary Integrated Community Service (PICS) who had facilitated the pilot project within the East Midlands. The objective of the consultation was to give an early picture of what communicative activity looked like for the CPs as a new role in primary care. The reports looked at three specific areas of the CPiGP data; CP's consulting with patients in the practices, the professional networks created by the CPs within practices – and their relative success or failure – and finally, patient feedback on the CPiGP experience. Anonymised examples of these reports can be found in the data repository. The reports were subsequently delivered to the Practice Manager and CP of the participating practices over autumn 2018 and were accompanied by a follow up interview and further consultation observations.

The Clinical Pharmacy Corpus (henceforth CPC) for this study is comprised of the consultation data collected in the later LiPP practice visits (approx. 37,000 words) in 2018.

Unlike the PDC, these consultations are non-simulated, 'real world' consultations undertaken by four Clinical Pharmacists involved in the initial CPiGP project. The sampling of the much broader Perfect Day dataset to create the PDC was undertaken to approximate the word total of the data yielded for the CPC, creating two equitably-sized corpora. The site data has been anonymised by adopting the pseudonyms *Orchards*, *Ashbourne*, *Foxhole* and *Greenheath* for the GP practices; the breakdown of consultation and language data by each site is illustrated in Table 3.2, below. Whilst a total of eighteen consultations comprise the corpus, an additional seven were observed during the visits but not recorded due to either participant request, or primarily, because they were conducted over the phone, and as such were not included due to ethical reasons.

SITE:	PATIENT:	CP:	PT:	SITE TOTALS:
ORCHARDS	1	791	1228	
ORCHARDS	2	1245	286	
ORCHARDS	3	1310	341	
ORCHARDS	4	1296	1623	
ORCHARDS	5	956	391	
ORCHARDS	6	1597	1463	
ORCHARDS	7	975	1563	15065
ASHBOURNE	1	315	68	
ASHBOURNE	2	1348	1522	3253
FOXHOLE	1	2013	833	
FOXHOLE	2	1383	406	
FOXHOLE	3	554	223	
FOXHOLE	4	1498	772	
FOXHOLE	5	2257	2077	12016
GREENHEATH	1	981	717	
GREENHEATH	2	859	390	
GREENHEATH	3	1493	1049	
GREENHEATH	4	948	570	7007

Table 3.2 – CPiGP site breakdown and word totals

3.4.3 Commonalities in the datasets

Despite sharing a common contextual healthcare background, there are of course differences in the nature of each professional endeavour at hand within these datasets, as well as a distinction between simulated and authentic consultations with patients.

Nonetheless, a number of important commonalities exist in regard to the use and subsequent analysis of language within this data: Firstly, both datasets are primarily consultative and dyadic in their structure; clinical pharmacy in general practice – similar to other non-GP primary care roles such as a nurse practitioner – follows a comparable model to the typical GP consultation, rather than the more traditional, shop-based, ‘service role’ (Pilnick 2003: 849) of the community pharmacist.

The second similarity is perhaps the most important to the focus of this particular doctoral study; namely that both datasets involve the establishment and discursive enactment of nascent professional roles and identities. The GP registrars within the Perfect Day data have not yet passed their Certificate of Completion of Training (CCT) to allow them to practice independently and are accordingly still, professionally, considered trainees. The simulated scenarios they undertake within this educational intervention are designed to allow the registrars to practice and solidify their consultation skills in a non-critical environment. Whilst clinical pharmacy in a primary care context is itself an emergent role – with the CPs featured within this research all holding various levels of experience and accreditation and afforded dissimilar amounts of responsibility within their role. Notably, during research visits a number of the CPs involved in the study voiced concern over a historic paucity of communication and consultation training within their undergraduate syllabus, which had accordingly left them ill-equipped for the types of dyadic, long-form consultation they were now undertaking.

The final commonality between the datasets concerns the overarching context in which this research sits, and the means by which it has been funded. Namely the geographic locality in which these datasets originate and in which these various professionals practice. As I detailed in Section 3.3.2, this research is funded by the

European Regional Development Fund's *Enabling Innovation* grant to promote professional innovation via university-based collaborations within select regions of the UK. Accordingly, this study not only considers the GP registrars and CPs within the data as members of a specific professional community, but also as a professional community that is based in and intended to serve the East Midlands explicitly.

Throughout the analysis chapters the datasets are consistently presented in the order of PDC then CPC throughout. Whilst a direct comparison between the two is not a primary aim of this research, given that, arguably, the GP-patient dyad represents an archetypical consultation with well-established conventions, this allows the newer CP dyads to be contextualised against a pre-existing and typified form of primary care interview.

3.4.4 Ethics

Due to the wider, project-based remit of both of these datasets, ethical clearance was already in place for LiPP as a research team. For the Perfect Day project, ethical approval for the data collection had been originally gained in the initial planning by the School of Medicine and Health Sciences; with LiPP added onto the ethics for the purposes of consent to record and use of the consultations for research purposes. Whilst for the data collection at the CPiGP sites, the NHS ethical clearance gained by the School of Pharmacy in 2017 covered the ongoing collection of dyadic data under the project remit.

It is worth highlighting, however, that the practicalities of gaining on-site informed consent from patients varied from practice-to-practice for the CPiGP data. This was a product of each practices' individual administration of CP appointments, which meant that it was necessary to adapt my approach to the individual patient, so as not impinge on the consultation nor the potential recording of it. Although there contained an element of variation, full informed consent was sought from each participant in the research in line with the School of English's ethics guidance – I reflect further on this aspect of the research within the discussion chapter. Nonetheless, these practical constraints meant that during some consultations recording commenced with the consultation already having begun .

3.5 Methodological framework:

3.5.1 Introduction

In order to analyse the naturally occurring language within these two datasets, this study adopts a hybrid, mixed-methods approach to examine professional identity, asymmetry and expertise. The selected methodological framework combines the quantitative, statistical approaches of corpus linguistic tools, with an overarching qualitative, pragmatic analysis, as well as integrating concepts from conversation analysis, social psychology and ethnographic 'thick participation' (Sarangi 2006).

Sections 3.5.2 and 3.5.3 will detail the corpus approach taken within this study, outlining the relevance of corpus methods to this data and healthcare language generally. I then outline the various measures applied to the data, demonstrating how keywords later inform the selection of qualitative data extracts via an innovative approach proposed by Louw et al. (2014) – giving the corpus analysis a dual function. In Section 3.5.4, I introduce the pragmatic basis of the qualitative framework, discussing existing work that combines corpus methodologies with discourse analysis. From there, I then outline the discursive pragmatic approach and the meso-level of analysis this affords the research, before finally discussing how 'thick participation' (Sarangi 2006) in the data collection contributes an ethnographic element to the analysis.

3.5.2 Quantitative framework – The corpus method

Given the intention to identify salient aspects of discursive, professional identity within this study, the utilisation of corpus linguistic methods provide an apt means of uncovering language patterns or recurrence in a corpus of transcripts that are ostensibly disparate; foregrounding language phenomena that might otherwise require numerous examples before being noticed as salient by a researcher (Clancy and McCarthy 2015: 438). Mahlberg (2014: 220) has also noted the importance of context to corpus approaches, and how recurrent language patterns demonstrates the link between meaning and form in certain contexts. This facet is especially important for this study given the focus on contextually-based professional identity in two distinct professional environments,

Whilst the distinction drawn by Tognini-Bonelli's (2001) between research that is corpus-based or corpus-driven (broadly, starting with a preconceived hypothesis or theory towards the data, or allowing the saliency of the data itself to drive the focus of the research) has received much discussion, the present study's use of corpus tools aligns with Partington's (2006) notion of a *corpus-assisted* approach: That is, that the corpus methods are 'one sort amongst others' (Partington et al. 2013: 11), deployed in order to allow the trends uncovered to be examined in full contextual detail. The use of corpus linguistics in this respect serves to acquaint the researcher 'as much as possible with the discourse type(s) at hand' (Partington et al. 2013: 12).

The corpus-assisted approach echoes Adolphs et al.'s (2004: 25) notion of using quantitative methods to 'take the pulse' of a dataset in order to guide further qualitative analysis. Whilst the corpus methodology ostensibly provides the research with a transparent starting point (Baker 2010) by which to approach the data and can serve as a manner of checks and balances (O'Halloran and Coffin 2004) for any assumptions, there are undoubtedly aspects in which researcher input and interpretation remains in place as the following sections will attest.

In regard to the notion of collaborative research 'on and for' (Cameron et al. 1992) discussed previously in Section 3.2.3, it should be highlighted that the selection of

quantitative, corpus methods also has practical ramifications in terms of feedback to external stakeholders. As Brookes et al. (2018: 109) outline, corpus methods can provide external professional bodies with results that are empirical and can build credibility for the researcher in science and health-based disciplines where objective, statistical evidence is commonplace. Corpus methods are also advantageous for the development of healthcare-based pedagogical language interventions as Brown et al. (2006: 132) highlight; functioning as a form of evidence-based learning which may ultimately render the learning of healthcare communication similar to that of learning a new language (see also; Crawford and Brown 2010 on corpus-based, data-driven learning in healthcare communication).

This is especially important to the datasets within this thesis given both the intention to provide feedback for the research partners, and that both Perfect Day and the CPiGP project (via the School of Pharmacy) have an explicitly pedagogical purpose.

The application of corpus methods within healthcare communication became increasingly prevalent in the late 1990s, with a number of studies (e.g., Thomas and Wilson 1996, Skelton and Hobbs 1999a) utilising this ability for corpus procedures to contend with large amounts of language data; a distinct difference from preceding research in healthcare language that predominantly relied upon discreet, small-scale analysis (Adolphs et al. 2004: 10). Early corpus-based health studies such as Skelton and Hobbs (1999) identified the need for the quantitative aspects of corpus methods to be paired with qualitative elucidation of the findings in full context. This early amalgam of quantitative and qualitative linguistic methods later yielding a prototypical model of pronominal usage in primary care consultations (Skelton et al. 2002) for example.

Latterly, following the work of Seale (2006) and Seale et al. (2006) examining the experiential discourses of users of cancer online forums, a rich vein of corpus-based research has examined how experiences of various illness and conditions are represented in online spaces (for example, see Charteris-Black and Seale 2010, Harvey 2013, Hunt 2013, Brookes 2016).

3.5.3 Corpus procedures

The following sections will detail the corpus processes used within this study and explicate the rationale behind their use to these datasets. The corpus-assisted methodology utilised within this research was primarily developed from a 2017 pilot study of simulated pharmacy consultations undertaken for this thesis. As such, the analysis contained within this PhD study adheres to Baker et al.'s (2008: 284) notion that corpora should not be approached from a 'naive position'. The initial pilot research was based on data provided to LiPP by the School of Pharmacy at the University of Nottingham as part of the ongoing collaboration between both parties. The early access to this data also aided my acculturation and familiarity with the dyadic pharmacy encounters and the corresponding research literature.

This pilot analysis utilised corpus tools such as frequency analysis, keyness measures and concordance lines to investigate how pharmacists used directives and obligational speech acts in enacting their advisory role to the patient. The results of this analysis revealed how the significance of pronouns and the epistemic lexis *think* construed an evaluative professional identity for the pharmacist, whilst the key items *so* and *we* uncovered a means by which the consultation was discursively framed as a dynamic, shared process.

Although the data for the pilot analysis had a different character to that used for this thesis, it represented authentic, dyadic language data from a pedagogical, clinical context. As such, the findings – as they related to professional identity and themes of expertise and power within the consultation – were considered significant enough to inform the methodology of the present study. Indeed, this also prompts the decision taken in this methodology to retain functional lexis within the corpus' keywords, which, whilst not without precedent (e.g., Rayson 2008, Weninger 2010, Pearce 2014) is rare within corpus-based discourse analysis. Similarly, it should be highlighted that the pilot study also demonstrated how medical-based, content lexis such as anatomical, technical and pharmaceutical nouns – although demonstrating high keyness in the analysis – appeared to not play a significant role in the construal of advice giving in the data.

The transcription of data for this research aligns with Sarangi's (2010b: 400) notion that it should be 'fit for purpose rather than just an application of a standard set of conventions'; in this particular instance the purpose being compatibility with corpus software. As such, the transcription was undertaken in a simplified manner with no annotations other than pause markers that indicate the duration of a break in speech.

As I noted in Section 3.4.1, the Perfect Day Corpus (PDC) for this research is a sample of the much larger Perfect Day dataset held by LiPP. The relative size of this PDC sample was determined by the amount of data collected for the Clinical Pharmacy Corpus (CPC), in order to keep both corpora a relatively equitable size. Whilst the CPC is emblematic of an 'opportunity sample' (Dörnyei 2007: 98), determined by practicalities around access as highlighted in Section 3.4.2, the PDC is a randomised selection of those Perfect Day consultations transcribed by LiPP. At 18,795 and 17,944 words respectively, both the PDC and CPC are small corpora. However, as Vaughn and Clancy (2013: 58) note, small corpora such as this are especially useful for pragmatic research through their 'close connection between language and context'. The relatively small size of each corpus also allows for an iterative process of analysis to take place (Vaughn and Clancy 2013: 10) in which statistical corpus results can be investigated in detail to account for results that may result from a speaker's idiolect for example. Indeed, this is the intent of the initial collocation and concordance analysis of both corpora found in Chapter 4. The following sections will systematically highlight each corpus procedure undertaken for this area of the analysis:

3.5.3.1 Keywords

The first aspect of corpus analysis for both datasets is to establish a series of keywords – lexis that appears within the data at a statistically significantly higher rate when compared to a reference corpus. Keywords were expected to provide an initial entry point to the data, presenting a series of salient words from the data that are both objectively arrived at, and that go beyond the basic picture provided by a frequency measure. This initial keyness measure is the starting point for answering the research question *how do discursive*

professional identities manifest in these datasets? In this research, keywords were determined using AntConc corpus software (Anthony 2019) that measures keyness via log-likelihood, with significance measuring 3.84 at the $p < 0.05$ level (95th percentile), or 15.13 at the $p < 0.0001$ level (99.99th percentile), meaning that the researcher can be certain that any keyness value above 15.13 has not arisen in error or by chance. In this instance the reference corpus used to establish keyness values was the spoken English sub-corpora of the British National Corpus. AntConc was selected for its simplicity and compatibility with iOS, and as Section 3.5.3.4, upcoming, will detail, for its ability to produce concordance plots integral to the selection of qualitative data samples in this research.

3.5.3.2 Thematic categorisation of key areas

Whilst a keyness measure will yield an extensive list of keywords, these items require further categorisation to facilitate a more in-depth analysis. A process of thematic categorisation was advocated by Seale and Charteris-Black (2010) as a natural lineage of coding qualitative data within social science research and has subsequently been utilised by a number of healthcare-based studies (e.g., Harvey 2013) as a means to manage findings. In this process the raw keyness lexis generated by the corpus analysis are thematically grouped up to a select cut-off value – item 100 for this particular study.

This is another aspect of the analysis in which smaller corpora are advantageous – allowing for a close reading of each keyword in its various contexts within the data. Given the retention of functional lexis within this analysis, this categorisation initially partitions the keywords into overarching functional and lexical categories for each dataset. These are then further categorised into non-exclusive, thematised sub-categories, informed by a broader reading of the keyword's context within concordance lines. It is important to note that, despite the perceived layer of objectivity provided by corpus methodologies, an element of researcher interpretation remains in the establishment of these sub-categories (Baker 2006: 148). To aid the analytical reading of the keywords once categorised, they were also colour-coded within their tabulation in order to illustrate whether they were either a top twenty

keyness item, a top fifty item or a top hundred item. An example of this categorisation procedure is demonstrated in Table 3.3, below:

Lexical / Content:	Keywords:	Function:	Keywords:
Lexical Category 1	<i>Keyword 3, Keyword 7, Keyword 14, Keyword 22, Keyword 38, Keyword 51, Keyword 74, Keyword 77</i>	Function Category 1	<i>Keyword 1, Keyword 5, Keyword 21</i>

Table 3.3 – Demonstration of thematic categorisation of the keyness data

(Key: Red = top 20 keyness, orange = top 50, black = top 100)

3.5.3.3 Collocation of keywords

The final step in the corpus analysis of the PDC and CPC data is an examination of the collocates of keywords in order to determine how discreet key lexis are functioning in a broader context. Collocation, or, the statistically significant ‘company’ a word keeps (Firth 1957) in a particular text, should elucidate the keywords in context, thus building an initial picture of discursive professional identity beyond singular lexical items. Naturally, there isn’t the scope within this study to investigate all of the keywords within each corpus, as such, in accordance with Baker (2006: 133-136) a practicable approach is taken that focuses on the most key lexical items. Chapter 4 will report the threshold of keyness taken for each corpus. The statistical measure of collocation within this analysis is undertaken using log-likelihood. This measure is favoured over a comparable statistical approach such as mutual information (MI), because as Baker (2006: 102) highlights, MI can foreground low-frequency words. Given the expected number of novel, but potentially infrequent medical lexis in both corpora – such as names of medications, conditions or procedures – log-likelihood therefore, is arguably better placed to report more accurate results. The removal of novel, but low-frequency words from the keyness scores also has ramifications for the next step in the methodology:

3.5.3.4 Keywords concordance plots – data selections

Within this study, the quantitative corpus approach is also utilised to select extracts of both the PDC and CPC for in depth qualitative analysis. This procedure is based upon a 'principled' method advocated by Louw et al. (2014), specifically devised to remove the notion of the researcher 'cherry picking' data extracts and also avoids the 'code and count' method and its associated pitfalls I highlighted Chapter 2. The process in question relies primarily on keywords derived from the corpora, charting them across a specified area of the corpus using AntConc's concordance plot tool. From there, an area of 'typical' discourse can be visually located (Louw et al. 2014: 163); 'typicality' in this respect is defined as the co-occurrence and distribution of key lexis throughout the data sample (167). An illustrated example of this is shown below:



Fig. 3.1 – An example of the Louw et al. 2014 concordance plot from the Perfect Day Corpus

For the Clinical Pharmacy Corpus, the specified areas being plotted will be dictated on site basis – i.e., each of the four CP sites is assigned a chart such as Figure 3.1 above, from which a typical area of discourse is selected. Because the Perfect Day data is orientated around two specific training scenarios rather than sites, four randomised consultations from each of the scenarios are merged into a singular corpus file, forming a plot chart for a particular exercise scenario. From these two resultant PDC plot charts, two areas of

typicality are selected for qualitative analysis. A visual illustration of this selection process is shown in Figure 3.2:

Application of the Louw et al. 2014 process to each corpus:

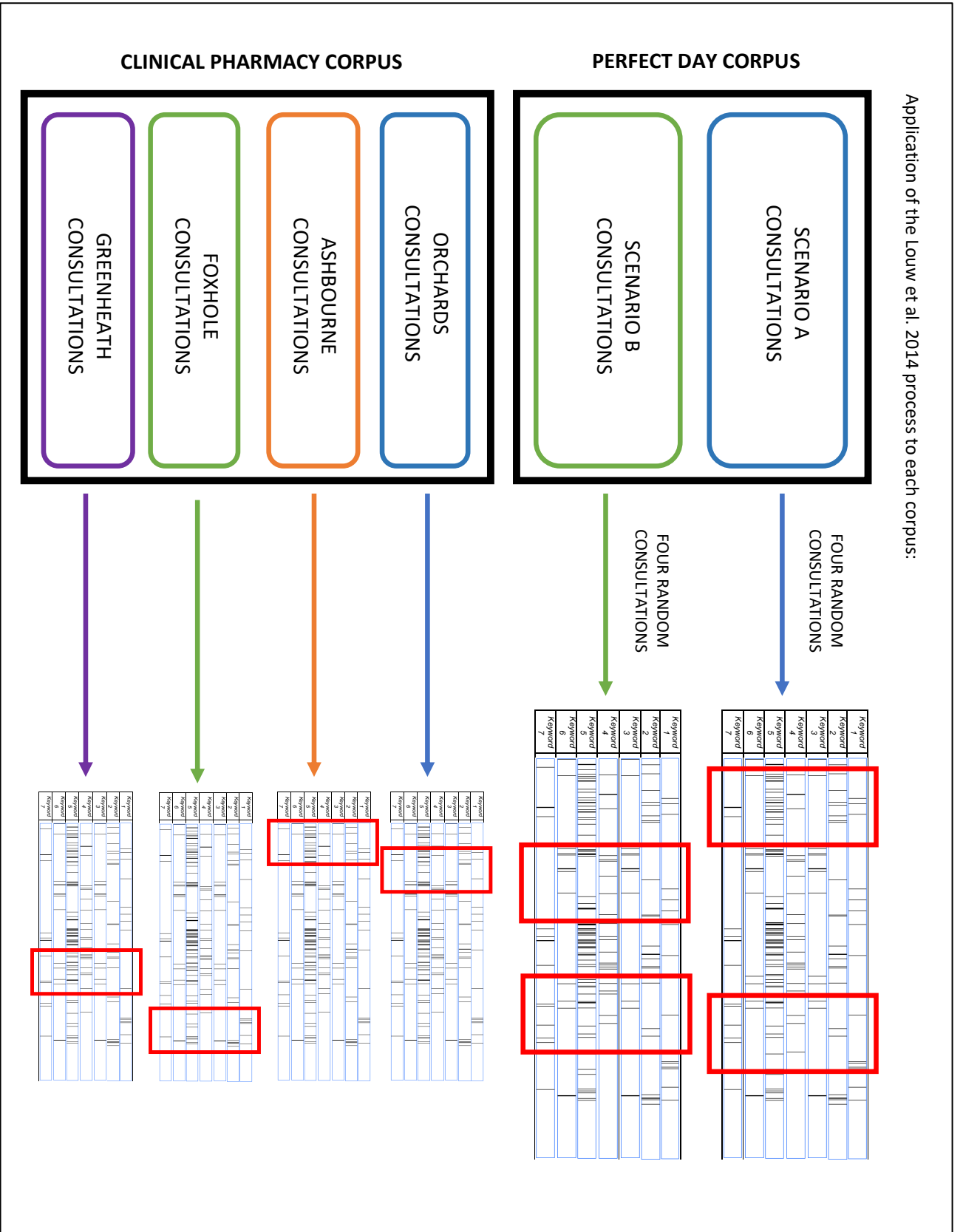


Fig. 3.2 – An illustration of the application of the Louw et al. (2014) method to the data

The keywords chartered in each of the concordance plots is dependent on the results of the initial keyword analysis and their subsequent thematization. Accordingly, this systematic process will be documented throughout the corpus analysis of Chapter 4. Whilst the Louw et al. (2014) process is geared towards removing bias in data selections, like any corpus procedure, there remains elements in which researcher judgement is required. For example, once the blind selection (typified by the red box in Figure 3.1 above) is applied to the data, it may encompass the end of one transcript and the beginning of another, providing a selection of data that is incoherent for analysis. Whilst then, the Louw et al. (2014) method minimises conscious or unconscious bias in selecting data for further in-depth analysis, it cannot claim complete impartiality and objectivity. With this in mind, throughout the qualitative analysis of chapters five and six I will document where any changes have been made to the original area of typicality.

There are also questions to be raised around whether typicality can truly be defined by a homogenous distribution of keywords within a transcript, as well as the role of the researcher in defining and identifying typical sections within the plots. Nonetheless, whilst these considerations of the process exist, I believe that the Louw et al. (2014) procedure remains a valid means by which to 'broad[en] the empirical basis for the study of discourse phenomena' (Mahlberg 2014: 221).

3.5.4 Qualitative framework – Introduction

Whilst the corpus area of the framework provides this study with a quantitative base on which to observe patterns of recurrent language use that otherwise may elude analytic attention, it largely does so in a decontextualized manner. There is, therefore, a need to partner the largely quantitative corpus tools with a more detailed qualitative method to demonstrate how these recurring elements are being used in specific clinical contexts.

In the wide body of research examining language use in clinical encounters, a number of discourse-based approaches have been taken to investigate persistent themes such as doctor-patient asymmetry. For example, conversational analysis (e.g., Heritage and Maynard 2006), discourse analysis (e.g., Wodak 1996, Roberts and Sarangi 1999) and interactional sociolinguistics (e.g., Atkins and Roberts 2018). Pragmatic methodologies have not been used as extensively within linguistic healthcare research (Mullany 2009, Martin 2014, Locher and Schnurr 2017), although their use and relevance in areas of miscommunication has been increasingly noted (for example, Chalupnik and Atkins 2020).

The selection of a pragmatic approach for the qualitative area of this research is specifically tied to the axiomatic definition of pragmatics as ‘language use and language users in interaction’ (Bublitz and Norrick 2011: 4). The traditional purview of a pragmatic approach has been the examination of language data within its specific contextual domain – along with the elaborative effects this context has on language use (Griffiths 2006: 133). Whilst critical discourse analysis (CDA) has been utilised in order to uncover dominant discourses within clinical encounters, Wilson (2006) has demonstrated how pragmatic concepts such as implicatures can shed light on how discursive power relations unfold within specific contexts.

A pragmatic approach therefore in its inclusion of the ‘full complexity of [language’s] cognitive, social and cultural functioning’ (Verschueren 1999: 16) is well placed to examine how professionals may construe their professional identity as an expert within both datasets. The adoption of a broadly pragmatic approach also accords with the Bucholtz and Hall

(2005) model of the linguistic identity adopted in this research; especially in regard to the 'less direct' (595) indexical aspect of discursive identity formation.

There are also a number of practical, external implications that relate to the research as the product of LiPP in which a pragmatic approach is favourable. The practical utility of pragmatics has already been demonstrated in areas such as intercultural communication and its application to second language acquisition (see for example, Spencer-Oatey and Franklin 2009, and the advocacy of Martin 2014). A number of the workshops provided by LiPP are also based around pragmatic concepts such as politeness and face (see; Goffman 1955, Brown & Levinson 1987) as they potentially apply in the workplace. From my own involvement in these workshops, I have seen how insight into interactions 'beyond the word' translates favourably to non-linguist addressees – arguably more so than conceptualising the role of dominant discourses across speech might, for example. The tangible practicality of this approach seemingly highlights the value of academic research to external audiences in a manner that is neither esoteric nor abstract.

3.5.4.1 Corpus linguistics and discourse-based analysis

The now commonplace synthesis of quantitative, corpus linguistics with various forms of discourse analysis has gone some way to address the criticisms levied at a purely qualitative discourse approach by work such as Stubbs (1997) and Widdowson (2000), who point to over-interpretation and political bias inherent in frameworks such as CDA as a methodological weakness. A hybrid methodological approach that incorporates corpus tools strengthens the interpretative basis of any qualitative claims (Koteyko 2006: 151), and the locative quality of initial corpus analysis has been shown to be beneficial in the workplace discourse research of McCarthy and Handford (2004) and in healthcare discourse within Adolphs et al. (2004). Although Baker et al. (2008: 277) are keen to temper claims of stringent objectivity, highlighting that despite providing a 'reasonably high degree of objectivity', corpus analysis itself entails a high degree of subjective interpretation in the application of appropriate methods and cut-off points for significance.

Whilst the methodological amalgamation of corpus linguistics with general elements of discourse analysis has received attention in a variety of studies, the combination of corpus methods with pragmatics is so far relatively less developed (Aijmer and Rühlemann 2015: 1). McEnery and Wilson (2001: 193-194) suggest that the general paucity of corpus-based pragmatic research may be due to the inherent removal of context from corpus mediated language data. The traditional differences in corpus linguistics and pragmatic approaches have been observed by Knight and Adolphs (2008: 187); they note that whilst corpus linguistics has at its core a focus on 'discrete' items such as word or grammatical categories, pragmatics on the other hand has primarily focused on non-discrete language functions that require application of different frameworks.

Despite these seemingly disparate foci, Romero-Trillo (2008: 5) contends that the alignment of corpus methods and pragmatics demonstrates two versions of the same phenomena – similar to Halliday's fusion of grammar and vocabulary into the lexicogrammar – 'the mechanics ... and its interpretation'. In keeping with the general theme of a reciprocal methodology throughout this chapter, it is hoped that the combination of corpus methods and pragmatics will mitigate overreliance on analytic 'intuitions' (O'Halloran and Coffin 2004, McEnery and Gabrielatos 2006), in particular, to provide results and feedback for an audience that sits outside of academia.

Alongside the overall pragmatic approach to the qualitative analysis – i.e., a focus on that which exists contextually beyond the word – this thesis will also integrate a number of phenomena from other applied linguistic and psychological research disciplines. The following sections will outline the qualitative framework applied in chapters five and six, concluding with a specific focus on aspects of language considered potentially important for the data at hand.

3.5.4.2 A discursive pragmatic approach

Whilst pragmatic-based research in applied linguistics usually orients around concepts at an utterance-level (for example, speech-act theory, Austin 1962), the approach taken within this thesis follows the notion of the ‘pragmatics of discourse’ (Barron and Schneider 2014: 1) or ‘discursive pragmatics’ (Blum-Kulka and Hamo 2011, Zienkowski et al. 2011); an approach that will, in this study, consider how pragmatic intent is encoded over extended periods of discourse. Whilst I have defined what I understand pragmatics to be, I will also briefly return to the conceptualisation of discourse outlined at the beginning of Chapter 2 – as an extended unit of speech ‘beyond the sentence’ (Tannen et al. 2015: 1), that is, in accordance with Gee’s (1999) definition of ‘little d’ discourse as ‘language in use’. For this thesis then, a discursive pragmatic approach is one that analyses language use in a particular context over an extended stretch of interaction – the length of discourse in this instance, dictated by the Louw et al. (2014) procedure illustrated in Section 3.5.3.4. The linguistic focus of the analysis will be outlined in Section 3.5.5.

Of relevance to this thesis in particular, Blum-Kulka and Hamo (2011: 177-178) highlight a number of advantages of a discursive approach: Firstly, that speech can be ‘ambiguous and multi-layered’, meaning that intent behind questions or requests can only be surmised in the ongoing interaction of interlocutors. Secondly, that ‘discourse is context embedded’ and that ‘context is crucially important for interpretation’ which is critically important to the understanding of both of these professional environments. And finally, that ‘discourse is context shaping, as it does identity and power work’, which in these datasets, could manifest, for example, as a consultation being shaped by an ‘expert patient’ (Shaw and Baker 2004) asserting their agency, thus affecting traditionally perceived asymmetry.

The upshot for the present study is – similar to the findings of the pilot analysis – that identity, expertise and the inherent asymmetry contained within a consultation is unlikely to be identifiable from a specific type of utterance (i.e., by focusing on just directives) but is much more likely to manifest across the extended discourse of the dyad. As Mills (2011: 50)

notes in regard towards a discursive approach to politeness, whilst the process may be more 'chaotic' it may ultimately lead to 'more fruitful' analysis and theorising.

3.5.4.3 Level of analysis – 'activity contexts'

Blitvich and Sifianou (2019: 93) observe that whilst Gee's (1999) dual conception of discourse types distinguishes broadly between the micro and macro, it does not precisely distinguish between the micro / meso / macro level of analysis often applied in social science research. The discursive pragmatic approach taken within this thesis analyses linguistic identity at a meso level, that is, an analytic focus that sits between the micro-level utterance and the wider, macro purview of approaches such as critical discourse analysis. This level of language investigation has been previously approached in a variety of different manners by numerous researchers – for example, Goffman's (1974) notion of frame, Levinson's (1979) work on activity types as a conceptual unit of analysis (developed further by Sarangi 2000 and Gu 2010), whilst more recently Blitvich and Sifianou (2019) have advocated for speech genre as an appropriate unit for meso-level analysis of im/politeness.

The approach taken within this thesis, however, aligns most closely with Linell and Thunqvist (2003) in viewing the consultations found in both the CPC and PDC as 'activity contexts' in which the production and performance of discursive identity exists in the accomplishment of, and alongside, a number of other dialogic activities and tasks within the dyad. Notably, both Linell and Thunqvist (2003) and Sarangi (2000) have utilised meso-level analysis of this nature for nascent and emergent roles – very similar to those professional remits found within the dataset of this thesis.

There are of course other meso-level conceptions that could have been adopted within this research – the most obvious perhaps being the 'communities of practice' (CofP) model (Lave and Wenger 1991) in a professional context. However, whilst the GP registrars of Perfect Day could legitimately be classified as a CofP with a 'shared repertoire of ideas' and practice (23), the clinical pharmacists of the CPiGP project with differing remits,

experience and prescribing qualifications are more difficult to characterise (at least in this early stage of the role) as a coherent 'community' per se.

3.5.4.4 Thick participation – an ethnographic approach

Within this study the contextual understanding is driven by an informed, thick, ethnographic participation (Sarangi 2006) in the projects and data collection. As Sarangi (2006: 204) outlines, 'thick participation' is an approach to research that goes beyond data collection and analysis; propagating the feedback of findings to research participants as collaborators, alongside the 'socialisation' of the researcher into professional research sites, yielding a greater understanding of the practices under analysis.

For the two datasets at hand this contextual grounding manifests in slightly different modes, as is commonplace with ethnographic approaches: For the CPC data, I undertook the data collection myself, worked on and analysed existing CPiGP data, and participated in feedback sessions with each site; providing to some extent the 'continuity of involvement' which Sarangi (2006: 204) notes. Whilst the Perfect Day consultations are a secondary dataset in which the activity context – i.e., pedagogic simulations – remains relatively stable, but for which I am able to access the immediate reflections of the participants via their feedback to the educator team. A detailed explanation of the simulations as an activity context also remained available via the long-term institutional access to the medical educators who manage the project.

Meso-level contextual understanding, therefore, is a dual-layered concept within the qualitative analysis: On one hand it is an awareness that the context dictates the activity as Blum-Kulka and Hamo (2011) noted – for example, that the dyadic activity is a pedagogical exercise, or a patient's annual health check and it is likely therefore, that this may manifest or constrain certain dialogic areas. On the other hand, it is an acknowledgment that further contextual details uncovered from either the data collection (in the case of the CPC) or the candidate's reflections (for the PDC) may contribute towards the understanding of the shape of talk within a particular consultation.

For example, was a CP running behind schedule which led to a consultation being more truncated and transactional? Did a CP report during the data collection that a particular patient was a 'heart sink patient' and was therefore treated differently to other patients? Did a candidate report that they had trouble understanding a simulator's accent, or had misunderstood a scenario in the debrief? The acknowledgment of these details throughout the analysis is designed to take the reading of the transcripts beyond an inert, purely textual perspective and to fully contextualise each piece of analysis within the immediate dynamic of its individual context. Figure 3.3 illustrates the analytic processes of the framework described so far in this chapter:

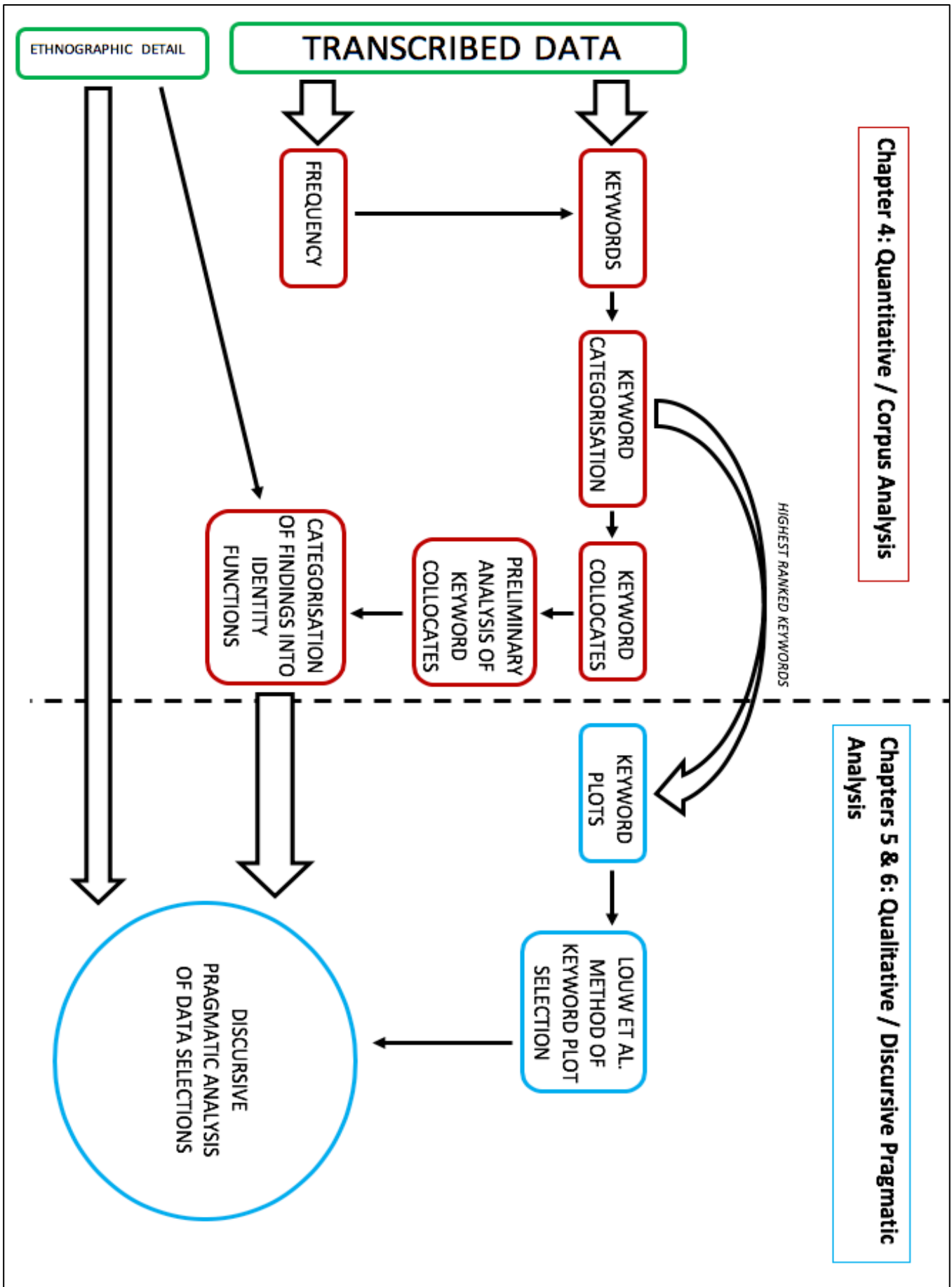


Fig. 3.3 – An illustrated overview of the thesis' methodology

3.5.5 Linguistic variables

As Section 3.5.3 highlighted, elements of this framework have been derived from an initial pilot analysis of dyadic healthcare encounters undertaken in 2017. The pilot set out to examine the role played by directive speech acts in healthcare dyads, ultimately finding that they were not a significant constituent of the consultations. Instead, the medical professionals integrated advice into long form sequences where modality and an overall dialogic mood functioned in the proposition of advisory action. As I noted in Section 3.5.4.2, this echoed the sentiments of several proponents of a discursive pragmatic methodology and directly influenced the decision to adopt a discursive approach in this framework.

Accordingly, an analytic starting point for this thesis is the hypothesis that areas such as mood, modality, epistemic and deontic stances as well as pronouns will be an important component of professional identity within the Perfect Day and clinical pharmacy datasets. Given that few studies of the considerable body of research into clinical dyads have focused on these areas (studies such as Skelton et al. 2002 and Landmark et al. 2015 proving the exception), this is also an underappreciated area of clinician discursivity. The following sections will outline these linguistic variables and propose how they might contribute to professional identity in the datasets, thus building a working framework of how the discursive enaction of professional identity, expertise and clinician-patient asymmetry may potentially occur within the data.

3.5.5.1 Mood & modality

Modality has been concisely defined by Sawada (2006: 2) as a 'category which expresses how the propositional content (i.e., the event or state of affairs) should be, not just how it is (or true), or the speaker's or subject's perception and feeling of it'. Halliday's (1970: 335) own, earlier definition accords with that of Sawada, whilst also highlighting the interpersonal characteristic of modality which is both an 'expression of [a] role' and the establishment of a position for a speaker. Thusly demonstrating how modality and its contextual usage would

have ramifications for both the establishment of expertise as well as discursive professional identity within a dyad.

Whilst Palmer's (2001) extensive taxonomy of modality splits the functionality into propositional (containing epistemic and evidential forms) and event modality (deontic and dynamic forms), this thesis is primarily concerned with essential epistemic and deontic modality. These will be explicated in sections 3.5.5.2 and 3.5.5.3 imminently. Another primary distinction in modality identified by Palmer amongst others (e.g., Mithun 1999) is the classification of realis and irrealis moods. Whilst a conclusive, canonical definition of these terms is still illusive, for the purposes of this thesis I adopt Elliott's (2000: 56) view that realis moods identify an event as taking place in 'perceived reality' (and 'having occurred or actually occurring' – Mithun 1999: 173), whilst the irrealis describes those events 'existing only as a conceptual idea, thought or hypothetical notion'.

Gaik (1992) has demonstrated how irrealis moods are utilised in therapeutic sequences on radio talk shows to explore the possible reasons for a patient's anxiety, and importantly, to also mitigate the illocutionary force behind a statement or judgement. Accordingly, for this thesis, realis / irrealis moods are expected to play an important role in the judgment of conditions, symptoms and future actions by the clinicians – negotiating what is discursively presented as known and accordingly proposing action that ought to be undertaken.

3.5.5.2 Epistemics & epistemic stance

The pilot analysis for this thesis illustrated how the saliency of the lexis *think*, coupled with the pronominal *I*, produced a mitigated epistemic identity for the clinician that provided evaluation in a scalar, and non-absolute manner – allowing possibility within their judgements. Epistemic modality and the adoption of an epistemic stance, therefore, was expected to be an important area of professional expertise conveyance within these datasets.

Epistemic-focused language, or 'epistemics' have seen considerable attention in conversation analysis research (see for example, Heritage and Raymond 2005, Heritage 2012, Drew 2018) primarily considering the role that they play in the portrayal of knowledge within interaction, or the 'exchange of information in social interaction' (Lynch and Wong (2018: 527). Crucially for the current research, this involves how these knowledge claims construe elements of identity – as Raymond and Heritage (2006: 680) highlight, stating that 'the management of rights to knowledge and, relatedly rights to describe or evaluate states of affairs can be a resource for invoking identity in interaction'. Furthermore, that it is the mediation of knowledge rights between interlocutors that illuminates how identities are produced in specific contexts (701).

It is important to note however, that although the term epistemic connotes cognitive states, the level of analysis is strictly at a linguistic level, and is concerned with attributions of knowledge, not specifically what an individual may or may not know (Drew 2018: 19), whilst Heritage (2018: 555-6) adds that the analysis concerns knowledge claims that are registered, asserted and sequentially defended by interlocutors. This conceptualisation also accords with Halliday's (1993: 94) notion of language not as a domain of knowledge in of itself but instead the 'essential condition for knowing'. Whilst Drew (2018: 182) foregrounds a number of conversational design elements that speak of the overtness with which participants orient to knowledge claims within interaction, from a pragmatic perspective, Heritage (2013: 372) shows that in certain forms of questioning, for example, speakers can 'subliminally project knowledge, identity and power'. Echoing Sarangi's (2010a: 192) notion that professional interaction is a 'knowledge system, laminated with expertise and authority'.

The notion of epistemic stance and status form an integral part of how knowledge claims are asserted and potentially contested. Epistemic status has previously been defined by Heritage (2012: 4) as the relative level of access to a knowledge domain held by a particular locutor in a given context. Heritage argues that access to knowledge domains within conversation is socially mediated – for example, an expert might take a higher

epistemic status than a layman – and that, for the most part, this is presupposed by locutors (6).

Epistemic stance, meanwhile, concerns the ‘moment by moment’ orientation towards a state of knowledge by interlocutors (7), with research such as Kärkkäinen (2003) emphasising the interactional, pragmatic component of stance adoption, that relies on context and recipient effect more than ‘precise semantic meaning’ of epistemic lexis (26). And whilst Heritage (2012: 7) points out that there is often congruency between an interactional epistemic stance and a locutor who holds a higher epistemic status, this is not a conversational given, as epistemic status can be ‘dissembled’ by a speaker using an epistemic stance to appear more or less knowledgeable than they actually are (ibid). An example of this resides in the radio therapists examined by Gaik (1992) that I highlighted in the previous section; there the therapists’ use of the irrealis to invoke possibility arguably mitigated the strength of their epistemic stance in order that their expertise did not appear didactic to the hearer. Accordingly, there is potential for clear applicability of these concepts to the data at hand.

Whilst the foregoing discussion has implicated an association between asymmetry and epistemic accesses, Heritage and Raymond’s (2005) original work on epistemics explicitly conceptualised lexis of knowing in regard to authority, or ‘whose view is the more significant or the more authoritative with respect to the matter at hand’ (15). Whilst in both the datasets for this thesis the clinician is considered the expert professional identity, an ‘expert patient’ (Shaw and Baker 2004) making a high-agency claim, for example, could render this a fluid and negotiated discursive process.

A related – albeit contentiously (see for example the debate by Palmer 2001) – concept to epistemic modality is the notion of evidentiality. Within this thesis I adopt the relatively straightforward definition of McCready (2015: 150) that evidentiality amounts to ‘expressions indicating something about the speaker’s basis for the speech act performed’ indicating ‘the source of information or the evidence, on which the speaker basis her assertion’. Again, this has clear application to the assertion of a professional identity within

the data; as a means by which clinician may discursively index the underpinning of their decision-making.

3.5.5.3 Deontic status

Whereas epistemics may determine the negotiation of knowledge claims in a particular interaction, the notion of deontics, and more specifically the deontic status of a speaker is associated with ‘their right to determine others’ future actions’ (Stevanovic and Peräkylä 2012: 297). Given that this concept is aligned with rights over other’s actions, Stevanovic and Peräkylä relate it more explicitly to notions of authority in interaction; in doing so they explicate that authority in this sense is the observance of power that is understood as ‘legitimate’ by a hearer, in opposition to a generalized notion of ideological or political power (ibid).

This is an important conceptual distinction to be made, with clear applicability to dyadic asymmetry within medical encounters, and one that also accords with French and Raven’s (1959) conceptualisation of legitimate power mentioned in Chapter 2. The notion of deontic stance is also invoked by Stevanovic (2013: 25) to describe the position a speaker may occupy on a ‘deontic gradient’ – highlighting how obligational constructions can exist on a continuum from possibility to necessity. Again, this is a concept that is clearly applicable to clinical activities in which advisory lifestyle advice might be part of the discursive activity.

As with epistemics, there is as Heritage (2018: 570) suggests, ‘a preference for congruence between deontic stance and deontic status’ that may speak of how social hierarchies themselves are managed within talk. However, incongruence can be demonstrated by intentionally flouting the maxim for conversational effect (ibid), or by denying the speakers deontic authority via atypical responses or counterproposals – which serves to convey a more symmetrical relationship than originally conceived (Stevanovic and Peräkylä 2012: 309-313). Accordingly, deontics are expected to discursively navigate the mediation of agency between interlocutors within the data. In this thesis, agency is

understood in line with Ahearn's (2001: 112) definition as a 'socioculturally mediated capacity to act'.

3.5.5.4 Pronouns

Another area of note resulting from the initial pilot analysis was the significance of pronouns within the dyadic interaction. As spoken language is under analysis, it is somewhat inevitable that functional language such as pronouns would be prominent within the data. Nonetheless, this significance of the first-person, singular *I* was tied to the lexis *think* in constructions that proposed epistemic evaluation of a set of circumstances presented by the patient.

The deictic relationship between speaker identity and pronouns has previously been observed by Hardt-Mautner (1995:16) who highlights the 'crucial role' played by pronominal use in the construction of social identities and relations, as well as Vaughn and Clancy (2014: 64) who go as far to say that pronouns can be considered 'linguistic proxies' for identity. In a professional context, Bargiela-Chiappini and Harris (1997) have demonstrated how a speaker shifting from first person *I* to *we* can index a move from the 'personal to the corporate' identity in an organisational context. Whilst in clinical dyads, Skelton et al. (2002) have proposed an archetypical usage pattern of pronouns between the locutors as; *patient: I suffer, doctor: I think, both: we will act*.

The deictic use of pronouns is also relevant to how the speakers orient themselves in contextual time and space (Lenz 2003), which has implications for how the unrealis might be conceived of by a clinician. For example, how is future or hypothetical advice and action discursively enacted by a professional speaker? The importance of deixis is underscored in Levinson's (1983: 54) assertion that they are 'the single most obvious way in which the relationship between language and context is reflected in the structures of languages themselves'. Whilst Hanks (1992: 48) highlights that 'deixis links language to context in distinguishable ways, the better we understand it, the more we know about context'.

Alongside the deictic, identity functions of pronouns, this study also integrates work largely stemming from the research of James Pennebaker and colleagues in considering the social-psychological implications of pronominal use in spoken interaction. This body of work seeks to understand how language and pronouns use in particular reflect who a speaker is (Chung and Pennebaker 2007: 343), and it is hoped that this insight into pronominal usage will provide a view of dyadic interactions and asymmetry that has so far not been incorporated into clinical consultations. In terms of identity, this not only demonstrates how the 'proxy for self' (Vaughn and Clancy 2014) exists in language, but also how reference to the self, or to the other, in a dyad may provide insights into how ostensibly asymmetrical roles are construed within the discourse.

In a relatively early study of this type, Sexton and Helmreich (2000) observed that airline captains tended to use the first-person plural *we* at a higher rate than their subordinates, which they suggested could be due to the perceived higher status occupied by the captain, affording them the means to discursively team build by addressing the crew as a collective. The notion of a (perceived) higher-status locutor invoking the collective to promote collegial inclusiveness was also found by Cassell et al. (2006: 443) and also Zimmermann et al. (2013). Zimmermann et al.'s research also suggests that self-reference in pronominal usage indicates where a speaker's attention lies; be it on the self or with others, with their findings also correlating high first-person singular pronoun use with negative moods. Repeated inward discursive attention they suggest could be a strategy to pull for 'friendly-submissive attention from others' (Zimmermann et al. 2013: 223).

Pronoun use has also been associated with a speaker's level of focus on their interlocutor (Pennebaker et al. 2003), with Kacewicz et al. (2013) developing this notion to suggest that social hierarchies can be illustrated by pronoun use. They again reiterate the finding that 'high-status individuals' are more collectively and other-orientated through their recurrent use of *we* (13). Although, as the authors note, in their study 'status' was a relatively homogeneously assigned rank and did not include contributing and interrelated factors such as power and leadership. Whilst in applying this principle, 'high-status individual' will be

taken to be the clinician within the dyad (in line with a notion that the patient is attending to receive advice from an individual of professionally certified knowledge), consideration is given to work such as de la Croix and Skelton (2009) that has made the case that in medical simulations it is the simulator – as a representative of institutional assessment – occupying the superordinate position.

Nonetheless, this ‘remote sensor of group dynamics’ (Kacewicz et al. 2013: 14) illustrates how potentially asymmetrical discursive identities are established in dialogue. Indeed, Toma and D’Angelo (2015) have proposed that pronoun use can also affect how medical advice is perceived; with messages containing fewer *I* pronouns perceived as ‘more expert’ (37). Although the applicability of these findings to this particular study should be tempered given that these results were based on written discourse, the authors do note that their conclusions have ramifications for patient-centric communication and how trust is perceived (39), demonstrating that linguistic cues ‘powerfully shape[s] impressions of expertise and trustworthiness (38).

It should be noted however, that underpinning much of this research is the assumption that pronouns are generally non-consciously used by speakers (Chung and Pennebaker 2007), running contrary to previously discussed work such as Bargiela-Chiappini and Harris (1997), for example, in which pronouns are selected by a speaker to index a particular institutional group membership. Whilst there is not the space within this thesis to fully explore this area of theoretical contention, wherever findings traverse this fundamental difference in conception, I will comment to whether they strengthen the debate on either side.

Figure 3.4 hypothesises how the areas of language discussed in this section may function in the enaction of discursive professional identities within the corpora:

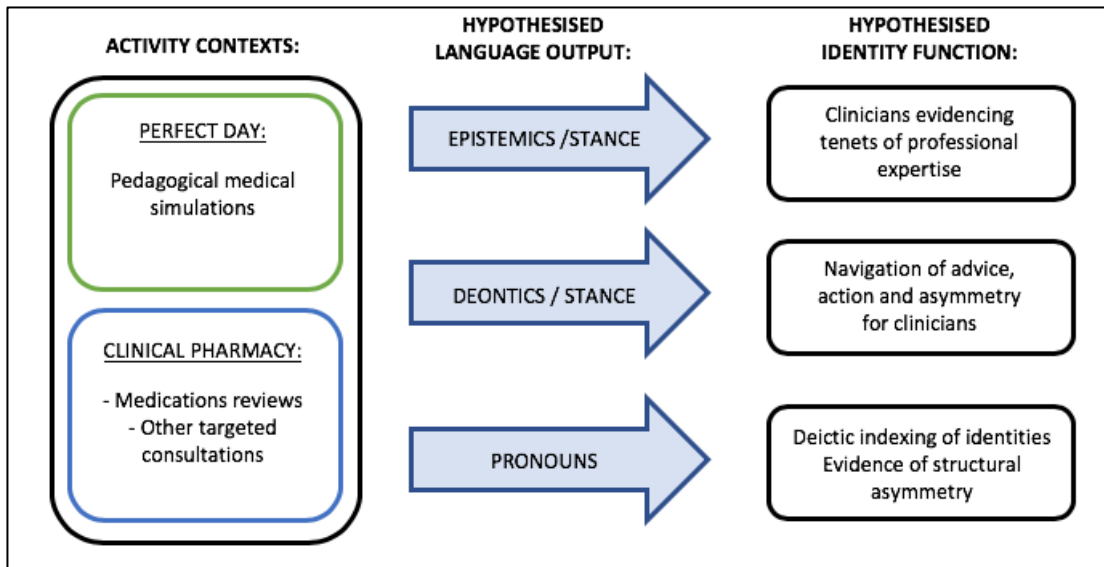


Fig. 3.4 – A hypothesised, pre-analysis working model of professional identity

3.6 Methodological summary

This chapter has presented both an overview of theoretical, applied linguistics ethos underpinning of this study, as well as the mixed-methods, corpus-assisted discourse analysis methodology approach to the data. It has shown how the quantitative starting point of corpus linguistics will inform the data in two distinct ways – to identify significant areas of language use, and to later use that significance to select areas of the corpora for an in-depth qualitative analysis. I highlighted that this qualitative analysis would take a discursive-pragmatic approach informed by ‘thick participation’ (Sarangi 2006), and in the final section, that there were several aspects of language use that are expected to play a crucial part in discursive professional identity.

4. Data Analysis: Corpus Perspectives

4.1 Introduction

This initial analysis chapter reports the linguistic trends displayed in both the Perfect Day (PDC) and clinical pharmacy (CPC) corpora. In line with the overall research aim of this study, the analysis concentrates on how GP registrars and clinical pharmacists construe their discursive professional identity and expertise within these encounters and accordingly, how elements of interactional asymmetry manifest. As I outlined in Chapter 3, this initial application of corpus methods to the data is to primarily construct an inductive analytical picture of discursive identity, elucidating significant areas of concern for a more comprehensive textual analysis in subsequent chapters. Following Bucholtz and Hall's (2005: 586) assertion that identity is not emergent at a single analytical layer, the analysis herein is necessarily broad and driven by the corpus significances.

Accordingly, this chapter will firstly discuss the keyness trends in the clinicians' language use for each dataset and will then expand to consider collocates of a select number of keywords – establishing recurrent significant lexical pairings in the data. The chapter will then investigate how these recurrent formulations function in the data; presenting a primary examination of discreet extracts to illustrate how they serve in the enaction of discursive professional identity. To conclude the chapter, the findings from the corpus analysis will be applied to the Bucholtz and Hall (2005) model of identity in order to provide the study a working understanding of the key components of identity enaction within the data.

Whilst the primary focus within this analysis is on the professionals within the consultations, findings derived from analyses of the simulated patient and real patient data will also be discussed to provide a full contextual picture of the dyads.

4.2 Perfect Day

The initial step in the corpus analysis involved establishing statistically significant keywords within the Perfect Day dataset – those lexical items that recur or are absent from the data at a rate that computational methods determined to be higher than chance (Baker 2006: 125). As well as potentially signposting the salient ways in which professionals are performing identity, or displaying expertise within the data, the keyness measure also allows the researcher to compare how these particular interactions are significantly similar or dissimilar to a reference corpus – in this case the British National Corpus (BNC) spoken sub-corpus. Thus, demonstrating the concepts or experiences that are of higher or lesser relevance to candidates undertaking the scenarios, in comparison to a corpus representing a broader use of spoken English.

Because the PDC demonstrates a poor type-token score (8%) characteristic of the lower lexical density of spoken language (Halliday 1994: 61), it was expected that a large number of lexical items would show significant keyness within the data – especially those of a specifically medical, pharmaceutical or technical nature. As I reported in the previous chapter, keyness is measured via log-likelihood with a significance measure of 15.13 equating to 99.99% certainty. The top twenty keyword scores of the PDC were significantly above this value as Table 4.1 illustrates below. This presents a dilemma in terms of managing a large number of key lexis and establishing a cut-off point as Mahlberg and McIntyre (2011) note. For this study the keyness cut off was set at item one hundred (keyness value = 33.66 for the PDC) – a compromise between a manageable number of items and retaining highly key lexis. Whilst other studies have included a higher number of key items in their analysis (for example, Seale et al. 2006 operationalise the top 300 items), this value also reflects the relatively small size of both the PDC and CPC. The top keyness items in Table 4.1 are also shown alongside the highest negative keyness items – i.e., those lexis significantly absent from the PDC – for illustrative purposes.

	POSITIVE:			NEGATIVE	
Word:	Frequency:	Keyness:	Word:	Frequency:	Keyness:
ok	203	2048.86	s	4	485.1
i'm	104	1167.46	t	1	270.81
mmm	105	1144.42	re	2	116.71
it's	92	1032.68	they	52	71.82
that's	62	695.82	m	1	69.7
you're	58	650.92	the	565	64.62
ah	123	575.43	was	50	54.75
ahm	50	561.11	d	2	51.07
you've	50	561.11	mm	3	40.16
blood	79	484.32	them	10	38.62
you	837	439.55	one	41	33.05
hmm	47	397.47	their	3	31.59
alcohol	45	377.84	used	1	31.12
your	216	356.61	two	16	29.89
liver	38	347.72	of	251	27.43
don't	30	336.63	his	1	24.94
ulcer	32	322.42	who	7	24.45
stomach	39	310.47	it	256	23.08
test	56	283.37	people	16	21.73
symptoms	35	276.89	in	182	21.37

Table 4.1 – PDC top 20 positive and negative keyness items

Beyond establishing the top hundred key items for both the PDC and later the CPC, the next step entailed categorizing these lexis for further analysis. Whilst content lexis were categorised into semantic groups – a well-established corpus method (see for example, Charteris-Black and Seale 2010, Harvey 2013) – the key functional lexis in the top hundred items were grouped into their respective function aspects. These non-exclusive, sub-categories are informed by a broader reading of the keyword's context within concordance lines.

The present study aligns with the advice of previous researchers, e.g. O'Halloran and Coffin (2004: 294), Baker (2010: 154), that corpus methods are a transparent starting point from which the researcher should familiarise themselves with the wider context of the data at hand. However, similar to Charteris-Black and Seale's (2010: 34) 'key concepts', these smaller sub-categories are a significant area where human judgment is involved and are fraught with potential overlap; for example, in the classification of pronouns as both pronouns and deixis. Fortunately, the relatively small size of both the PDC and CPC datasets allowed a method of close reading to be practicable where it otherwise might not be

in larger corpora; delivering the distinct advantage of allowing for any polysemic items to be categorised correctly in line with the suggestions of Mahlberg and McIntyre (2011: 213).

The lexical items of each sub-category were then ranked and coded as either as top 20 / 50 / 100 keyness items – as demonstrated in Table 4.2 below – in order to illustrate particularly high concentrations of thematic keyness within the data. This same corpus process was undertaken for the simulator data (or in the case of the CPC, the real-life patients) to fully illuminate the discursive context of the interactions; these tabulations are available in the online data repository.

Lexical / Content:	Keywords:	Function:	Keywords:
Anatomical	<i>Blood, liver, ulcer, stomach, tummy, lining, bowel, nerve, throat, brain</i>	Backchannels / response tokens	<i>Ok, mmm, yeah</i>
Medical procedural	<i>Test, results, tests, scan, appointment, medications</i>	Indicative / realis contractions	<i>It's, that's, what's, there's</i>
Medical professional	<i>Neurologist, doctor, specialist</i>	Pronominal aux contractions	<i>I'm, you're, you've, I'll, we'll, I've, they're, we've, we're, they've</i>
Experiential	<i>Worried, know, pain, questions, thoughts, discuss, feel, shock</i>	Deixis	<i>That's, you, your, today</i>
Conditions - symptoms	<i>Ulcer, symptoms, sclerosis, sick, sickness, vomiting, pain, condition, trapped, feel, unwell, shock</i>	Negation	<i>Don't, didn't, isn't, haven't, doesn't,</i>
Case specific	<i>Alcohol, drinking,</i>	Conjunctions	<i>So, also</i>

Table 4.2 – PDC candidate lexical and functional keywords

(Key: Red = top 20 keyness, orange = top 50, black = top 100)

4.2.1 Keyness trends within Perfect Day

For the candidates in Perfect Day, it is perhaps unsurprising that the corpus shows lexical keyword significance centred on items of anatomy and of the conditions at hand within the consultations. Notably, the key content words of the PDC also highlight a distinct discursive

profile for each of the scenarios; all lexis within the *anatomical* category are from Scenario B – the underlying alcohol problem – whilst half of the *conditions-symptoms* category are also exclusively from this scenario, indicating that each consultation exercise is being discursively enacted in meaningfully different manners by the candidates.

Similarly noteworthy at this stage of the analysis is that, of keyness groups consisting of five lexical items or more, the grouping addressing the simulator's experiential or emotive states is the lowest thematic keyness group. Perhaps suggesting a focus on the bio-medical 'voice of medicine' (Mishler 1984) for the candidate. Although, it should be noted that the experiential domain does not show a high significance for the simulators' data either (containing only three lexical items ranked 62, 63 and 70 in keyness).

The candidates' functional area of keyness demonstrates the saliency of pronominal auxiliary contractions, lexis that indicate a realis mood, deixis and tokens of negation within the data. As I identified in Section 3.5.5.4 of the previous chapter, pronominal use is potentially a significant component of identity, and within these corpora may account for a speaker signalling where their attention lies (Zimmerman et al. 2013), deictically locating themselves in time and space (Lenz 2003) and establishing their discursive identity against that of the other interlocutor within the dyad – especially in regard to a perceived social hierarchy (Kacewicz et al. 2013). Research into clinicians' pronoun use has also shown that the plural *we* within consultations can be used in a number of functional manners: To ascribe a mood of a tacit collaboration within the dyad (Aronsson and Satterlund-Larsson 1987), or, in an ambiguous manner that can either refer directly to the participants within the dyad, the medical community as a collective, or as a generic referent of mankind (Skelton et al. 2002). Also of interest at this point is that no explicitly epistemic lexis (for example, *think*, *know*) are key within the PDC.

Initial observations of the data would suggest that the candidate's use of pronominal contractions, realis moods and deixis are closely linked; invoking discursive strategies that point at the individual interlocutors within the dyad, distinguish roles and action and comment on, and evaluate states of affairs; as Extract 1 and Extract 2, below, illustrate

(keywords emboldened). Extracts throughout this chapter are extracted from randomised concordance lines exhibiting the keyword under analysis.

Extract 1: (Scenario A)

<CAN:> No no absolutely fine **you you** <0.5> made a good decision to come in and have a chat with me of course for me to know **what's** happening **isn't** it <0.5> right ok right **I'm** glad **you're** feeling alright at the moment

Extract 2: (Scenario B)

<CAN:> So **that's** the reason **I'm** asking **you** about the er ah <0.5> the alcohol intake please **don't** be offended with that **it's** just that I want to help **you**

In these extracts the pronominal auxiliary contraction of *I + am* in alignment with the main verb serves as epistemic modality to place the candidate's identity as one of credible evaluator (Extract 1) of the simulator's health, and as the interlocutor with implicit access to personal health concerns. The indicative contractions *what's* and *it's* meanwhile, create a realis mood ratifying the symptoms at hand as an established reality, or, as in Extract 2, serving to reinforce the candidate's motivation behind their questioning of the patient. In both of these small extracts the simulator is also explicitly delineated by the pronominal deixis *you* spoken by the candidate. Not only does this direct attention towards the simulator, but it can also function as a linguistic compliance device via the focus on the patient and their actions (Brown et al. 2006: 172). Negation also features within these extracts; whilst in Extract 1 it is in the construction of a colloquial tag question (demonstrating how particular idiolects or dialects can influence keyness significance), in Extract 2 the negation functions as a mitigation of a potential response by the patient, framing this dispreferred reaction in terms of candidate's professional obligations.

In regard to notions of asymmetry within medical dyads (or its reversal in simulated consultations), it is of particular note that the simulator keywords of the PDC exhibit a

markedly different profile for pronoun use. In contrast to the candidate's usage, the simulators tended to use pronouns in both their non-contracted and first-person singular forms. This accords with the aforementioned work of Skelton et al. (2002: 486) that clinicians are far less likely to use singular first-person pronouns than patients. The usage of pronominal auxiliary contractions is also slightly higher overall for the simulators (five items in the top twenty keyness, opposed to three for the candidates), demonstrating the increased importance of this category to their overall discursive identity. Notably, pronouns are also the only area of deictic significance for the simulators within Perfect Day. As Charteris-Black and Seale (2010: 63) highlight, this has significance for how the condition of a patient is expressed – an abundance of first-person pronouns conveys a centralised lived experience.

4.2.2 Keyword collocates within Perfect Day

Beyond observations of the singular keywords, the analysis moves to a wider understanding of key areas by looking at their collocates, in order to investigate significant pairings in the candidates' discursive identities. To facilitate a sharper focus for the analysis and to manage the multitude of potential avenues for investigation, collocations were only sought for keyness categories containing two or more lexical items in the overall top twenty keyness – for the PDC these are the categories *indicative*, *pronominal auxiliary contractions*, *deixis* and *anatomical*. As per Baker (2006: 133-136), this strategy is a researcher-initiated approach to the keyness data to balance the numerous outputs with a practical means for its use.

For all lexis within a particular keyness category, the collocation measurement was taken at a span of 3L and 3R of the node word with a minimum frequency of $f \geq 5$. Given the small corpus size, this threshold is arguably more constraining than the generally utilitarian measure of 5L and 5R but was used due to the low type-token ratio of this data and the previously discussed low lexical density of spoken language generally. As I detailed in Chapter 3, collocation is measured using a log-likelihood score.

For each of the lexis within a thematic keyness category, its top five collocates were established. From here, each of the initial node words plus these five collocates were examined in their wider context through an analysis of concordance lines. Once again, the relatively small size of both the PDC and the CPC made this a feasible methodology. Because the corpus method within this study is being used primarily as a guide towards a more in-depth discursive pragmatic analysis and is concerned with multiple, categorised keywords (as opposed to a set of specific node words of interest) the collocational profiles are kept relatively simple and are not illustrated in regard to their distance from the initial node word.

As I stated in Chapter 3's methodology, the utility of the corpus analysis is twofold within this research, with keyness also driving the areas of focus for the qualitative analysis. As such, the *indicative*, *pronominal auxiliary contraction*, *deixis* and *anatomical* keyness categories will also be utilised for the Louw et al. (2014) method in Chapter 5 to identify extracts or analysis; this process will also remain constant for the clinical pharmacy data. Table 4.4 demonstrates the top five collocates for the high keyness value items within each of the aforementioned categories:

Indicative :		Pronoun contractions:		Deixis:		Anatomical:	
KEYWORD:	COLLOCATES:	KEYWORD:	COLLOCATES:	KEYWORD:	COLLOCATES:	KEYWORD:	COLLOCATES:
It's	Big	I'm	Sorry	You	Mention	Blood	Count
	Difficult		Really		Drive		Test
	Thing		Trying		Thank		Tests
	It's		Doctor		Noticed		Up
	Very		I'm		Tell		Results
That's	Good	You're	Sick	Your	Husband	Liver	Checked
	Fine		When		Health		Well
	Right		See		Count		Test
	Yes		Because		Body		As
	Ok		At		Wife		Your
		You've	Seen			Ulcer	Stomach
			Been				An
			Sick				Ok
			Got				A
			Not				Is
						Stomach	Lining
							Ulcer
							With
							The
							Of

Table 4.3 – Collocates of the top keywords of the PDC

Following a closer analytic reading from concordance lines, the overarching discursive motifs arising from the key / node words and their collocates within the corpus were thematised into three distinct areas for the purpose of initial exploratory analysis within this chapter. They are as follows:

1. *The candidate indexing states of affairs within the consultation*
2. *The candidate indexing themselves*
3. *The candidate indexing the simulator*

The following sections will discuss how the candidates approach these three areas within Perfect Day. As a detailed qualitative analysis will follow in the subsequent chapters, the following discussion is to comment on general overarching trends within the data using general pragmatic concepts – illustrated with short examples – and to examine any contextual factors possibly influencing the results.

4.2.3 Candidate indexing states of affairs

The primary *it is* collocations of interest within this category are *it's + difficult (+very)* and *it's + thing*. Although the collocation of *it's + big* demonstrates a higher log-likelihood score (7.21) than these two constructions (6.64 & 6.61 respectively), a contextual investigation of concordance lines demonstrates that this is one candidate repeatedly (n=4) describing the simulators shock at the diagnosis within a particular consultation and thus is an idiolectic speech pattern influencing the data. *It's + difficult* along with the occasional intensifier *very* is used by the candidates to comment on levels of certainty in regard to the simulator's prognosis in Scenario A and in reference to a diagnosis, or the ramifications of the test results in Scenario B:

Extract 3: (Scenario A)

<CAN>: **It's difficult** to say whether it's going to happen again or it's er going to stay calm
<0.5> ok would you like to tell you a bit more about multiple sclerosis what it is <5.0>

Extract 4: (Scenario B)

<CAN> hmm sure we <0.5> with the results **it's very difficult** to comment on you know the stomach ulcer but the <0.5> when someone has got a stomach ulcer they generally sort of a
<0.5> they bring up blood when they're sick

Within these two examples of the *it's + difficult* collocation, two linguistic functions can be discerned – hedging in regard to an uncertain prognosis, and an evaluative metacommentary on the difficulty of the clinician ascribing a diagnosis. As a multitude of studies have already shown (e.g., Prince et al. 1982, Atkinson 1995, Babrow et al. 1998, Skelton et al. 1999), hedged constructions are frequent within medical encounters and not necessarily negative in their effect; functioning to navigate areas of ambiguity within the dyad as a form of epistemic modality.

The lowered speaker commitment evident in the *it's + difficult* formulations have been labelled 'plausibility shields' by Prince et al. (1982); in that these strategies introduce an

element of plausible reasoning into a statement, though not rendering them untrue for the patient. Whilst Babrow et al.'s (1998) taxonomy of medical uncertainty stated that hedges and ambiguity could arise from questions of complexity, qualities of information, probability, the structure of information and lay epistemology. The *it's + difficult* construction in both scenarios seemingly appraises the complexity of the condition at hand but does so arguably in a construction that could be seen to problematize or occlude the condition further; as Sarangi and Clarke (2002: 151) suggest, statements that convey such diagnostic uncertainty should ideally be qualified with *who is likely know*.

In the metacommunicative function, the usage of *difficult* in these contexts also operates as a scalar implicature, eliding the inability of the candidate to provide certainty to the simulator. By which, the lexis *difficult* is used in place of a stronger statement that would explicitly outline the diagnostic uncertainty. While it has been established that metacommunication is a strategy employed extensively by successful candidates in simulated consultations (Roberts et al. 2014: ix), here the signposting function provided by metacommunication potentially foregrounds the inability of the candidate to deliver certainty. Whilst from a non-clinical perspective, the necessarily 'correct' approach here can't be stated, this strategy may suggest that the provision of certainty is of primary importance to this particular candidate.

The *it's + thing* formulation also deals with uncertainty within the consultation, as an area of vague language use within the dyad by which the candidates reify conditions or concepts that have not yet been fully developed within the consultation:

Extract 5: (Scenario B)

<CAN:> Certainly certainly yeah and how are you coping with this **it's** an everyday **thing** isn't it

Notably, this collocation is predominantly found within Scenario B, in which the condition at hand still requires investigation from the clinician. As with the previous example, the

appearance or use of elements of vague language such as this should not be considered inherently negative; as Adolphs et al. (2007: 63) highlight, the use of elements of vague language such as this can demarcate the transition of specialist concepts into lay terminology. Channell (1994: 190) also points out the use of vague categorisers such as *thing* can also become a politeness strategy mitigating directness and promoting informality. This can be seen in the following extract from a candidate attempting to promote a convivial atmosphere whilst beginning their potentially sensitive lifestyle questions with the simulated patient in Scenario B:

Extract 6: (Scenario B)

<CAN:> About your lifestyle <0.5> er do you smoke at all sir

<SIM:> No I used to <0.5> erm I stopped <0.5> erm <0.5> six months ago so I'm pleased

<CAN:> Alright <0.5> and erm **that's** a **very** good **thing it's** really good that you know

This extract also highlights the final area of collocational significance for this particular category – candidates proffering evaluation or affirmation on the simulator's narrative in the form of *that's + good / fine / right* constructions. The extract above is an instance of a lifestyle question yielding a non-problematic answer (Sorjonen et al. 2006: 347), to which the candidate can explicitly adopt an evaluative stance within the consultation. The uptake of an evaluative, epistemological stance (Mushin 2001) would appear to be a key area in which the candidates can perform elements of expertise within the dyad. As Mushin (2001: 57) emphasises, an epistemological stance is not necessarily contingent on formal properties of language, but the pragmatic, functional way language is utilised in certain contexts to convey a speaker's attitude towards the status of the knowledge they hold. Furthermore, these pragmatic conventions of formulating a position towards a piece of knowledge can be conventionalised within specific speech communities (ibid).

Given that constructions of affirmation such as this can also be utilised in sequences in which a potentially problematic answer is yielded (such as Extract 7, below), this

discursive strategy further endorses the sense of the candidate as a 'credible evaluator', as has been previously observed in Section 4.2:

Extract 7: (Scenario B)

<CAN>: So with these vomiting episodes have you noticed any blood at all

<SIM>: A few flecks just little flecks nothing major just bits you know

<CAN>: <unclear> fresh red or a darker colour

<SIM>: Hmm can't say just just blood sorry

<CAN>: Ok **that's fine** erm and have you noticed if its associated with anything that you do at all or what you eat or drink

4.2.4 Candidate indexing self

Although demonstrating an overall high significance, this particular category most clearly demonstrates how an individual speaker's idiolect can effect keyness in a small corpus of language data: Of the *I am* contractions spoken by candidates within the PDC, fifty five per cent of *I'm* plus their collocates *sorry* and the intensifier *really* are spoken by one particular candidate over both scenarios. The construction *I'm + trying* meanwhile, also shows significance in terms of the collocational values, but is used by only two candidates in five instances within Scenario B to justify their investigation of the patient's alcohol intake. These anomalies aside, the general paucity of candidate data in this area accords with the idea (Kacewicz et al. 2013, Zimmerman et al. 2013) that through the distribution of first-person pronouns we can determine where attention is focused within the dyad and conversely where power is situated. By way of comparative illustration, first person pronouns and their contractions account for four of the top ten keyness items for the simulator, including *I'm* as the top keyness value overall.

Nonetheless, it is still worth investigating how the candidates undertake this particular form of discursive identity work, especially as the data demonstrates that the majority of this self-reference is in the formulation of apology. These apology expressions

are utilised by the candidates primarily in two divergent modes; what I have termed here 'empathy tokens' and 'institutional apologies'. Alongside a third less frequent, self-reflexive mode termed 'meta-apologies' for the purposes of this analysis. The two primary forms of apology found here traverse Tavuchis' (1994) distinction of the dynamics between interpersonal and collective apology; that is, that the interpersonal apology is hallmarked by a sense of speaker remorse, whilst the collective apology is an on-record acknowledgment of wrongdoing. Unsurprisingly, it is the construction *I'm* + intensifier + *sorry* that is mostly deployed as a marker of empathy in response to the critical diagnosis within Scenario A:

Empathy Token

Extract 8: (Scenario A)

<SIM> So I won't be in a wheelchair

<CAN> It's a it's very difficult to say but if we look into it now and look at the treatment <0.5> see what type of it needs lot more investigation <1.0> I'm really sorry <12.0> I see it's a big shock <0.5> and er <0.5> there's a there's a lot going on <0.5>

Extract 9: (Scenario A)

<CAN> I'm so sorry <3.0> would you like to have <0.5> your husband here some of the time because to still talk about it and things like that

Subsequently, it is many of *I'm* + *sorry* formulations where an intensifier is not present, that function as a collective or organisational apology for contextual circumstances in both Scenario A and Scenario B in which the patient feels they have not been given the full range of information by the healthcare institution. Davies et al. (2007: 58) have highlighted how institutional apologies such as these can have identity enhancing components, promoting the apologisee as the 'good [doctor]'. Markedly, in the first example here, the apology is coupled with the pronominalization adoption of a collective, institutional *we* by the candidate.

Institutional Apology:

Extract 10: (Scenario B)

<CAN> I- I'm sorry that this happened but because <1.0> it's it's a part of the routine blood test I we might not have told it to you I'm sorry that we missed it <0.5> but er

Extract 11: (Scenario B)

<SIM:> Well yeah it does if you put it like that I was just a bit <0.5> annoyed when they're doing tests and not telling me about it

<CAN:> I'm sorry about that <0.5> now what these tests tells me is that your liver is under strain

The third, less frequent usage contends with the candidates levelling an apology for their own role in the delivery of the bad news at hand – what I have termed here a meta-apology. Of particular note in regard to this particular mode of apology is that it emphasises the responsibility domain of apology foregrounded in a number of studies (see for example; Meier 1998, 2004, Holmes 1998) as integral component, via recurrent alignment with the phrase *I have to*; potentially problematizing the discursive enactment of diagnosis itself. Buckman (1984: 1598) has observed a similar effect in regard to the ambiguity behind apologies in clinical encounters, arguing that clinicians can implicate themselves into blame by apologising. Similar to the implicatures noted in Section 4.2.3 then, these apology formulations are metacommunication that foregrounds problematic areas of the candidate's discursive task at hand, rather than signposting intentions for the patient.

Given the pedagogical intent of Perfect Day as a tool to promote self-regulation in the consultation, this form of self-reflexive apology may bear particular relevance to the educators as an atypical discursive enactment of professional identity for the candidates:

Meta-Apology

Extract 12: (Scenario A)

<CAN>: Yes <1.0> I'm really sorry that I have to tell you this <7.0>

Extract 13: (Scenario A)

<CAN>: I'm really sorry I have to bring this up and I have to

<SIM>: It's not your fault is it

<CAN>: Bring this news to you

4.2.5 Candidate indexing the simulator

Further reinforcing the overall notion taken from Kacewicz et al. (2013) that deictic pronominal use can indicate where locutionary power exists within the dyad, this particular category is the largest of the collocational sub-categories discussed so far. The collocational profile for the second person pronominal constructions *you're +*, *you've +*, *you +* and *your +* demonstrate a number of discursive approaches that address the simulator's symptoms at hand; locating them in various temporal, evaluative and epistemic dimensions in which they are to be considered within the dyad. For example, the *you're + at* formulations construe a realis narrative that deictically points to the simulator and establishes their symptoms or condition as a presently understood and on-going phenomenon. Predominantly found within Scenario A, these formulations generally locate the simulator on the temporal progression of M.S as a chronic illness:

Extract 14: (Scenario A)

<CAN> That is the very very very last stages of <0.5> multiple sclerosis we are here <0.5> and this is where the wheelchair is you're at a stage where it's very early and we can still accomplish <0.5> your desire to go on holiday to walk and to be fit and healthy and we can support you in multiple different ways to help you achieve that

Invoking progressive temporality in regard to illness in this respect is comparable to the discursive enactment of the 'illness as a journey' metaphor documented by a multitude of metaphor-focused healthcare research (e.g., Semino et al. 2003, Reisfield and Wilson 2004) – the effects of which are inconclusive in terms of the patient experience (Demmen et al.

2015). In Scenario B however, where diagnostic certainty is not yet present, the expression of pronominal *you're* + *when* constructions are used by the candidates as a questioning device to gather evidence within the consultation, by verifying the detail of the symptoms the simulator has reported:

Extract 15: (Scenario B)

<CAN> And you mentioned about some tummy pain do you get it all the time or is it only **when you're** being sick

This evocation of a *wh*- interrogative mood becomes crucial to a jointly constructed, temporal understanding of the condition at hand, allowing for its explication into more detailed discussion, as well as ultimately, its potential alignment with any of the patient's concerns. This is demonstrated in Extract 15(a) below, in which the candidate utilises the information the simulator has yielded from Extract 15 onwards to address their on-going concerns in regard to a stomach ulcer:

Extract 15(a): Approx. 30 lines after Extract 15 [above]

<CAN> Hmm sure we <0.5> with the results it's very difficult to comment on you know the stomach ulcer but the <0.5> when someone has got a stomach ulcer they generally sort of a <0.5> they bring up blood when they're sick

The *you're* + *because* collocations – also found predominantly within Scenario B – however, serve to formulate ways for the candidate to elucidate the reported symptoms, or reasoning for treatment, to the simulator. This is also true of the *you've* + *been* past participial constructions which feature exclusively within Scenario B in addressing the reported symptoms:

Extract 16: (Scenario B)

<CAN:> I know your wife is been nagging you but I think she is pretty much right **because** **you're** drinking a lot more than ahm <0.5> what is safe for you <3.0> and the symptoms of this vomiting and retching and you know the little amount of blood that you noticed all these symptoms you had is related to the alcohol

Extract 17: (Scenario B)

<SIM> Yeah can I ask you why you checked my liver because of my stomach

<CAN> It was just because **you've been** sick for a couple of time <0.5> and we were trying to work out whether this is coming from the liver or not <0.5> people we do check it ah as a routine especially

Arguably in these two extracts the overall effect is an enacting of the epistemic authority of the candidate; these constructions specifically point at the simulator, ascribing to them actions or symptoms that the candidate is then able to take an evaluative, epistemic stance towards – similar to the manner previously noted in Section 4.2.3. Indeed, the formulation found in Extract 17 is deployed by the candidate as a riposte to a direct challenge towards their status as a holder of knowledge-based authority within the consultation. The contracted pronominal use in this regard is crucial as it discursively reinforces where attention is concerned within the dyad.

The collocations considered within the *candidate indexing simulator* domain are also concerned with verbalising the role of evidence within the dyad, by either its explicit marking (Extracts 14, 16, 17), or by the establishment of evidence from which clinical judgments can be made (Extract 15). This usage aligns with Palmer's (2001) conception of a propositional modality – the intertwining of epistemic and evidential modality in modes such as the deductive; by which interlocutors can create a rhetoric inference synthesised from observable evidence (24). Within these extracts, the use of deductive, epistemic moods by the candidate provides the consultation with an emergent and overt discursive cause and

effect logic. Notably, in relation to notions of symmetry within the dyad, these deductive formulations are often based upon evidence offered by the patient – such as in Extract 15 – and not merely from esoteric professional knowledge.

4.3 Clinical Pharmacy

Although previously outlined in Chapter 3, it is briefly worthwhile restating that the corpus methods, measures and subsequent processes of functional / lexical categorisation were applied consistently to both the Perfect Day Corpus and Clinical Pharmacy Corpus within the present study. With a type-token score of 10.2% the CPC shows a higher lexical variety than the PDC; a difference that may be accounted for by the broader range of participants in the consultations, as well as the fact that the CPC is constituted of 'real life' language data and not centred around two recurrent pedagogical scenarios.

The keyness cut-off value of number one hundred shows a value of 44.16 for the CPC, whilst the corpus yielded thirty negative keyness items. Table 4.4, below, illustrates the top twenty positive and negative keyness items for the CPC, whilst Table 4.5 shows the functional / lexical categorisation of keyness items:

POSITIVE:			NEGATIVE		
Word:	Frequency:	Keyness:	Word:	Frequency:	Keyness:
ok	251	2526.51	t	2	287.79
that's	144	1590.99	i	140	267.78
ahm	109	1204.08	er	94	95
you're	96	1060.41	we	99	92.76
you've	78	861.5	was	47	74.74
i'll	70	773.11	yes	9	72.51
it's	59	651.59	people	5	60.64
so	429	538.61	they	67	60.31
don't	44	485.89	he	18	57.98
we'll	40	441.71	mm	1	56.6
yeah	319	426.68	of	246	51.13
your	246	421.85	our	2	43.62
there's	33	364.4	d	5	42.7
ah	85	325.48	this	53	39.4
i'm	29	320.22	mean	6	38.61
i've	29	320.22	in	180	37.7
its	94	301.03	there	63	33.35
haven't	24	265.01	the	687	33.33
blood	45	222.43	know	34	32.24
they're	20	220.83	who	6	31.86

Table 4.4 - Top 20 positive & negative keyness items CPC

Lexical / Content:	Keywords:	Function:	Keywords:
Anatomical	<i>Blood, mouth, scalp, kidneys, cholesterol, throat, skin, thyroid</i>	Backchannels / response tokens	<i>Ok, yeah, ah, yep, mmm, ar</i>
Pharmaceutical	<i>Inhaler, dose, amitriptyline, lansoprazole, tablets, milligrams, medication, preventer, pressure [blood], salbutamol, medications, quetiapine, citalopram, ECG, ramopril, spray, antibiotics, mouthwash, steroid, paracetamol, vitamin, alendronic</i>	Pronominal aux contractions	<i>You're, you've, I'll, we'll, I'm, I've, they're, we've, we're, she's, they'll, they've, you'll, I'd, he's, you'd</i>
Medical professional	<i>GP, dentist</i>	Quantity	<i>Any, just, repeat [prescription], twice</i>
Experiential	<i>Pain, symptoms</i>	Deixis	<i>That's, your, you</i>
Conditions - symptoms	<i>Asthma</i>	Negation	<i>Don't, haven't, doesn't, isn't, won't, can't, didn't, aren't</i>
		Irrealis	<i>I'll, we'll, they'll, you'll, it'll, that'll</i>

Table 4.5 – CPC lexical and functional keywords

(Key: Red = top 20 keyness, orange = top 50, black = top 100)

4.3.1 Keyness trends within Clinical Pharmacy

Similar to the PDC, the CPC demonstrates a high volume of key items of a technical, medical or anatomic nature, as might be expected when comparatively analysed against a corpus of standard spoken English. Also comparable to the discursive profile of the candidates in Perfect Day is the clinical pharmacists' significant use of pronominal auxiliary contractions, deixis and negation within the consultations. Although, notably within the CPC, not only are a broader range of pronominal contractions utilised within the data, but also, collective or third person pronouns show a higher significance comparatively to the PDC – potentially an early indicator of a greater concern for cooperative principles, as well as

phenomena external to the dyad. And whilst realis moods and indicative states are significant within the PDC, the CPC instead shows the significance of irrealis moods facilitated by the use of deontic modality such as in Extracts 18 and 19, below. This variance in grammatical mood between the datasets could generally be characterised – at this point – as a tendency for the speakers in the CPC to lexicalise *what could / should be*, rather than the predisposition to state *what is* within the PDC, with the respective areas of irrealis and realis moods in each data set showing comparable levels of significance. Extracts 18 and 19 below, demonstrate how the interaction of these areas of significance can create the discursive enaction of on-going, or future action attributed to either the CP themselves, or as a shared, collective action (keywords emboldened):

Extract 18: (Greenheath)

<CP:> So carry on with **your** tablets and then **I'll** either send **you** a letter or find a way of getting in touch all right

Extract 19: (Orchards)

<CP:> So um **I** think **your** control's good **your** peak flow is good **we'll** stay on the same dosage basically <2.5> so this is **just** a reminder <0.5> **you've** got **your** pink one which is **your** Fostair and that prevents **your** symptoms

In a similar vein to the candidates within the PDC, the CP's use of pronominals within these extracts clearly outlines the role and responsibilities of the two participants within the dyad. But in this instance, it does so by aligning the interlocutors with action and objects, rather than evaluation and knowing. Indeed, the discursive enaction of an epistemic mood – including the lexis *know*, *think* and *fact* – is one of the thematic areas of negative keyness found within the CPC. Clearly this could be said to be a characteristic element of two distinct professional enterprises at hand within the datasets – despite their ostensible sharing of a similar, dyadic context.

Given that the clinical pharmacist role within general practice is still a relatively new and mutable role (Mann et al. 2018), a key area of this analysis is expected to be in establishing the identity work that constitutes this emergent role, with the verbal demarcation of professional roles and responsibilities being especially salient. Work such as Pilnick (2000) has already demonstrated the problems that can arise in service provision when patients faced with pharmacists with an extended remit do not accede to the role of 'advice recipient'.

The critical establishment of a professional remit, alongside the contextualisation of the CP role within a wider healthcare domain can seemingly be found in the significant use of negation within the CPC data. For example, 47% of the usage of the lexical item *haven't* is as part of a tag question to not only check the patient's medication and adherence, but to establish the broader, on-going context of their treatment as Extracts 20 and 21 demonstrate below:

Extract 20: (Ashbourne)

<CP:> Yep your blood pressure's ok and you've had some blood tests done haven't you as well

Extract 21: (Greenheath)

<CP:> Yesterday mmm ok <0.5> you've got an appointment haven't you next week <0.5> or week after next

Tag questions such as these can serve a potential dual function as Holmes (1984) has suggested; a primarily speaker-centric mode which seeks to clarify a piece of information, or in an affective, hearer-centric mode that softens imposition and demonstrates concern. The key use of negation in these instances also renders the constructions as 'reverse polarity' tag questions (Cattell 1973: 615), by which the tag verb (*haven't*) negates the initial verb (*had*) to pragmatically convey a speaker's statement and ultimately, to request accordance

with the statement. Within the CPC tag formulations such as these arguably serve as a rhetoric device to ratify the patients' procedural interaction with the wider, institutional healthcare structure, but arguably can dually function more locally as a politeness device; prompting the patient to provide necessary information in manner that mitigates the CP's imposition and the patient's requirement to provide their own discursive evidence into the dyad.

By way of a brief comparison, the patient area of the CPC – similar to the simulator area of the PDC – demonstrates high keyness significance in regard to both contracted and non-contracted pronominal use. Reinforcing the notion that high personal pronoun use indicates a self-attentive establishment of identity (Zimmermann et al. 2013) typically found in patients (Skelton et al. 2002). However, similar to the CPs, the patients within the CPC also show keyness significance around areas of negation – albeit in constructions that mitigate ownership of medical knowledge or judgement (e.g., *yeah I **don't** know what's going on with the hip at the moment*) or delineate perceived negative future outcomes from potential treatment plans (e.g., *I'm happy to just carry on and I **don't** want to come off it*).

4.3.2 Keyword collocates within Clinical Pharmacy

As with all other corpus methods, the procedure of determining significant collocations for the CPC followed the same process as that already utilised for the PDC. The collocational analysis here accordingly focuses on the *Pronominal Auxiliary Contraction*, *Deixis* and *Irrealis* thematic categories within the CPC as they exhibited two or more lexis in the overall top twenty-keyness rank. Table 4.6 below, displays the top five collocates for the high keyness value items within each of these categories. As the *Irrealis* and *Pronominal Auxiliary Contraction* categories overlap in their keyness items, the contractions *I'll* and *we'll* indicating an irrealis mood within the corpus have been exclusively assigned to the *Irrealis* category:

Pronoun contractions:		Deixis:		Irrealis / pronoun contractions:	
KEYWORD:	COLLOCATES:	KEYWORD:	COLLOCATES:	KEYWORD:	COLLOCATES:
you're	welcome	that's	full	I'll	sort
	taking		great		check
	getting		fine		I'll
	not		good		give
	because		that's		what
you've	got	your	legs	we'll	get
	had		medications		do
	been		date		on
	done		arm		that
	some		change		so
I'm	going				
	not				
	to				
	just				

Table 4.6 – Collocates of the top keywords with the CPC

Once again, the concordance lines for each collocate were analysed in context to provide a greater understanding of their use within the corpus. The resulting thematic areas of analysis stemming from this wider reading are as follows:

1. *The CP indexing the patient*
2. *The CP indexing themselves*
3. *The CP indexing future action*
4. *The CP indexing the collective*

The subsequent sections will investigate how these four thematic areas function within the CPC data and contribute to the CPs' discursive professional identities within these consultations. This section will also reference any relevant contextual, ethnographic, 'thick participation' commentary from the data gathering and overall Clinical Pharmacists in General Practice project wherever relevant to the analysis. As a comparative point between the PDC and CPC corpora at this stage, it is worth highlighting that the earlier observation that the CPC shows a predisposition for the grammatical future – opposed to the PDC's

tendency to convey states as they are currently understood – is further reinforced by the establishment of these areas of collocational significance.

4.3.3 CP indexing the patient

The strongest overall collocation of *you're - welcome* - again demonstrates the effect particular idiolects can have on this relatively small corpus of data. This construction, used as token of politeness / rapport, is the product of one particular CP in one site, principally at the end of their consultations. It is also used as an epizeuxis in these contexts, further skewing its significance within the corpus.

The deictic *you're + taking* and *you're + getting* formulations in the data meanwhile, establish a key area of the CP's responsibilities in checking the medication the patient is currently taking, alongside any on-going symptoms and their potential worsening or alleviation, as Extracts 22 and 23 illustrate below:

Extract 22: (Foxhole)

<CP> : But but <0.5> having said that <0.5> you're literally on twenty thirty milligrams of amitriptyline at night ahh

<PT> : No I'm not I'm on a hundred and forty

<CP> : **You're taking** the other one as well oh yeah yeah

Extract 23: (Greenheath)

<CP> : Ok <0.5> that's that sorted in terms of your tablets <0.5> **you're taking** them all <0.5> your taking all your tablets <1.5>

The statistical significance of the *you're + taking* constructions in the data demarcates the medication review; an activity found in both CP and GP consultations, but as evidence from CPiGP pilot study and LiPP's follow up visits attest, it is a task being increasingly transferred from GP to CP responsibility within primary care:

'Our medication reviews, we have got up to just short of 12,000 patients, so a lot of patients need a lot of medication reviews. That was impacting negatively on the GP's time on a daily basis...the list kept growing and growing and it became a bit of a clinical safety issue. So the last [CP] came in and basically concentrated on the med reviews' (Practice Manager interview, Ashbourne)

The medication review itself is consultation in which the pharmacist is tasked with monitoring adherence to, and the effectiveness of, treatment and to modify medication levels accordingly (Clyne et al. 2008). An analogous activity to this covered by a multitude of existing language research is history taking within GP consultations (e.g., Stivers and Heritage 2001, Boyd and Heritage 2006), in that it constitutes a distinct area of the dyad in which the clinician invokes a sequence of questions in order to illicit the completion of a series of tasks (Frankel 1995). Martin (2014: 497) designates recurrent discourse activity such as this as 'routines', noting that they can 'reveal the rules that determine language use in medical contexts' and that patients become socialised into the 'necessary pragmatic competence' via their recurrence. As Extract 22 and 23 demonstrates however, within a medication review declarative questions can be integrated into the on-going dialogue within the dyad, rather than as a discrete set form of *wh*-interrogatives.

The realisation of the medication review in this form seemingly has a very practical basis within the CP dyads observed within this research; with the CP often checking the details of the patient's medication concurrently from a computer screen in a manner that has previously been described as a 'triadic' form of consultation (Scott and Purves 1996, Pearce et al. 2011, Swinglehurst 2014). This contextual detail is important as these declarative questions are also a form of inferential evidentiality, in which the triadic involvement of the computer – as an official record – functions as a mode of epistemic authority within the dyad, to which the CP is able to defer whilst still allowing the patient to input their own experience. This is particularly seen in the patient's correction in Extract 22. In this sense, the primary epistemic authority and agency within the dyad becomes shared between the CP and the

computer as a signifier of the official institutional record. This triadic form of consultation is also utilised wherever the patient is unable to verify their own medication regime, whilst the lack of an interrogative mood and promotion of shared agency also mitigates imposition for the patient.

The other significant collocations of *you're* and *you've* uncovered by the corpus analysis – namely *getting / not / because / got / had / been done / some*, either refer to the detail of the medication (“and then **you've got** the simvastatin”) or temporality (“so **you've had** this for a couple of years”) in regard to the condition at hand and its recovery (Extract 24, below), or a causal narrative link between the two (“anyways **because you're** not on any blood thinners”), in a similar to that already highlighted within the PDC.

Extract 24: (Orchards)

<CP> : So we want to try and bring that down to three times a week <0.5> that's blue <0.5> you can have one puff whenever you need it <0.5> so you don't its not that you're not allowed to take it but we're aiming for better control so you don't have to take it <0.5> so that's where we'll start you off <0.5> if its not really working and **you're getting** worse you can take the preventer up to two puffs morning and night

<PT> : Ok

<CP> : And you can use the blue one again as much as you need to <0.5> and then if **you're** still not really **getting** anywhere still on that come back and see us

Nonetheless, it is worth referring back to the raw keyness values at this point to highlight that the deictic *you're* and *you've* show a far higher keyness values in the CPC (1060 and 862) than in PDC (651 and 561); indicating that this dialogic exploration of conditions, that explicitly points to the patient within the dyad, constitutes a significant amount of the talk at hand within the CPC consultations. A recurrent theme within the patient focus groups of the initial CPiGP pilot study was the perceived advantages of a more attentive and longer consultation, hallmarked by procedural thoroughness. As Seale et al. (2005) have already

shown in consultations featuring nurse practitioners, longer consultation times and the dialogic contribution of a higher degree of information is paramount for patients in terms of service satisfaction. The discursive attention provided by *you're / you've* constructions and its accordant patient satisfaction would appear to contradict the notion of a second person pronominal 'deictic distancing' proposed by Charteris-Black and Seale (2010:62).

'I felt that he had a little bit more time than you generally find with the doctor. He was able to discuss how are you getting on with the tablets, are you taking them on a regular basis...I felt it was a little bit more of a one to one and not sort of; 'ok, right, next' (Patient feedback, Greenheath)

4.3.4 CP indexing themselves

Within the CPC, first-person contracted pronominals are wider in range (four forms versus three) and have higher representation in the overall top hundred keyness values than in the PDC. Indicating that, comparatively, the CPs reference themselves significantly more than the candidates in Perfect Day do. Taken from a position of pronominal use indicating a social hierarchy (Kacewicz et al. 2013) this could intimate that the CPC dyads are more discursively egalitarian – a notion that has obvious ramifications for asymmetry. Although the first person pronouns here have been split between the present category and the forthcoming section (*CP indexing future action*), it is worthwhile briefly noting that deeper exploration of the concordance lines of the CPC indicates that all of the key first person pronominals lexis – *I'm, I've* and *I'll* – and their associated collocates are performing a broadly similar function for the CPs; outlining action and responsibility within the dyad and thus becoming a key area of the CPs performative identity. Looking in particular at the *I + am* and *I + have* contractions, unveils how this is achieved in the consultations:

Extract 25: (Orchards)

<CP> : That's lovely <3.0> and can you just do that again for me I'm going to ask you two more times

<PT> : Ok right

Extract 26: (Foxhole)

<CP> : A month will be too long <59.0> ok so keep to <nurse name> keep that one

<PT> : Yeah

<CP> : I'm just going to change the dosage

<PT> : Yeah

Extract 25 above is a fairly typical manifestation of the *I'm + going* formulation used by a CP to discursively demarcate procedural tasks to be undertaken within the consultation, in this case to administer a test of inhaler technique. This particular instance also illustrates how this approach is also a meta-communicative act, dialogically signposting the patient as to the next steps of the consultation. In Extract 26 a number of the primary collocates of *I'm* are used by the CP as they negotiate the patient's follow-up action, including the mitigatory *just* as a politeness token within the exchange. Here also, the contextual, triadic use of the computer within the consultation is a factor as the softening *just* also excuses the CP's use of the computer to complete an administrative task, temporarily breaking the exchange. The discursive navigation of routine practicalities such as this is another area that is distinct from the simulated consultations of the PDC.

In a similar manner, the significant collocates of *I've* coalesce around a general thematic axis evidencing tasks that have been undertaken by the CP in the immediate temporal duration of the consultation:

Extract 27: (Ashbourne)

<CP> : **So** I'll I can give you some Lactulose just to loosen **it** <15.0> **so I've** added **that** onto your repeat for you

<PT> : Thank you

Arguably the effect of formulations such as this – corroborating work as it has been undertaken – if viewed from a basic speech act (Austin 1962) perspective, could be said to exist on a number of levels: Whilst the locutionary and illocutionary domains demonstrate that a task or request has been completed within the dyad, the perlocutionary effect of this is to both progress the agenda of the consultation, as well as performing an affirmational, transactional component that may also contribute to high levels of patient satisfaction reported within these particular consultations.

It is worth noting that these formulations are generally found towards the end of the consultation and therefore also possess a summative quality within the exchange. Formulations of transactional certainty such as these are directly contrastable to the areas of vagueness found in the PDC, which perhaps again, gives an indication of the discursive enaction of two differing enterprises in ostensibly similar environments.

4.3.5 CP indexing future action

As this section is primarily concerned with the irrealis, deontic moods created by pronominal *I'll* + constructions uttered by the CPs, the collocational profile exhibits lexis principally centred around action within the dyad, similar to the preceding section. Fritz (2003: 143) has noted how, despite the lack of a modal verb, *I + will* formulations such as these can pragmatically convey an epistemic quality. Once again, this highlights the performative, task-based, 'talk as action' aspect of the CP role, as can be seen in the following extracts:

Extract 28: (*Greenheath*)

<CP> : Ok what I'll do I'll give you another lot of four <1.0>

<PT> : That'll do me till Christmas

Extract 29: (*Foxhole*)

<CP> : Ok that's fine <1.5> and er <2.5> I'll just double check on the bloods ah done by the hospital <16.5> ok tenth of October <7.5> right what I want to do is this side is fine so I'm downloading these bloods for our records so that <1.0> only on tenth of October so won't need these particular ones <0.5>

Extract 28 again illustrates the signposting, meta-communicative and ultimately transactional nature of these self-referent projections of future action by the CP. In this particular instance the temporal realisation of this speech act sits outside of the remit of the immediate consultation – the commitment to a new prescription will be ultimately fulfilled by another healthcare professional. Nonetheless, this extract also evidences how the evocation of unrealis moods centred around the first-person also has a contributory quality towards professional identity; in this instance with the lexical item *give* reinforcing the CP as provider and gatekeeper of healthcare services.

The example in Extract 29 however, presages an explicit discursive outline of the CP's undertaking and as such is temporally focussed within the consultation – another example in which the unfolding work being done within the dyad is narrativized by the CP, seemingly for the benefit of the patient at hand. In Goffman's (1959) classic distinction of a metaphorical, performative frontstage and backstage, a strategy such as this could be viewed as emphatic front staging; with the CP explicitly drawing attention to their action and obligations within the dyad to promote either understanding or transparency. An interesting parallel exists between this emphatic front staging and the metacommunication found within the PDC; whilst the former is talk about action as opposed to the latter's talk about talk, both

discursive strategies ostensibly 'signpost' the clinician's intent and agenda for the benefit of the patient within the consultation.

At this point it would also perhaps be remiss not to consider the potential effect that the observational data collection itself may have had on these consultations, especially in light of the idea of an observer's paradox (Labov 1972) occluding any perceived naturalism. Whilst the effect at hand might not be as pronounced as Wilson's (1987) notion of 'tape-effected speech' – especially as healthcare education and provision arguably contains a culture of observation (Clarke 2003) – it is worth questioning whether some of the consultations were more closely conducted in 'best practice' with an observer in the consultation room.

Comparatively, this notion of clinician identity primarily centred on continuing and future action highlighted here within Sections 4.3.4 and 4.3.5 is not found in the PDC, where, as Section 4.2.4 highlights, the candidates primarily index themselves to apologise. The distinction between the first-person pronominal referent as infrequent gestural apology and frequent procedural narrative establishes a contrast in the types of discursivity found in the two datasets: Whilst in the CPC it may be the researcher in the room that unwittingly engenders a more self-attentive professional performance from the CP, marked by a higher use of first-person pronouns, in the PDC the pedagogical, reflective nature of the simulation may provoke a significant proportion of self-reference as collective, on-record apologies – in order to convey the notion of being both a good trainee and caring professional. This indeed may also be a difference between real and simulated consultations, the latter of which can be said to have no tangible external consequences as a real consultation would (Hanna and Fins 2006: 266).

4.3.6 CP indexing the collective

Similar to the instances of the CPs indexing themselves, their evocation of the collective via *we'll* + collocations also thematically centre around lexis of practical action. As the following discussion will attest, these uses broadly fall into two distinct functions within the data – *we*

as a collective referent to the participants of the dyad in sharing decision-making and treatment action, and *we* as an institutional referent to either the GP practice where they are based, or to the general wider healthcare setting. Pennycook (1994: 176) for example, has argued that *we* is 'simultaneously inclusive and exclusive' and often 'a covert assumption about shared communality'.

Extract 30: (*Greenheath*)

<CP> : And the oestrogen and everything so I think when you come <0.5> to then when you're going through <0.5> menopause we'd obviously want to avoid the hormonal side of things just because that can increase your risk of blood clots as well **so** what **we'll do** <0.5> is **we'll get** rid of the Rivaroxaban <0.5> off your repeat <2.5> to avoid that confusion then

Extract 30 is the culmination of a number of minutes of somewhat confused deliberation in the consultation between the patient and CP as to whether the patient is still required to take the medication in question. In this concluding summation, the CP presents the upshot of this exchange as a jointly achieved, collective decision – despite both the discursive and procedural enaction of this decision lying with the CP. The use of *we'll* in this particular instance by the CP serves somewhat as a linguistic sleight of hand, occluding the asymmetry that is present in the professional and institutional judgement required for the action, instead presenting the assumed 'shared communality' (Pennycook 1994: 176) as a joint decision.

That of course is not to say all usage of *we'll* + formulations within the data demonstrates this illusory projection of shared decision making between the participants – especially as the clinical pharmacy environment contains a number of participatory tasks such as blood pressure tests, asthma examinations etcetera:

Extract 31: (*Orchards*)

<CP> : And lastly <6.5> that's lovely <3.0> its quite normal for you from what you've done before so there's no change there <1.0> so if you're ready we'll move on to the technique <1.0> so you have one that's looks like that don't you <0.5> you press it and

<PT> : Yeah <2.0>

<CP> : So <3.0> now I want you to pretend that this is your inhaler

And, because *we'll* is also a marker of an irrealis mood, many of the functional instances of use are aligned with the emphatic front staging discussed previously, albeit in a collective form. In many of these occurrences (e.g. "so we'll do the erm the asthma review again next year") the collectivised future action presents the patient's condition as temporally on-going via the suggestion of the irrealis. In certain instances, the CP also uses the communal *we'll* + future action in place of the subject pronominal *you* to soften the illocutionary force of the speech act at hand; in this instance to underline the dosage they are recommending to the patient – "and we'll do one puff twice a day to start with".

Extract 32: (*Greenheath*)

<CP> : Um obviously your tongues a bit coated as well and a bit sore we'll get you two lots of drugs <0.5> so we'll get you a mouthwash and that's got an anaesthetic in it so that will kind of numb <0.5> the back of your mouth so if you use that as a mouthwash gargle spit out don't swallow that'll just numb the inside of your mouth and the back of your throat

Beyond construing action and decision making within the dyad as shared, the collocates of *we'll* also demonstrate how it is utilised to collectivise the CP as part of a wider medical institution, as Extracts 32 and 33 illustrate. As I briefly argued in Section 4.3.1, reverse polarity tag questions appear to be used by CPs to check the patient's treatment status in the wider institutional healthcare context, here however, the CP aligns their discursive identity to this wider organisational identity. Work such as Bargiela-Chiappini and Harris

(1997) and Planken (2005) has shown how use of the collective *we* in professional contexts can be marker of an uptake of institutional identity for strategic purpose. In this particular healthcare context, however, it perhaps echoes more with Iedema and Scheeres' (2003) notion of worker identities broadening out and renegotiated to account for the wider contexts in which they participate. The broadening out in this instance arguably producing a dialogic sense of a wider agency and responsibility for the treatment decisions and patient care at hand.

Extract 33: (Foxhole)

<CP> : What we can do er we'll do that bit ah <1.0> ahm sometimes yeah <0.5> I was explaining <name> specialises in asthma and those type of and things like that and acute inner ear nose throat and things like that ah <name> specialises in diabetes one GP er two GP's specialises in diabetes another on specialises in cancer and another one

As these examples perhaps illustrate however, the reading of *we'll* is not always clearly attributable to a particular function and the determiner can often be ambiguous. This is a notable instance in which the 'thick participation' (Sarangi 2006) of on-site data gathering particularly aids the analysis of the CPC data. Extract 33 for example, is a CP's preamble with a patient as she makes her way through the door of the consultation room and takes her seat. It is only through field notes made to account for missing audio recording at the very start of this exchange, that I'm aware that the *we'll* in this instance is the CP referring to the GP practice and its associated functions rather than being an instance of collective action as in Extract 30.

A further issue with the attribution of the collective *we* is that it is mutable across a single exchange – deictically switching from the dyadic *we*, the illusory dyadic *we* and the institutional *we* throughout a single consultation. A wider reading of the lemma *we* and contractions such as *we're* and *we've* demonstrates how prevalent notions of the collective are beyond the *we + will* constructions highlighted in this section.

4.4 Corpus analysis summary

In this opening analysis chapter, the utilisation of corpus tools such as keywords, collocations and the contextual grounding of concordance lines has begun to deliver an early picture of the significant lexical areas that comprise discursive professional identity in both the PDC and CPC. These have been initially explicated at an utterance level using a number of pragmatic concepts.

In the Perfect Day Corpus, the analysis has uncovered the importance of the grammatical present for the candidates and how this is navigated by utilising epistemic stances towards information, how these stances can be mitigated via hedges, implicatures and vague language where uncertainty may be present within the dyad. The analysis has also shown that candidates do not index themselves in a significant manner within the exercises, and where they do it is in the form of apology, some of which could be said to detrimental to the delivery of a diagnosis. In accord with much of the research highlighted in Chapter 3 regarding pronominal use, the candidates show a significant tendency to direct attention towards the simulator; using the second person to place conditions in temporal dimensions or to attribute symptoms to the simulator as evidential reasoning for their own judgement. The primary keyword areas and their collocational findings are shown in Table 4.7, below:

Keyword area:	Collocational findings:
<i>The candidate indexing states of affairs within the consultation</i>	<ul style="list-style-type: none">- Discursive management of uncertainty- Affirmation of patient narratives- Reification and explication of undeveloped concepts or potential illnesses
<i>The candidate indexing themselves</i>	<ul style="list-style-type: none">- Three predominant apology functions:<ul style="list-style-type: none">A) Empathy tokensB) Organisational apologies

	C) Meta-apologies
<i>The candidate indexing the simulator</i>	<ul style="list-style-type: none"> - Establishment of illness temporality - Establishment of evidence - Evaluative and epistemic stances towards both of these areas

Table 4.7 – PDC Keyword areas and primary collocational findings

The analysis of the Clinical Pharmacy Corpus data has unveiled the linguistic prominence of the medication review within the data as a recurrent activity context. And how the systematic checking it entails interacts with the use of a computer within the consultation to mitigate the professional authority and agency associated with the CP, instead forming a triadic epistemic stance. I noted that tag questions appeared to be a recurrent device by which the CP temporally aligns the patients ongoing treatment to the activity and responsibility of the wider healthcare institution.

First person pronominal use is also much more significant for the CPs, and largely utilised to narrativize procedural action within the consultation – signposting work being done as well as work to be done, which appears to have a transactional, interpersonal function. I have characterised this discursive identity work here as emphatic front-staging (EFS). Notions of the collective within clinical pharmacy consultations have been shown to promote shared decision-making, although, some of this an illusory collective – masking asymmetry in the agency behind lay and professional decisions.

Keyword area:	Collocational findings:
<i>The CP indexing the patient</i>	<ul style="list-style-type: none"> - Discursive enaction of the medication review - Shows significance of deictic / pronominal direction of attention towards the patient
<i>The CP indexing themselves</i>	<ul style="list-style-type: none"> - Outlining professional action and responsibility within the dyad - Summative closing effect this has in the consultation
<i>The CP indexing future action</i>	<ul style="list-style-type: none"> - Highlighting action to be undertaken; the CP identity as a healthcare provider - Narrativization of work being undertaken; the emphatic front stage (EFS)
<i>The CP indexing the collective</i>	<ul style="list-style-type: none"> - Lexicalising shared decision making and shared future action - Grounding treatment and action in the wider healthcare institutions

Table 4.8 – CPC Keyword areas and primary collocational findings

These initial corpus findings present an expanded and more complex picture of professional identity than that originally conceived of in Chapter 3. As I observed in within the analysis, there are no epistemic lexis demonstrating keyness within either corpora, and indeed, in the CPC the lexis *know* was the nineteenth highest negative key item, thus underscoring its scarcity. This adds weight to the idea that aspects of identity such as the portrayal of expertise are more likely to be discursively realised, rather than achieved within singular utterances. Similarly, this analysis has demonstrated that the hypothesised significance of deontic moods, exists primarily as the commissive, irrealis of the EFS – a dialogic

evidencing of clinical action – in opposition to a directive modality of requests or advisory statements.

The hypothesised areas in Chapter 3 also did not account for each corpus displaying a distinct preference in terms of mood evident in the keyness scores. A preliminary observation might be that this is due to the simulated / non-simulated split in the data, with the non-simulated CP encounters affording more opportunity for the speakers to deictically project action into the future in manner that might be difficult for the trainees within a temporally finite simulation.

4.5 Formulating a working picture of professional identity in the PDC and CPC

Beyond merely uncovering these various areas of linguistic saliency within the data, the findings are now applied to the Bucholtz and Hall (2005) identity model established in Chapter 2 to determine how they constitute various components of discursive professional identity. It is expected that this process – shown in Figure 4.1 below – will build a working understanding of discursive identity in each corpus to finalise this entry point to the analysis.

Although the Bucholtz and Hall (2005) model has four distinct components (*emergence, positionality, indexicality* and *relationality*), it is *positionality*, and most importantly, *indexicality* that are the principles most relevant to the corpus findings. *Indexicality* is of primary importance to this study as it pertains to ‘linguistic form[s] that depend on the interactional context for its meaning’ and encompasses ‘overt mentions’ of identity categories, implicatures and presuppositions, ‘evaluative and epistemic orientations to ... talk’ as well as the use of language structures that are aligned to specific groups (Bucholtz and Hall 2005: 294). Whilst *positionality* concerns a speaker’s orientation to ‘local identity categories’ as discourse unfolds, forming ‘transitory interactional positions’ such as, listener or advice giver. The *positionality* concept, therefore, echoes the notion of ‘layers’ of identity foregrounded by Hall et al. (1999) in their study of the role-identity of social workers.

The *relationality* principle – how identity is established against other speakers and ‘available identity positions’ (Bucholtz and Hall 2005: 598) – will be of most relevance in the

forthcoming discursive pragmatic analytic chapters, however in the model below, any relevant aspects yielded from this stage of the analysis are illustrated where applicable.

Model adapted from Bucholtz and Hall 2004 & 2005:

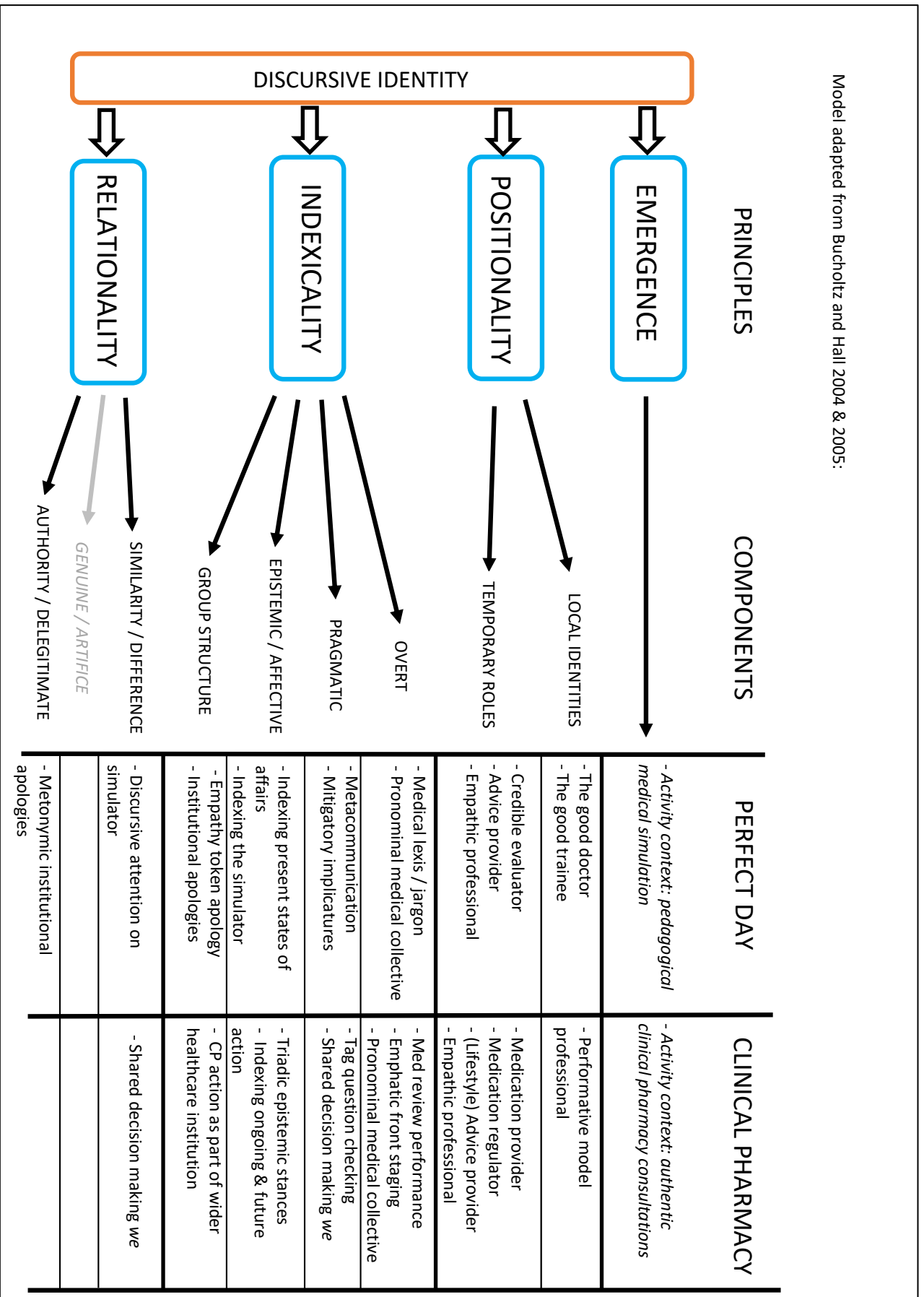


Fig. 4.1 – The PDC & CPC findings applied to Bucholtz and Hall (2005)

5. Data Analysis, Perfect Day: A Discursive Pragmatic Approach

5.1 Introduction

So far, the analysis within this thesis has primarily examined discrete and decontextualized examples of language data thematised around the keyness trends discovered from the inductive corpus analysis. The following two chapters will broaden out the analysis to not only examine longer stretches of contextualized data, but also to investigate how the areas of significant language use discovered in the corpus analysis function and interact in these specific contexts in the enaction of the speaker's discursive professional identity. The analysis will also consider how expertise is conveyed in this discursive performance and accordingly, what the ramifications of these performances are to notions of asymmetry within the dyads. The approach taken within this, and the subsequent clinical pharmacy chapter, will be an initial exploratory analysis of the data; broadly discussing the three research interests of the thesis, before specifically concluding each dataset with a summation of the overall themes of identity yielded from the extracts.

5.1.1 Identifying extracts of discourse

In moving beyond the singular utterances of Chapter 4's collocational examples to a discursive approach here, there is of course the methodological pressure to resist 'cherry picking' dyadic extracts that most conveniently exemplify the research enquiries at hand.

Accordingly, as discussed in Chapter 3, this thesis adopts the 'principled' procedure advocated by Louw et al. (2014) in the selection of extracts from the data to be analysed within the discursive pragmatic framework: To briefly recap, this procedure is driven by AntConc's (Anthony 2019) concordance plot tool, which is able to project selected keywords across a corpus to visually illustrate where typical stretches of discourse are located – 'typical' in this respect being defined by the co-occurrence of keywords (Louw et al. 2014: 167). This methodology utilises the areas of keyness identified previously in Chapter 4; for the Perfect Day Corpus these are the key areas *Indicative* (including the key lexis *it's*,

that's), *Pronominal Auxiliary Contractions* (I'm, you're, you've) and *Deixis* (you, your).

Because the *Anatomical* keyness area of the PDC contains within it lexis that are specific to each of the scenarios at hand, it was omitted from the concordance plots.

From the random sampling of each scenario two datasets were then identified for analysis. (The standardisation of terminology regarding the various levels of data analysis will be defined in Section 5.1.3) Using the concordance plot tool each of these keywords was charted across the Perfect Day Corpus and a typical stretch of discourse identified for each of the data sites. By way of illustration, the concordance plotting of Scenario A is shown below for the seven keywords contained within the key categories; the red boxes illustrate the selected areas of typical discourse (those areas in which a visually even distribution of keywords exists):

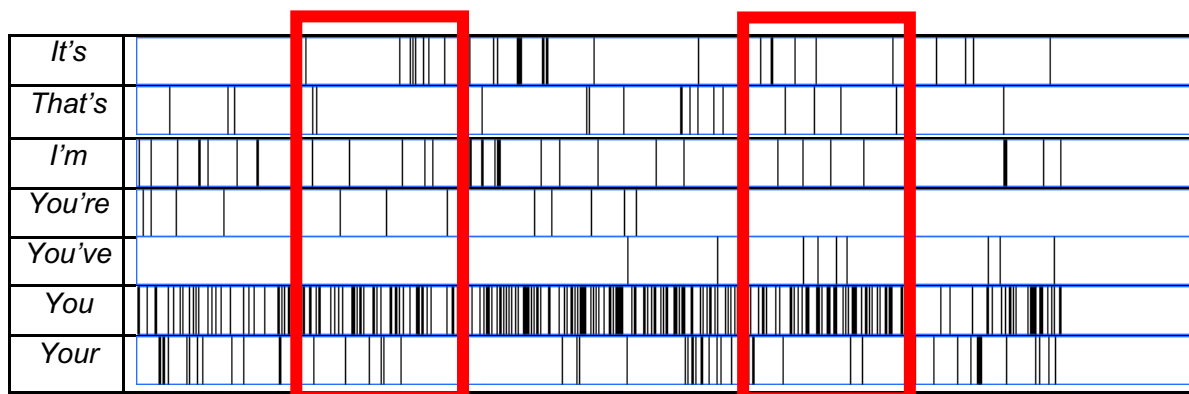


Table 5:1 – Concordance plots of the areas *Indicative*, *Pronominal Auxiliary Contraction* and *Deixis* for Scenario A

Once a specific area of the corpus has been identified, the researcher can then locate and examine this in greater detail by using AntConc's keywords in context tool. As I emphasised in Chapter 3 – and is the case with most corpus methods – there is still a degree of researcher interpretation involved in this process; to not only interpret the visual cross section of distribution and delineate the area of typicality within the corpus, but also as Louw

et al. (2014) point out, to identify relevant points in the raw transcription data at which to begin and end the analysis of the nebulous initial selection area.

For Scenario A illustrated above, for example, the first typified section of discourse initially encompassed the closing exchange of the first consultation of the corpus file and approximately the first quarter of the second consultation. For coherence sake, this dataset was adjusted so that it omitted the end of consultation one, instead beginning at the start of consultation two and extended slightly to take account of the diagnosis being conveyed to the simulator – thusly the candidate’s preparation towards breaking bad news could be analysed. This particular chapter will constitute two datasets from the collated datafiles of both Scenario A and Scenario B, after which, each dataset will be split into smaller extracts for the means of analysis.

5.1.2 The Perfect Day data

For the Perfect Day Corpus there are several additional details to take into account regarding the data: Firstly, in terms of practicality and extract selection, the PDC concordance plots comprise of four separate candidates and therefore areas with an atypical distribution of keywords that connote an idiolect at play will be avoided. (This is distinct from the CPC in which the concordance plots are based around particular sites and therefore contain only one clinician speaking throughout). Additionally, whilst I outline in Section 6.1 of the following chapter that elements of the patient’s discursive identity will need to be accounted for (in line with Bucholtz and Hall’s (2005) notion of a ‘relationality principle’ of identity), within the PDC analysis, this understanding is tempered by an acknowledgment that the simulators dialogic identity – whilst also contributing to that of the candidate’s – expressly functions to enact the pedagogical purpose of the simulation. That said, whilst their role is prescriptive in its aims and intent for the dyad (as Excerpt. 5.1 - from the simulators briefing of Scenario A demonstrates, below), there is of course an element of unfolding dynamism in each performance – not only between the two individual simulators who feature in the scenarios, but also between the individual simulator’s responses and

performances from candidate to candidate. Given these circumstantial factors within the Perfect Day dataset, the first extract analysis (sections 5.2 and 5.4) for each scenario will closely detail many of the design details of the simulation itself, providing a contextual backdrop for the forthcoming analysis.

You are now almost completely better having only mild weakness of your left leg and you are expecting continued and complete recovery. You are happy and optimistic that all is well. This view has been reinforced by the fact the hospital gave you no alternative opinion prior to your discharge. You assumed all is well and you expect to be given good news.

Opening statements:

- “You will be pleased to see I am now almost completely better, all of those tests weren’t necessary after all”.
- “The hospital said they would write to you, have you received the letter”?

Excerpt 5.1: *Perfect Day Programme, Information for Simulated Patients*

5.1.3 Linguistic focus

In Chapter 3 I hypothesised that the areas of primary language concern in the enactment of professional identities within these datasets would be pronominal lexis and various aspects of mood and modality. The inductive process of the methodology within this thesis has refined these assumptions in Chapter 4’s corpus analysis, illustrating how these hypothesised areas lexicographically exist within the dual datasets in a number of keyness trends. Whilst also demonstrating how intertwined these elements are with other aspects of language in the enactment of professional identity and thus reinforcing the need for an extended, discursive approach. The key areas have been applied to Bucholtz and Hall’s (2005) model to present a working notion of how identity exists within the datasets – providing the study with a series of thematic patterns with which an in-depth discursive pragmatic analysis can be approached.

The ensuing analysis in the following two chapters will be a close reading of extracts from both datasets investigating these key areas in a discursive context. The analysis will also contain contextual commentary of the consultations that will draw upon the ethnographic detail yielded for both datasets; therefore, addressing the interactions within their particular activity contexts (Linell and Thunqvist 2003). Overall, this discursive pragmatic approach should provide a richer insight into how the areas of significance identified from the corpus operate in their specific, long form context – also contributing areas as yet uncovered and undiscussed.

5.1.4 Notes on the data presentation

Whilst the data presentation within these discursive analysis chapters is largely in a case study format, these chapters adopt a consistent application of the following terminology in reference to the various levels of data reproduced here:

- **Datasets** are the initial keyness areas of the corpus identified by the Louw et al. (2014) method and outlined in the red boxes. There are four datasets per chapter (in the case of this PDC chapter, two per scenario) and they represent the largest level of data sample within the chapters.
- **Extracts** are the focused areas of datasets for the purpose of discursive analysis. Datasets are divided into approximately three extracts; however, this number varies depending on the length and lexical density of each dataset. Due to space constraints, some extracts contain ellipses – these are notated within the transcripts. The line numbering of each extract reflects the position of the extract in the original source consultation from which it is taken. Therefore, numbering is not always continuous as it illustrates where there are ellipses in the data presentation.
- **Excerpts** are any presented, relevant stretch of discourse smaller than an extract, usually from an additional source to the corpus data – such as the Perfect Day exercise literature

Consequently, the numbering conventions and structure for each section of analysis follows this pattern, for example:

1.1 Dataset X (Scenario Y)

Extract 1

Extract 2

Extract 3

Throughout the transcribed data of Perfect Day, the candidates are referred to by the epithet 'CAN' and the simulated patient as 'SIM'.

5.2 Dataset 1 (Scenario A) – *Prelude to breaking bad news*

To briefly recap, the Scenario A simulation involves a patient attending an appointment to ostensibly receive the results of a batch of hospital tests taken a few weeks prior on the authority of another GP at the practice. The tests were based upon the patient's reporting of intermittent pins and needles and unsteadiness in the previous six months. Whilst the patient believes they are getting better, the GP is tasked with delivering the news from the consultant's letter, which is a diagnosis of multiple sclerosis. As I identified in Section 5.1.1 previously, this keyness area has been slightly adjusted to exclude the end of the prior consultation and to include the point at which the candidate delivers bad news – this originally fell just outside of the marked area.

Extract 1:

[Not shown: initial greeting]

18 **SIM:** He said probably about a week or two but I

19 **CAN:** Mmm

20 **SIM:** Was quite surprised to be honest 'cos erm <0.5> I got a phone call from one of
21 the secretaries saying I've got an appointment with a rheumatologist is it <0.5>
22 er so I went up to see him he was really a nice chappy and erm <0.5> he had
23 me things doing things with me arms me legs and me balance and me eyes and
24 er <0.5> said they just wanted to double check on a few things so he said would
25 I mind coming in for a couple of days and er <0.5> I I said yeah I don't mind
26 <0.5> erm I think I had a brain scan erm <0.5> some blood tests took and <0.5>
27 and to be honest I had this really <1.0> er this needle in me back was <0.5>
28 really painful to be honest doctor

29 **CAN:** I'm sorry

30 **SIM:** And it gave me a <0.5> terrible head headache afterwards anyway <1.0> he's
31 yeah <0.5> everything seemed to go well and he said erm <0.5> he'll be in
32 touch with doctor <name> shortly and erm to come back for if any if there's
33 any results to be honest I nearly didn't come because erm <0.5> I'm more or
34 less back to 'ow I was and er <0.5> it's only 'cos me husband said no go go and
35 see what's what <0.5> that I'm here but er <0.5> as you can see I'm I'm all back

36 to normal <0.5> me leg's more or less <0.5> back to a hundred percent so
37 <0.5> life's good at the moment
38 **CAN:** Well that's a good thing that your leg is back to normal and you feel well in
39 yourself
40 **SIM:** Yeah
41 **CAN:** That that's great and reassuring <0.5> and erm you just said that you had been
42 to see a rheumatologist <0.5> was it a neurologist or a rheumatologist
[Not shown: CAN & SIM establish that it had been a neurologist]
60 **SIM:** He had a smile on his face and he said erm <0.5> erm like I say we'd like to
61 admit you for some more tests but he said not to worry and erm <0.5> to be
62 honest I've not been worried I <0.5> I feel like I've had a <0.5> overall check for
63 sort of <0.5> wasting time to be honest 'cos like I say <0.5> I feel back to normal
64 which is such <0.5> a nice relief to have

The consultation begins with a introductory opening sequence, although a seemingly mundane area of a non-simulated consultation, the simulator's responses (*morning doctor*: line 1, *I must admit you've got a full waiting room this morning*: line 3 – not shown) are contextually significant as they are immediately 'in character' and therefore denote that the simulation is underway. Roberts et al. (2000), Seale et al. (2007) and Thomassen (2009) have all observed that within simulated consultations there can be ambiguities around the framing of the exercise to begin with; initiating 'out of frame' greetings or meta-communicative acts between the participants to orient the interaction specifically towards the simulation. The utterances by the simulator here, therefore, allow the pedagogic context to be established from the very start. As can be seen from line 20 onwards, this early part of the consultation is largely dominated by the simulator and their explanations for attendance.

Within a 'real-life' consultation it might be expected that during this early area of the consultation the patient would explicate their reasons for attendance or outline a narrative of symptom discovery in a means that is 'doctorable' (Heritage & Robinson 2006: 58) – that is, presenting their concerns in such a way that they appear worthy of clinical attention. However, as is notable from both the extract at hand and the instructional excerpt from

Perfect Day (Excerpt. 5:1) presented on page 140, the contextual grounding of this consultation is almost a reverse of the 'doctorable' concept, in that the patient must portray that they believe their ailment is no longer worthy of medical attention; demonstrated most explicitly in lines 33-37 and 60-64.

I suggest therefore, that the starting point for the discursive identity of the simulator in Scenario A is one of contextual infelicity: That is not to suggest that the stance is entirely anomalous or unrealistic, but rather that a 'doctorable' response would be more likely to be relationally conventional, and as such, this contextual subversion is a key area of this particular Perfect Day exercise and its pedagogical challenge. Gill and Maynard (2006) for example outline three typical explanation and response sequences found within primary care dyads, all of which exemplify the patient as a generally co-operative participant in the consultation's unfolding.

Contextually therefore, it could be said that this opening provides a distinct set up which has subsequent ramifications for the candidate's performative identity. (It is worth noting however, that within the CPC consultations the 'doctorable' concept is not as relevant, as many of the consultations are for obligatory purposes such as annual medication reviews. I suggest what makes the concept especially pertinent to the PDC consultations is that they deal with cases of serious illness and that the consultations have been ostensibly initiated by the patients).

As the simulator narrativizes her treatment history, the candidate offers an apology in line 29, which could be alternatively typified from Chapter 4's findings as an empathy token or as an institutional apology – thus illustrating Buckman's (1984) notion of medical apologies as ambiguous. Given the contextual placement of this apology in the ongoing exchange however, I suggest that it primarily serves an institutional function in the assumption of responsibility for the procedure causing pain. And as such, the integration of this apology usage within the candidate's professional identity indexes particular tenets of professional group membership; notably the status and ability of the candidate to apologise on behalf of other areas of the healthcare institution.

This is followed by another construction identified from the keyword corpus analysis as the candidate offers their general epistemic judgement – qualifying the *states of affairs* – on the experiential narrative of the patient in lines 41 (*that's great and reassuring*) and 44 (not shown). Whilst it may be tempting to view the simulator-dominated opening of this consultation in light of research findings that indicate simulators generally speak more in simulated consultations (de la Croix and Skelton 2009) creating a reversed asymmetry, I suggest that given the setup of the scenario – a locum doctor recapping a number of symptoms and subsequent tests over a significant length of time – that the discursive prevalence of the simulator is contextually unproblematic at this early point of the consultation.

Extract 2:

- 65 **CAN:** Ok
- 66 **SIM:** So life's quite good
- 67 **CAN:** With this being going on for such a long time <0.5> did you have any thoughts
68 as to what this could be
- 69 **SIM:** You know what I thought it was and I still think it is as well I think I trapped a
70 nerve somewhere <0.5> and erm <0.5> I know sometimes I they can be a
71 bother to heal <0.5> you know what I mean they can take quite a long time to
72 and I think that's what I <0.5> I did and I think it's just coming back to normal
73 now
- 74 **CAN:** Ok
- 75 **SIM:** So er <0.5> it's nice to have some nice news 'cos erm <0.5> it's been a <0.5>
76 pretty erm <0.5> crap year a couple of years for me and my husband <0.5>
77 you know what i mean me mum had breast cancer so
- 78 **CAN:** Sorry
- [Not shown: SIM details mother's illness]*
- 108 **CAN:** So with all this going on er what were you worried about it you know you said
109 that you thought it <0.5> could be a trapped nerve but anything in particular
110 that worried you
- 111 **SIM:** No I thought that'd correct itself and I think er given time it I think it has
112 corrected it self

113 **CAN:** Yeah

114 **SIM:** And er in many ways I know I was time-wasting going up to the hospital

115 **CAN:** <clears throat>

116 **SIM:** But he gave me a little bit of reassurance cos not everyone gets brain scans
 117 and everything so er <0.5> yeah so I'm least I know I'm good for the next few
 118 years anyway doctor <0.5> so

119 **CAN:** Ok <0.5> and er <1.0> did you have any thoughts how we could help you
 120 today

121 **SIM:** No to be honest I <0.5> like I say I nearly didn't come because I feel so well
 122 and erm <0.5> sitting out there listening to everybody else's ailments I feel a bit
 123 of a fraud so er <0.5> no there's nothing you can do for me today doctor and
 124 like I say it I've got plenty to do today myself so I won't waste any more of your
 125 time <SIM gets up to leave>

126 **CAN:** No not all we need to go so <0.5> er the reason for you coming in here today
 127 was sorry I couldn't get that

128 **SIM:** Er just to get erm <0.5> I suppose just a <0.5> a con- er the end to the er
 129 scheduled meeting some results I if there was any results you

130 **CAN:** Ok <0.5> right

After the simulator has established the conditions of her attendance in the opening of the dyad, in lines 67-68 the candidate requests the simulator share her thoughts on what the underlying problem might be. My colleagues and I have labelled dyadic formulations such as those in lines 67-68 as 'invitations to input' (ITI) (Emerson et al. 2020); a means by which the clinician can build rapport and discursively enact patient centrism via interrogative elicitation of thoughts or attitudinal assessments of the condition at hand. Notably, ITIs were not apparent in the initial corpus-based analysis of Chapter 4, possibly because they are not tied to a precise linguistic form or construction. Generally, they are dynamically enacted around a variety of *wh*-interrogatives, such as in lines 67-68 and therefore are more easily discerned from a close discursive reading of the data. As both this chapter and our previous work will attest, ITIs are recurrent throughout the Perfect Day consultations.

The dialogic exploration of patient concerns in ITIs directly accords with elements of the Calgary-Cambridge model (Silverman et al. 2005) of consultation – such as points 17

and 18 in the establishment of the patient perspective – as well as the RCGP’s own knowledge and skills guide to consultations. These interrogative constructions, therefore, are tied to a specific clinical function within the consultation as well as being a tool for potentially building rapport within the dyad.

Nonetheless, I wish to suggest that in terms of professional identity, ITI constructions such as the example in lines 67-68 – in their enaction of a patient centric approach – form a discursive token of the clinician sharing an epistemic stance within the consultation. In the model of dyadic pronominal typicality suggested by Skelton et al. (2002: 487) consultations could be characterised as; patient: ‘I suffer’, doctor: ‘I think’, both: ‘we act’. The invitation contained within an ITI is a notable instance of deictic, pronominal attention being explicitly reversed, placing epistemic agency with the simulator. Albeit, this in a manner that retains the preconceived idea that a patient’s epistemic stance within the dyad is primarily experiential or attitudinal modes of knowing, whilst that of the clinician is principally evaluative – or, as the keyness for this research has shown, to index and comment on *states of affairs* presented to them.

Significantly, the patient’s explication of their ideas and exploration of various details of their life in response to the ITI meets with backchannels and minimal affirmation tokens from the candidate (lines 78 to 107). The candidate’s minimal input here could be interpreted as allowing the simulator to take the floor, or alternatively, could be a case – as de La Croix and Skelton (2009) suggest – of a simulated patient talking more and exerting conversational dominance in the exercise. The subsequent questioning by the candidate in lines 108-110 echoes Boyd and Heritage’s (2006: 164) notion that clinical questions, in their wording and construction, can ‘embody the concerns and understandings of the physician’; in so far as the candidate’s attempts to elicit the simulator’s concerns runs contrary to the simulator’s unconcerned and non-‘doctorable’ identity (lines 72-73, 75, 111-112 and 121-125).

The candidate’s mentioning of *anything in particular* therefore functions as a weak relational implicature that the simulator’s assertion of her health *coming back to normal now*

(lines 72-73) is potentially inaccurate. That the simulator chooses not to express any further concern at this point, instead reinforcing the position that everything appears *normal* (even suggesting that the hospital visit was a waste of time in line 114) could be interpreted in two ways: Firstly, as a contextual detail that is part of the pedagogical architecture of this particular scenario and therefore designed to test the candidate's consultation skills. Otherwise, that because the candidate has yet to establish any notable epistemic stance towards what the symptoms *are* at this point of the consultation – engendering a, so far, purely exploratory consultation – that the simulator has reacted in accordance with their own assumptions being correct. In essence, the candidate's diminished epistemic stance, confined so far to the affirmative generalities of line 38 and 41's *that's a good thing, that's great* has been relationally interpreted in accordance with the simulator's own infelicitous identity.

The ITI phenomena reoccurs in lines 119-120, this time with the candidate invoking an institutional, medical *we*; again, offering epistemic agency / agenda setting to the patient via the modalized *could help you*, in a manner that appears incongruous with the simulator's preceding utterance. The utilisation of what may seem to be stock, or formulaic interrogatives in this extract aligns with Atkins' (2018: 19) idea that – whilst stock constructions in themselves are not inherently problematic to the dyad – their contextual deployment is key to their successful functioning. As such, the ITI in lines 119-120 appears to suggest that the candidate has not taken account of the simulator's non-'doctorable' identity and has instead indexed her as a patient presenting a concern. The candidate's use of the ITI in lines 119-120, is ostensibly so inharmonious to the provision of a diagnosis that by line 121 onwards the simulator attempts to leave the consultation early – reading the candidate's affective questioning (and accordant lack of epistemic commentary on the condition) in line with her assertion that everything is *back to normal*.

Correspondingly, in lines 126-127 the candidate has to backtrack and re-establish the simulators reasons for attendance, leading to a precarious instance (delivered as the simulator sits back down) where the frame of the simulation itself is navigated by both

participants. Following this re-establishment of the consultation, the candidate follows up the ITI with a set of standard lifestyle questions; this is responded to by the simulator talking about her life and the holidays that she and her husband have planned, extract three begins immediately afterwards:

Extract 3:

- 169 **CAN:** Ok so <0.5> now I've had a chat with you <name> <0.5> and now I want to
170 tell you about the letter which the neurologist has sent us after having
171 investigated you so thoroughly
- 172 **SIM:** Yeah
- 173 **CAN:** Yeah because you had all these problems and things <0.5> so er I have to
174 discuss this letter with you alright
- 175 **SIM:** Yeah
- 176 **CAN:** Ok <0.5> so er I it's very good that all your symptoms are getting better I'm so
177 happy to see you today in such a good
- 178 **SIM:** Mmm
- 179 **CAN:** Mood and everything <0.5> but the the letter <0.5> has got some er news
180 which is not really good
- 181 **SIM:** Really <0.5>
- 182 **CAN:** Alright it it tells us about the condition you have
- 183 **SIM:** Are you sure you've got the right letter doctor I mean I know I've not seen you
184 before but <0.5> are you sure you know <0.5> who I am and you've got the
185 right letter
- 186 **CAN:** Yeah I I it's <name> isn't it
- 187 **SIM:** Yeah
- 188 **CAN:** Yeah we've got the right letter <0.5> and er <0.5> I it's not all that bad
- 189 **SIM:** Oh good
- 190 **CAN:** So I just need to discuss that with you so but <0.5> but it's it's to tell you
191 about what problem you have so would you want er <0.5> sort of <husband>
192 to be here when I discuss this with you or do you want <0.5> me to go
193 through the letter with you
- 194 **SIM:** Why would I want <husband> <0.5> why would I want <husband> <0.5> you
195 know what I mean is it just the trapped nerve
- 196 **CAN:** Er it's it's it's a bit more than a trapped nerve I'm sorry to say that <2.0>

197 **SIM:** Well what do you what do you mean by that doctor
198 **CAN:** Er <0.5> I do you want me to go through it
199 **SIM:** Well I want to know <0.5> what you mean by it yeah
200 **CAN:** So <0.5> er <0.5> I I it's a have you heard of a condition called multiple
201 sclerosis at all
202 **SIM:** Yeah I have and er to be honest <1.0> when I have <0.5> heard of that <0.5>
203 I've seen everybody in wheelchairs <0.5> who seems to have that problem
204 well what's that got to do with me
205 **CAN:** Erm I'm sorry to say that <0.5> but <0.5> the test results and the specialist
206 who has seen everything <0.5> he thinks it could be multiple sclerosis
207 **SIM:** Thinks <0.5> I think he's wrong there ducky <0.5> if he only thinks you know
208 what I mean
209 **CAN:** He he I think he er <0.5> the findings are
210 **SIM:** He's got it wrong ducky
211 **CAN:** I <0.5> I I I wish
212 **SIM:** You can see I'm
213 **CAN:** It was wrong but I think he has said that it the findings are pretty consistent
214 with the diagnosis <3.0>
215 **SIM:** Well if that's true my life's done with ain't it
216 **CAN:** It's not it's not that bad you know <0.5> because at the moment you're quite
217 well in yourself and these days a lot of treatments that are available <0.5> I
218 know it has come as a shock to you <0.5> but these days you know things
219 have changed it could not be that bad multiple sclerosis <0.5> comes in all
220 different forms you know <0.5> there are a few things <0.5> that are not that
221 bad there are <0.5> sometimes it can be just a mild one
222 **SIM:** So I won't be in a wheelchair
223 **CAN:** It's a it's very difficult to say but if we look into it now and look at the treatment
224 <0.5> see what type it needs lot more investigation <1.0> I'm really sorry
225 <12.0> I see it's a big shock <0.5> and er <0.5> there's a there's a lot going
226 on <0.5> and it's I'm not the I'm not <0.5> you know I'm not a specialist to
227 go through <0.5> each and every thing but we do know that there are various
228 forms of multiple sclerosis <0.5> some are mild ones and they can settle
229 <0.5> and now with the new treatment you know <0.5> there are many new
230 treatments available that can help <7.0>
231 **SIM:** I want to go home doctor
232 **CAN:** That's fine

In lines 169-171 the candidate demarcates an explicit transition between the preceding exploratory section of the dyad, to the area they have ostensibly set aside for the diagnosis, via the metacommunicative *now I've had a chat with you*. Suggesting that the candidate views these two components of the consultation as distinct in their undertaking and intent. Markedly, the diagnosis is metonymically objectified as *the letter* and attributed to an agent external to the dyad – again diminishing the candidate's own epistemic stance towards the diagnosis. As Peräkylä (2006: 217) has observed, clinicians 'adapt their ways of delivering the diagnosis to the availability of evidence' and here the candidate focuses primarily on the diagnostic agency contained within this official, external record.

In this discursive establishment of themselves as merely a conduit to the diagnosis, the candidate also collectivises the GP practice itself as a passive agent; *which the neurologist has sent us*. The discursive framing of *the letter* as the principle epistemic authority within the consultation is also reinforced in line 182's *it tells us about the condition you have*. However, this epistemic evasion is not unusual in cases of bad news as Maynard (2003) suggests, noting that clinicians often 'eviscerate displays of their agency and responsibility' in the delivery of bad news in order to avoid blame. Whilst blame, or the uncomfortable aftermath of bad news may be a principal motivation in this discursive distancing, I suggest that the externality of *the letter* also functions in this instance as a means to create patient-centric alignment between the interlocutors – especially in context of the *chat* just prior to this area of bad news delivery.

That the candidate doesn't address specifics of the diagnosis (instead utilising vague language in line 173 and a general affirmative comment on the simulator's health in line 176) at this point is, however, contextually unsurprising: Firstly, the letter itself expressly details that the patient has an appointment to see the neurologist in four weeks to discuss the diagnosis. And secondly – as a number of candidates noted in their initial interviews and debriefs – as a junior doctor, they might not feel fully equipped to extrapolate the prognosis confidently to the simulator.

As the candidate begins to signpost the diagnostic bad news at hand – once again with a specific focus on the letter as a proxy for the diagnosis (*has got, it tells us*) – in lines 183-185 the simulator establishes a direct challenge to the candidate’s epistemic stance in the dyad: Notably, this is a pedagogic function built into the characterisation of the simulator within the scenario, in order to convey the extreme sense of disbelief that may arise (see the document ‘Perfect Day Scenario A – Notes for Simulated Patient’ in the data repository). Also prescriptively written into the simulation is the simulator’s challenge for clarity in lines 197 and 199. Although these statements of disbelief are design features of the Perfect Day exercise, it is worth noting that Heath (1992: 264) reports that typically patients offer only minimal responses to clinician’s diagnostic statements.

Once the candidate has reasserted the direction of the consultation and permission to proceed with diagnosis, he directly indexes the patient in order to ostensibly garner their understanding of the condition (line 200). While this is an interrogative means of pursuing and promoting understanding within the consultation in accordance with the Calgary-Cambridge model (Silverman et al. 2005), it also functions as a relevance principle implicature; introducing the diagnosis to the simulator by establishing their own comprehension of the condition, without yet directly attributing it to them.

Following this indirect introduction of the condition, in line 205 the candidate uses a self-referential meta-apology formulation such as those identified in Chapter 4 Section 4.3.2, softening the revelation of the diagnosis to the simulator. Maynard (1996: 115) has suggested that ‘leading apologies’ such as the one in line 205 are frequently utilised as a means of ‘forecasting’ the delivery of bad news. Once finally delivered, the diagnosis is also minimised via the candidate’s use of *think* and the modal *could*. Given the infelicitous stance taken by the simulator, the candidate’s use of *think* as a mitigated epistemic claim within these utterances is combatively interpreted as a scalar implicature; in which a stronger knowledge claim has purposefully not been used by the candidate, because there is uncertainty towards the diagnosis. This is demonstrated by the simulator’s reported speech in line 207 that begins another challenge to the certainty of diagnosis that the candidate has

presented, forcing them to re-formulate and concretise the diagnosis as *the findings are* twice (line 209 and 213). The crucial role played by vague language in clinical dyads is also illustrated in lines 213-214, whereby – when pressed by the simulator – even the candidate’s strongest assertion of the diagnosis is formulated in the diminished *pretty consistent with*. This accords with Peräkylä’s (1998: 305) position that clinicians use elements of evidentiality to discursively point towards the basis of conclusions, rather than making unequivocal and ‘direct descriptions of reality’; as well as Prince et al.’s (1982) notion that imprecise formulations render suggestions of ‘plausible reasoning’ into a statement.

This mood of ambiguity continues following the delivery of the diagnosis, with the candidate making generalised comments on the simulator’s health in lines 216-217 as well as illustrating a homogenous and imprecise prognosis of multiple sclerosis. As Buchsbaum (1986: 426) highlights, reassurance is a key component of managing uncertainty and alleviating any potential anxiety for the patient. And whilst this particular instance is not successful – with the simulator taking this affective stance infelicitously as an implicature of general reassurance by the simulator (line 222) and forcing the candidate to take a more targeted epistemic stance (line 223) – the dual epistemic and affective components of reassurance are critical within other datasets in this chapter and will be discussed more comprehensively there.

Buckman (1984: 1598) has argued that, the more junior a clinician, the harder it is for them to state that they *don’t know* an answer to a question posed by a patient; a facet that has clear implications for performative identity within this data, given that all the candidates’ status as trainee general practitioners. This particular candidate navigates their own hesitancy in line 223 by utilizing a meta-communicative formulation identified in the keyness score of Chapter 4 (*it’s very difficult to say*), that indexes, again, the lack of certainty present in regard to the diagnosis. Following this, the candidate explicitly diminishes themselves as a non-expert through the declarative *I’m not a specialist to go through*, abating their epistemic stance towards the diagnosis further. This is important to note in terms of identity and asymmetry as Peräkylä (1998: 303-4) has suggested that patients orient towards the

'doctor's accountability for the evidential basis of the diagnosis' as much as they do the professional authority of the clinician.

Dataset 1 (Scenario A) – Summary

To recap, Dataset 1 from the PDC has demonstrated that the delivery of bad news is – as Brown et al. (2006: 155) highlight – a 'complex management of identity and agency' for the candidate. Within this extract, the candidate appears to purposefully curtail their own epistemic stance – and accordant professional identity – through use of ITI formulations that dialogically share the assessment of knowledge within the dyad. Additionally, the candidate variously presents the diagnosis as external to both himself and the simulated GP practice; diminishing his agency and responsibility towards the diagnosis in a manner that has already been documented in primary care research (Maynard 2003).

I suggest that these various factors are the candidate's attempts to discursively enact an egalitarian and patient-centric consultation. Indeed, the enaction of a patient-centric approach was seen as paramount in this candidate's feedback during the post-consultation debrief, and his metacommunicative demarcation of the early consolation as a *chat* perhaps suggests the primacy of this affective approach, albeit one that is seemingly unintegrated into the remainder of the consultation. This overtly patient-centric approach may also be a demand characteristic of undertaking the exercise itself as a number of prior studies of medical simulations have suggested (for example, Roberts et al. 2003).

The minimal professional identity conveyed by this candidate – indexed primarily via occasional institutional apology and basic *states of affairs* statements – creates a space in which the simulator is allowed to dominate the consultation; meaning that areas of imprecise vagueness, often characteristic of medical encounters (Adolphs et al. 2007), and conversational implicature are sites in which the simulator can challenge the candidate. Conversely, the candidate's own subtle implicatures in regard to the seriousness of the condition are not acknowledged in a felicitous and doctorable manner by the simulator.

Contextually, there may be a number of reasons for this; as de la Croix and Skelton (2009) have observed, simulated patients tend to talk more than real patients, or, as my colleagues and I have suggested (Emerson et al. 2020), it may be the status of this particular Perfect Day scenario as a challenging pedagogical exercise. Alternatively, the unfolding discourse within this extract could be attributed to Peräkylä's (1998: 303) notion that patients orient towards dialogic accountability for knowledge within dyads, alongside professional authority. Because this candidate conveys no personal epistemic certainty towards the diagnosis, this perhaps lessens their professional authority for the simulated patient.

5.3. Dataset 2 (Scenario A) – Explaining the diagnosis

The next dataset identified from the Scenario A sample initially covered an area of Consultation 33A; from shortly after the delivery of diagnosis, to almost the end of the consultation. For analysis purposes, this was adjusted to include the delivery of diagnosis at the beginning of the extract (in order to give context to the proceeding discourse) and lengthened slightly to include the very end of the consultation. The consultation within this dataset includes the same simulator as Dataset 1, albeit with another Perfect Day candidate. Prior to Extract 1 of this dataset, the candidate has administered a number of lifestyle questions against the backdrop of the simulator's concern regarding the test results. The extract begins in line 127 as the candidate establishes with the simulator that the tests were requested by the previous doctor because of the concerns over the patient's symptoms. Although, the exchange has also identified that this was not fully explained to the simulator at the time:

Extract 1:

- 127 **CAN:** Yeah <0.5> so erm <0.5> what I've got here is your brain scan result
128 **SIM:** Ok
129 **CAN:** Ok <0.5> erm <1.5> it isn't it isn't quite normal
130 **SIM:** What do you mean it's not quite normal
131 **CAN:** Erm the brain scan results shows that you have got something we call as
132 multiple sclerosis <0.5> it's a fancy term but have you heard about it <1.0>
133 **SIM:** Yeah I think everybody's heard of it
134 **CAN:** Ok <0.5> what do you know about it
135 **SIM:** Ah well <unclear> I watched this programme on it <0.5> I mean it was a very
136 sad programme this person ends up in a wheelchair it's life changing <0.5>
137 you're not saying that's what I've got <1.0>
138 **CAN:** Unfortunately <0.5> the scan does suggest <0.5> that you know <1.0> it is
139 the scan is consistent with some changes <0.5> that suggest its er that it
140 could be multiple sclerosis
141 **SIM:** So that episode with my leg <0.5>

142 **CAN:** Mmm
 143 **SIM:** Is that going to happen again <0.5>
 144 **CAN:** It's difficult to say whether it's going to happen again or it's er going to stay
 145 calm <0.5> ok would you like to tell you a bit more about multiple sclerosis
 146 what it is <5.0>
 147 **SIM:** I just need time to just take it in <0.5> are you sure
 148 **CAN:** Yes <1.0> I'm really sorry that I have to tell you this <7.0>
 149 **SIM:** And you're saying the that the other GP knew this <0.5> or suspected it
 150 **CAN:** He didn't know this or he hasn't written that he suspected this but he was
 151 concerned with your leg and erm that's the reason he called the erm
 152 specialist at the hospital to take his advice <1.5> and that from where er the
 153 investigations started from

To facilitate the diagnosis delivery the candidate introduces the consultant's letter in line 127 – one of two contextual, informative props within this particular scenario that provide background information for the candidate in lieu of an electronic patient record (EPR) within the consultation. To seemingly minimise the impact of the diagnosis, the candidate utilises a scalar implicature in line 129 (*it isn't quite normal*) to broach the results contained within the letter. Given this idiomatic construction, this utterance immediately receives a call for clarification from the simulator (line 130), forcing the candidate to state the diagnosis explicitly in the following line. The condition is markedly presaged in the metacommunicative *something we call* which utilises the collective, institutional medical *we* to introduce the condition via its technical terminology, whilst also diminishing this specialised form as *fancy*. A formulation such as this arguably both reinforces the professional in-group identity of the candidate, whilst also portraying discursive consideration for the simulator as a lay participant.

As the candidate attempts to ascertain the simulator's understanding of the condition (lines 131-140), the diagnosis itself is also delivered in a hedged manner – directly comparable to the example in Dataset 1, previously – ascribing agency to *the scan* that *suggests* consistency with a multiple sclerosis diagnosis. Once again, this illustrates the key role played by vague language in healthcare delivery; especially where the diagnosis

pertains to symptoms that present as a cline. Notably however, whereas the previous candidate in Dataset 1 dialogically presented *the letter* as an externally-authored dyadic authority and therefore a proxy for their own epistemic stance within the dyad, here this candidate reports *the scan* from his own deictic centre, combining the equivocal *scan does suggest* with their own evaluative *the scan is consistent with*, therefore foregrounding their own epistemic stance towards the diagnosis.

When the simulator asks for more specific details (lines 141 & 143), the candidate's metacommunicative evaluation is also exactly the same as that of the previous candidate (*it's difficult to say*) further demonstrating the keyness of the *it's + difficult* construction in the PDC and perhaps also illustrating that this is a formulaic response deployed by this cohort in scenarios of uncertain prognosis. The function of this construction as a 'plausibility shield' (Prince et al. 1982) for the candidate is clear, and in this respect, the *it's difficult to say* construction guards the candidate against taking an explicit position of epistemic paucity in this area of the dyad; a stance that may be seen as especially problematic given the pedagogical context of the exercise.

The candidate follows up by inviting the simulator to hear a more generalised account of the condition rather than details pertaining to the simulator's specific prognosis, and although this is rejected by the patient in line 147, it discursively indexes that epistemic accountability is available within the dyad. In confirmation of the diagnosis (line 148) the candidate utilises a meta-apology – a comprehensive discussion of these constructions will follow within the next section. Immediately after this area of the dataset, the candidate and simulator briefly discuss the patient's ability to drive following the diagnosis, Extract 2 of this dataset picks up following this discussion:

Extract 2:

156 **SIM:** If I can't drive I can't work <2.0> ooh this is huge <4.0>

157 **CAN:** I can see it's a very difficult situation at the moment <1.0> but there are lots of

158 ways you know we can work around and there's lots of things that can be
159 done <1.0> you look very you look quite shocked at the moment <1.5>
160 **SIM:** It's you know all our plans <0.5> have just pfft <1.0> I had no inkling
161 **CAN:** I'm sorry
162 **SIM:** I had no inklings <0.5> I need to ring my husband <2.0>
163 **CAN:** You've just mentioned plans <3.0>
164 **SIM:** He was going to retire next year <1.5> travel the world <0.5> I've got no
165 children no ties and now this
166 **CAN:** You can still do that
167 **SIM:** It's not going to be the same though is it
168 **CAN:** Er well let me explain to you erm er is it ok if I call you <name>
169 **SIM:** Yeah to be fair <0.5> I appreciate you trying to be but <0.5> I've got I've got to
170 just take this on board
171 **CAN:** Mmm
172 **SIM:** I've got to digest what you just told me <1.0> what I would like to do is ring my
173 husband and
174 **CAN:** sure
175 **SIM:** And I'll make another appointment
176 **CAN:** Sure sure we can certainly
177 **SIM:** Yeah
178 **CAN:** Organise another appointment and we can sit and talk together
179 **SIM:** Because I'm not going to be able to take in what you're saying <1.0> I'm not
180 having a go at you
181 **CAN:** No no that's fine
182 **SIM:** I've just got to
183 **CAN:** I absolutely appreciate that it's er <0.5> ah shocking news for you <2.0>
184 **SIM:** Right ok
185 **CAN:** But <0.5> would you like me to tell you basically what I know you've seen a
186 programme of the wheelchair but would like me to tell you how to treat it and
187 how things can
188 **SIM:** Not today
189 **CAN:** Not today certainly
190 **SIM:** Have you got a leaflet or anything
191 **CAN:** I do have a leaflet and I can

Lines 157-159 reveals two more instances of the candidate deploying evaluative utterances that comment on the *states of affairs* within the consultation. Whilst Cleland et al. (2013: 86-7) view evaluative formulations such as those in lines 157-159 as having a phatic, small-talk discourse function within clinical encounters, instead, I propose that they are a fundamental element of professional discursive identity within this dataset; a dialogic token of an epistemic stance within the dyad, that utilise realis moods to position the candidate as, what was termed in Chapter 4, a 'credible evaluator'. An alignment to a temporary discursive role in line with Bucholtz and Hall's (2005) notion of positional identity.

Although the instances in lines 157-159 are fairly typical epistemic-based examples of how this has already been identified and discussed within the corpus analysis of Chapter 4, line 166 contains an example of the deontic aspect of the phenomena, in which the candidate's adjudicative pronouncement outlines the allowable actions of the patient. In Scenario A especially, these evaluative constructions contrast directly against areas of diagnostic vagueness (for example; line 144), giving the candidate an opportunity to express certainty in an otherwise uncertain context. And as previous research has attested (for example, Atkins 2018: 19), a tendency towards modes of performative validation such as this, may be a product of the candidate's orientation towards utterances that exaggerate idealised versions of the professional role.

Despite the affirmation in line 166 not receiving full accord from the simulator, the candidate endeavours to provide the simulator with a more comprehensive explanation in line 168. The self-referential *let me explain* formulation to introduce this perhaps connotes permission being requested but is primarily a rhetoric strategy that alerts an interlocutor that the speaker is about to introduce an area of importance. This is also accompanied by a metacommunicative request for informality (*is it ok if I call you*), further suggesting that the candidate is seeking to alleviate the exchange in a patient-centric manner. However, in lines 169-170 the simulator hastily curtails any chance for the candidate to expand on the condition and therefore restricting their possibility of further explication within the dyad. Whilst this may also appear to be another challenging situational design element of the

exercise, the scripted brief for the simulator (see Excerpt 5.3, below) outlines that they should request a further explanation from the candidate. This is, therefore, seemingly a characterisation of disbelief by the simulator that perhaps unwittingly belies the scripted intent of the simulation exercise.

Once you have accepted the diagnosis you will enquire about the treatment possibilities.

- “Research is being done all the time, they must have found something that works by now

Excerpt 5.2: *Perfect Day Programme, Information for Simulated Patients*

By line 179 the simulator has outlined their reasons for not wanting the candidate to expand upon the condition, using the colloquial, negated *I'm not having a go at you*. This metacommunicative act, although ostensibly mitigating a potential insult or face threat, arguably does so whilst also implying that there may be reason, or the speaker may have indeed intended, some form of criticism in the utterance. (a comparable concept here would be Lakoff's (2004) notion of frame negation in which a frame is 'activated' by its negation – i.e. the simulators negation of *having a go* in fact activates a frame of potential insult within the hearer) Nonetheless, the candidate persists in attempting to provide more information to the simulator, albeit phrased in the modal interrogative *would you like*. Although this offer appears to have patient-centric intentions, its rejection once again (line 188) perhaps demonstrates that the candidate's alignment to an information-provision role (and therefore a favouring of an epistemic, rather than affective stance) is perceived as incongruent to the simulator. Again, in taking account of the activity context, it is worth noting that this goes against the characterisation of the patient outlined by the Perfect Day literature.

The final extract of this dataset continues immediately after Extract 2 and runs to the end of the consultation:

Extract 3:

- 192 **SIM:** I'll just make an appointment I think erm <0.5> to be fair I don't think I wouldn't
193 take it anyways I need my husband here
- 194 **CAN:** Yeah
- 195 **SIM:** <unclear> he is <2.5>
- 196 **CAN:** Do you want me to call him or
- 197 **SIM:** No <0.5> I need <0.5> thank you
- 198 **CAN:** Yeah
- 199 **SIM:** No <0.5>
- 200 **CAN:** Would you like to take some rest before you go or
- 201 **SIM:** Need to escape really I understand
- 202 **CAN:** Mmm
- 203 **SIM:** I wasn't expecting this
- 204 **CAN:** I'm really sorry I have to bring this up and I have to
- 205 **SIM:** It's not your fault is it
- 206 **CAN:** Bring this news to you
- 207 **SIM:** So <3.0> I'll just make another appointment
- 208 **CAN:** Sure <0.5> I can give you a leaflet now that you can you know <0.5> obviously
209 discuss
- 210 **SIM:** Will I see you again I don't want to have to see another doctor
- 211 **CAN:** You've got an appointment with the specialist who erm did the scan um that's
212 the neurologist the brain specialist so they've organised an appointment for you
213 should be in a week or so and they should be able to talk to you in more detail
- 214 **SIM:** So should I see them first
- 215 **CAN:** Yes it will be a good idea once you've seen them you know we can meet up
216 again and have another chat <0.5> erm when your husband is also with you we
217 can discuss things further you know <1.5> how does that sound to you <2.0>
- 218 **SIM:** Ok so once I've been to the hospital I'll make an appointment here
- 219 **CAN:** Yeah <2.0> but let me just reassure you <0.5> it is a very much treatable
220 condition there are lots of things that can be done and there are many things
221 that can be done to help er um you know with your symptoms <3.0>
- 222 **SIM:** Right <0.5> ok
- 223 **CAN:** Ok take care bye-bye
- 224 **SIM:** Bye

Both extracts 3 and 2 from Dataset 2 also demonstrate the challenge of dialogically managing external agents and temporality in medical simulations – in this case, the potential introduction of the husband into the consultation, alongside the temporal establishment of the appointments and action plan following the consultation.

As I highlighted previously, the simulation only contains the consultant's letter ostensibly outlining the diagnosis and requirement for the simulator to attend a follow-up appointment at the hospital, alongside a brief outline of the simulator's medical history. There is no computer, nor EPR, to which the candidate can refer or utilise. Not only are EPR's contextually integral to the delivery of modern healthcare (Pearce et al. 2011 & 2012), they also can propagate a collaborative function in the dyad (Lenert et al. 2014) which has ramifications in terms of potential asymmetry. As Chapter 4 illustrated, by way of contrast, the EPR features heavily in the clinical pharmacy consultations – to the extent that it allows the CP to project triadic epistemic stances. Arguably the omission of an EPR, therefore, forces the candidate into greater discursive work to maintain the veracity of the simulation as it closes (for example, lines 200, 208, 215-217). The lack of immediate contextual detail on which to convincingly base either sufficient closings or action planning may also – in part, at least – account for the relative paucity of unrealis moods within the PDC.

It should be noted however, that this contextual obstacle is often far more pronounced in the PDC data than it is within this consultation. In this particular extract, the candidate manages to deploy a basic action plan (lines 211-213, 215-217), despite the confusion over whether the husband should be called. As I previously noted in this chapter, numerous work has highlighted the difficulty often found between the simulator and candidate in defining and creating the beginning of the role play within a simulation. Conversely, de la Croix and Skelton (2012: 55) have demonstrated how medical students can lose control of a simulation as it closes. If we were to adopt a Goffmanian metaphor, it could be said that it is beginnings, endings and externalities where the 'stage' of simulation can be most fractious, which may itself have implications for the ability of the candidates to render a complete identity performance.

In line 204 the candidate proffers a meta-apology once again; as I highlighted in Chapter 4 Section 4.3.2 these constructions ostensibly problematize the discursive endeavour at hand. Buckman (1984: 1598) has previously emphasised the difficulty of medical apologies, in their traversing of the delicate balance between sympathy and the acceptance of responsibility towards patients. This precarious balance is highly noticeable within meta-apology formulations such as line 204, in which the candidate attempts to pragmatically convey tenets of sympathy whilst simultaneously apologising for their own, professional role in causing distress for the patient. As Buckman suggests (ibid), apology contains the potential for a patient to cast blame upon the clinician and therefore requires skilful navigation. In the instance within this extract, the candidate's apology elicits an absolving response from the simulator, which accordingly brings about questions of a potentially reversed asymmetry within these simulated consultations (Hanna and Fins 2006).

The closing exchange (lines 219-221) illustrates the candidate's commitment to an epistemic stance in the dyad, his alignment to the role of information provider, and indeed how this differs from the previous candidate's (Dataset 1) discursive portrayal of uncertainty and epistemic agency existing outside of the dyad. The contribution of expert information is a key juncture where the lay-professional divide is most explicitly navigated, and accordingly, where asymmetry is most perceptible between the interlocutors. The ambivalent reaction to expert knowledge here however, either connotes that the offer has been seen as incongruent in accordance with the simulator's portrayal of disbelief, or indeed, is another element of the simulator's infelicitous approach; denying the candidate an opportunity to discursively enact an overt display of knowledge.

The *let me just reassure you* construction in line 219 ostensibly seeks to minimise the perceived consequences and impact of the illness for the simulator. As numerous primary care-based research has shown (see for example, Kessel 1979, Girolodi et al. 2014(a) & (b)) the conveyance of reassurance is an important aspect of the clinician's discursive work within the dyad; functioning to engender trust and empathy with the patient (Epstein et al. 2007). And, as was previously highlighted in Dataset 1, reassurance is a key

part of managing uncertainty and alleviating any potential anxiety for the patient (Buchsbaum 1986: 426) – which is especially relevant given the prognosis characterised within this scenario.

As such, the case of discursive reassurance suggests that the adoption of an epistemic stance can, at times, have affective functions within a clinical context. Illustrating that the conveyance of specialist knowledge and its inherent asymmetrical nature within a clinical dyad is a more complex phenomenon than to be merely dismissed as a paternalistic discursive imposition by a more powerful speaker.

Dataset 2 (Scenario A) – Summary

In conclusion, Dataset 2 has demonstrated a candidate who seemingly orients around a strong epistemic identity within the consultation; using discursive in-group pronominal markers to align themselves with the wider medical establishment, whilst also projecting the diagnosis from their own deictic centre, rather than from that of an agent external to the dyad. Through recurrent commentary on the *states of affairs* within the interview, the candidate positions themselves as the evaluative identity in the consultation, with some examples illustrating how these commentaries can then have subsequent deontic functions within the discourse.

Contextually, that there should be this level of alignment to an epistemic stance is not wholly surprising – Dataset 2 after all, largely represents a post-diagnostic area of the consultation in which exposition of the diagnosis is to be expected. However, this dataset also highlights the difficult navigation faced by candidates in the discursive mediation between epistemic and affective stances within the Perfect Day simulations. In this area of consultation 33A of the PDC, the balance between these two areas must be traversed by the candidate following the delivery of the MS diagnosis and the consequent disbelief and shock depicted by the simulated patient. Subsequently, this candidate chooses to emphasize the offer of information over discursive strategies that may otherwise explicitly engender affect or empathy.

However, the analysis of this dataset has also demonstrated that in phrases of reassurance, the adoption of an expert epistemic stance by a clinician can perform affective functions for the patient. Furthermore, constructions of dialogic reassurance such as the examples in lines 166 and 219-221 of the dataset, constitute a key area of reported patient satisfaction (see for example, Fareed 1996, Williams et al. 1998). As such, the mediation and claims to expert knowledge within the dyad are perhaps more complex and dynamic than a simple dichotomous powerful-powerless split. This notion is also crucial to ideas of identity within medical consultations, given that – no matter how expert a patient is – it is the clinician as the professional representative of the medical institution that assumes the temporary, positional identity category (Bucholtz and Hall 2005) of provider of reassurance.

The analysis of this dataset has also considered how the contextual framing of the simulation may prove problematic for the candidate and their identity performance as the exercise draws to its conclusion; particularly, arising from a lack of contextual detail and externalities upon which a clinician can otherwise refer. I have suggested that this may account, at least in part, for the paucity of irrealis moods in the keyness values of the PDC. From an identity perspective, if medical simulations can broadly be said to assess the 'credible appearance' (Atkins et al. 2016: 7) of professional discourse, this contextual deficiency calls to question how credible any discursive performativity can be without integral components, such as an EPR, that are so integral to the provision of modern healthcare that clinicians spend on average 40% of the consultation interacting with them (Kumarapeli and de Lusignan 2013: 71). A factor that must arguably be taken into account in the design and pedagogic intention of any clinical simulation.

institutional claims to authority and expertise the candidate is able to make. It is worth noting however, that these challenges to the candidate's professional identity contained within Scenario B are not entirely prescribed by the simulator brief in the preparatory Perfect Day literature. Instead, it would appear that this particular simulator – Simulator 2 in this instance, and constant across both Scenario B datasets here – plays the patient role in a particularly abrupt manner.

The first area of keyness typicality for Scenario B runs from almost the start of Consultation 02B to the point at which both participants in the dyad agree a preliminary action plan. This dataset remains faithful to its original incarnation on the concordance plots and has not been adjusted.

Extract 1:

- 16 **CAN:** Right now you mentioned a couple of things there you mentioned the symptoms
17 you've been having just so that <0.5> I can put the results <0.5> into context
18 could you tell me a little bit more about what's <0.5> what's been going on
19 **SIM:** Well I did <0.5> tell the other doctor all this last week
20 **CAN:** Yeah <0.5> yeah
21 **SIM:** So <0.5> you want me to repeat it
22 **CAN:** Well just briefly just tell me what's been happening I can see from the records
23 you've been vomiting
24 **SIM:** Yep
25 **CAN:** And it's been going on for quite some time
26 **SIM:** It has <0.5> yeah
27 **CAN:** Yeah could you tell me if anything else has been going on alongside that
28 **SIM:** No well <0.5> various bits and pieces but the vomiting is the main concern
29 **CAN:** Yeah
30 **SIM:** You know and it started a long time ago
31 **CAN:** Right <0.5> you mentioned various bits and pieces <1.0> what do you mean by
32 that
33 **SIM:** Well just <0.5> sickness and <0.5> stuff like that had the odd headaches
34 **CAN:** Right ok ok and when you saw the doctor last week did he give you any ideas
35 as to what could be going on

36 **SIM:** No I mean <0.5> he he did actually say that <0.5> the blood tests would see if I
37 had any stomach ulcers which is a big concern to me
38 **CAN:** Mmm
39 **SIM:** Erm
40 **CAN:** Hmm
41 **SIM:** So <0.5> hopefully you've got the results
42 **CAN:** I do have the results
43 **SIM:** Ok
44 **CAN:** Erm <0.5> would you like me to go through them or is it okay if I <0.5> just ask a
45 couple more questions to just put them into <0.5> perspective
46 **SIM:** Ok
47 **CAN:** You mentioned stomach ulcers
48 **SIM:** Yeah <0.5> yeah <1.0>
49 **CAN:** What - <0.5> what makes you worry or think about them
50 **SIM:** Well an uncle who died from one from the bleeding burst and <0.5> so and
51 <0.5> from what I can remember it wasn't that long ago he had <0.5> sort of
52 similar <0.5> issues that I've got and I don't want one of those or I might even
53 **CAN:** Mhm
54 **SIM:** Have one
55 **CAN:** Hmm <0.5> hmm
56 **SIM:** So <0.5>
57 **CAN:** Alright I can understand where you're coming from it must <0.5> must have
58 been a difficult time for you for the family

Immediately prior to the opening of the first part of the extract, the simulator establishes the premise of the consultation; outlining that they saw a doctor a week earlier because of recurrent vomiting and are now attending the practice as they've received a call to say that their blood test results are ready. With the context established, in lines 16-18 the candidate immediately returns the dialogic attention to the simulators symptom reporting through the repeated *you* and *you've*, qualifying this attention through a requirement to establish the symptoms against the test results the candidate is required to report back to the simulator. Atkins (2018) has demonstrated how '*tell me*' constructions such as the one found in line 18 can be recurrent within simulated interactions, featuring in both successful and unsuccessful

consultations as a formulaic phrase structuring the dyad. I further suggest that the ‘*tell me*’ phrase here also performs a pragmatic function in signalling patient-centrism and attentiveness to the simulated patient, explicitly integrating the ‘lifeworld’ (Mishler 1984) narrative into the ensuing professional evaluations.

Following the candidate’s request in lines 16-18, the first potentially challenging utterance from the simulator occurs in lines 19 and 21. Apparent in this utterance is how these professional identity challenges discursively confront the epistemic authority of the candidate; manifesting in this instance as the simulator questioning the candidate’s legitimacy to request a narrative account of the symptoms, as well as questioning the efficacy of the simulator’s interaction with the healthcare institution as a whole. Accordingly, these challenges are another example of what I previously termed in Dataset 1 as the infelicity of the simulator’s characterisation within the exercises.

In line 31, the candidate’s request for the simulator to clarify what is meant by *various bits and pieces* demonstrates another potential contextual limitation to the candidate’s goals in this particular simulated scenario: Whilst the candidate is attempting gather data from the simulator, the simulator’s vague statement could be alternately construed as either an ‘in character’ avoidance strategy congruent with the underlying alcohol problem, or more ordinarily, could simply be the simulator not recalling the full detail of the symptoms they’re supposed to report. If we return to the Perfect Day literature for this scenario, the instructions to the simulator outline that it is primarily the sickness symptoms that are to be reported and that any symptoms the candidate asks about that are not on the brief should be assumed to be not present. Nonetheless, determining what is simulated vagueness – to be pursued with a data gathering agenda – and what is merely a performance glitch remains a challenge for the candidate.

Indeed, the simulator’s minimising *just* in line 33 and the added emphasis of the stomach ulcer as a *big concern* in line 37 – further addressed by the reported speech of the previous doctor – implies that this is the primary area of apprehension and agenda for the patient. And by line 41, the simulator explicitly imposes the reporting of *the results* as a

discursive agenda to address this principal area of concern. Accordingly, the candidate responds by tackling the concern in the interrogative, whilst also seeking permission to continue with their own data gathering agenda (lines 44-45). In doing so, implying that accord with this agenda will be more contextually beneficial for the simulator. Arguably the offer gesture contained within the modal *would you like* in line 44 presents a patient-centric approach to the simulator – demonstrating an irrealis formulation of agenda governance within the unfolding discourse of the consultation.

In lines 47 and 49 the candidate places dialogic attention back on the simulator, reporting their earlier speech in order to elicit their concerns in regard to the potential stomach ulcer. Once the simulator outlines his family history of similar complaints (lines 50-52), the candidate assumes an affective stance in line 57 in response. However, I wish to propose that the latter half of the candidate's utterance appears somewhat unmoored to the preceding dialogue, emerging almost as a stock phrase that does not address the immediate context but instead functions as general token of empathy. And whilst it is not the provision of this thesis to interrogate the discursive mechanics of empathy within the data necessarily, it is worth highlighting that, although lines 57-58 largely aligns with a useful working definition of empathy provided by Eisenberg and Fabes (1990: 132) as 'an affective response that stems from ... comprehension of another's emotional state or condition', it does so in a homogenous manner, rather than in a means that addresses the specific concern the simulator has conveyed in the consultation. Roberts et al. (2003: 200) note that 'trained empathy' such as this is often ultimately detrimental to candidates' success within simulated consultations.

Following this utterance, the simulator reasserts his desire to know what the blood test results are, at which point the candidate agrees to go through them and invites the simulator to interrupt him at any point if he doesn't understand. The exchange then continues in Extract 2, line 78:

Extract 2:

- 78 **CAN:** So we looked at a couple of things <0.5> now we looked at your kidneys
79 they're absolutely fine
- 80 **SIM:** Right
- 81 **CAN:** We <0.5> looked at your blood count now <0.5> that did show you were a little
82 bit anaemic <0.5> now I don't know what you understand by that
- 83 **SIM:** Well I would just assume that's because of all the vomiting
- 84 **CAN:** Hmm <0.5> hmm it could be down to the vomiting <0.5> erm but what it
85 suggests is that <0.5> we might <0.5> well be losing a little bit of blood from
86 somewhere causing the anaemia
- 87 **SIM:** Right
- 88 **CAN:** Now <0.5> we can come back to that erm and discuss how we try and tackle
89 that a little later on if that's okay with you
- 90 **SIM:** Ok
- 91 **CAN:** Yeah <0.5> on top of that we <0.5> we did a <0.5> blood test looking at your
92 your liver
- 93 **SIM:** Why
- 94 **CAN:** Now <0.5> we did that to as part of the blood test to see if there were any other
95 issues going on so we checked your kidneys as I said <0.5> we checked your
96 liver and we looked at your blood count now
- 97 **SIM:** I wasn't told any of this last week I wasn't told
- 98 **CAN:** Oh right
- 99 **SIM:** I was just told they was doing a blood test for <0.5> a possible stomach ulcer
- 100 **CAN:** Right <0.5> now
- 101 **SIM:** So <0.5> can I just <1.0> so these other <0.5> tests aren't you supposed to get
102 consent <0.5> before you do them 'cos nobody said anything to me
- 103 **CAN:** I'm I'm very sorry that erm <0.5> that we didn't explain things clearly to you
104 <0.5> erm <0.5> and yes you're right <0.5> we do need to get <0.5> your
105 consent to do the tests that we did <0.5> what I could do is point you in the
106 direction to organise <0.5> an investigation as to what happened
- 107 **SIM:** Well it's a bit late now isn't it
- 108 **CAN:** Mmm
- 109 **SIM:** You've done them
- 110 **CAN:** Yes but we could learn from it so that we don't have this situation in the future
111 <1.0>
- 112 **SIM:** Well you <0.5> there's not that much to learn is it you

113 **CAN:** Hmm

114 **SIM:** Either get consent or you don't

In beginning to report the blood test results (lines 78-79), the candidate invokes the institutional, medical *we* to narrativize the tests and their findings. This particular example illustrates how the utilisation of the collective medical *we* serves to index that decisions and judgments of the clinician go beyond immediate dyad. As such, the collective forms an institutional epistemic basis from which a candidate can lexicalise their own knowledge claims or evaluative judgements. (For instance, note the different discursive effect this candidate achieves in lines 78-79 & 81-82 utilising the collective medical comparatively to the candidate from Dataset 1's evocation of a discreet, external epistemic agent)

In accordance with the Calgary-Cambridge model (Silverman et al. 2005) in line 82 the candidate checks the simulator's understanding of anaemia whilst reporting the results, to which the simulator replies addressing the potential cause of the problem, rather than their understanding of the concept. Heritage (2013: 371) has argued that question formulations (such as in line 82) can be an indirect projection of a speaker's identity, expertise and power via the alignment towards yielding the professional's own expert judgment; 'conveying an expectation that the respondent will not be able to frame an answer'. The candidate responds to the simulator's proposal in line 84 by modalizing it into the possible *could*, before utilising the discourse marker *but* to evidentially index the blood count as a marker of underlying blood loss. In essence, the candidate's contrast of the modalized *could* against their own presentation of evidence appears to function as an implicature that the simulator's suggestion is likely incorrect – without stating this explicitly and presenting incongruence within the dyad.

The recurrence of *suggests* once again in this area of the consultation demonstrates that this is seemingly an important lexical component of the candidates' performing diagnostic probability within the PDC. It is also worth observing the candidate's use of the pronominal *we might well be losing* in line 85, as research has shown that the replacement

of *you* with *we* can appear condescending and reinforce ideas of paternalism, rather than promoting a sense of collegial inclusion (Quirk et al. 1985, Harwood 2005).

Once the candidate announces that a liver test has also been undertaken (lines 91-92), this prompts the simulator to begin a number of professional identity challenges – lines 93, 97 and 101-102 – that force the candidate to make an institutional apology in line 103 such as those discussed in Chapter 4 Section 4.3.2. Notably, this apology is pronominally modified during its utterance, shifting from the candidate assuming first person responsibility for the act of apology (*I'm very sorry*), to the action requiring the apology being grammaticised in the collective medical *we*. The closing of this extract exhibits another example of the contextual limits to dyadic simulation: In response to the simulator's irritation over not being informed of the liver test, the candidate offers to instigate a formal investigation into why this occurred (lines 105-106). Whilst this may be an appropriate 'real life' response, in this pedagogic context, given that there are no tangible means to accomplish this by formal record, it becomes a dialogic dead end within the exercise which the simulator must shut down to progress the consultation – lines 112, 114, and 119, 122 & 124-125 (viewable in the data repository transcription). Extract 3 of the dataset begins immediately after this exchange in regard to the unwitting liver test and potential investigation:

Extract 3 :

138 **CAN:** But in terms of the results we did find that the liver test results <0.5> were
139 abnormal <3.5> now what we found was that the liver was angry and inflamed
140 <2.0>
141 **SIM:** Right
142 **CAN:** Now
143 **SIM:** So what you saying
144 **CAN:** Now what I'm saying is that given <0.5> the blood test results
145 and given <0.5> what's been going on with you there are a number of
146 possibilities as to what's going on <0.5> you mentioned one of them yourselves

147 with your uncle <1.0> that could be a possibility <1.0> what's going through
 148 your mind <0.5> if you don't mind me asking
 149 **SIM:** Well <0.5> I just think I've <0.5> probably got stomach ulcer
 150 **CAN:** Hmm hmm hmm
 151 **SIM:** You know vomiting <0.5> feeling sick
 152 **CAN:** Hmm
 153 **SIM:** Sort of <0.5> retching <0.5>
 154 **CAN:** Yeah
 155 **SIM:** All the time
 156 **CAN:** Yeah <1.0> an- and you're right to think along those lines but <1.0> one thing
 157 we do know from <0.5> medical <0.5> erm literature and <0.5> science is that
 158 <1.0> when people like yourselves <0.5> of your age get symptoms like that it
 159 could <0.5> be mimicking something more serious
 160 **SIM:** Ok <0.5> well
 161 **CAN:** And <0.5> that's where the slight uncertainty is now
 162 **SIM:** So you're ruling out the stomach ulcer
 163 **CAN:** Not ruling out a
 164 **SIM:** Right
 165 **CAN:** Stomach ulcer it is <0.5> one possibility the my other thought is whether there
 166 could be an underlying <0.5> growth
 167 **SIM:** Growth
 168 **CAN:** Yeah
 169 **SIM:** What what type of growth
 170 **CAN:** So I'm thinking along the lines of <0.5> a possible cancer and at this stage
 171 these are all thoughts they're not confirmed <0.5> diagnosis <6.0> and I know
 172 it can be quite upsetting and and difficult not knowing
 173 **SIM:** This is not what I expected <0.5> from
 174 **CAN:** Hmm
 175 **SIM:** The phone call I got this morning

The candidate begins to report the results from the batch of tests administered in lines 138-140, characterising the results themselves in the unmitigated *abnormal* and personifying the liver as *angry*. Given this idiolectic usage, attributing an emotive quality to the liver, the utterance is met with a challenge for explanation by the simulator in the colloquial *what you saying* in line 143. As we have already seen in Dataset 1, instances in which the candidates

present results in potentially ambiguous manners are usually responded to in explicit challenges from the simulators for clarification. In response to the simulator's assertion, the candidate evidentially invokes the blood tests as an epistemic source alongside a nebulous reference to the simulator's symptoms (*what's been going on*).

Following this, the candidate returns dialogic attention to the simulator, deploying an 'invitation to input' (ITI) construction: This particular example demonstrates why in the original conception of ITIs (Emerson et al. 2020) they were characterised as 'linguistically distinct' from routine data gathering questions within consultations – instead, pertaining directly to the elicitation of 'attitudinal assessments' from the simulator on the prospect or likelihood of diagnosis and treatment. As such, they are intertwined with aspects of the clinician's own appraisals, creating the discursive impression of epistemic parity within the consultation or shared decision-making being enacted. However, as we noted (*ibid*) – and as is the case within the example in lines 147-148 – an ITI is often only successful where a preliminary diagnosis has already been established in the consultation; therefore concretising the basis by which the patient brings their own 'lifeworld' (Mishler, 1984) experience to bear on the dyad. Because no established diagnosis has been yet discussed by the candidate in this consultation, the simulator reverts back to their initial belief that they have an ulcer. Accordingly, either confirming that the earlier implicature in lines 84-85 (suggesting that an ulcer was not likely to be the diagnosis) was not understood by the simulator, or infelicitously ignored as a pedagogical challenge.

Consequently, and similarly to Dataset 1 of this chapter, the candidate in this dataset doesn't appear to have asserted their epistemic stance strongly enough in conveying that the simulator's preliminary thoughts are likely incorrect. In line 156 this forces the candidate to invoke a diminished disagreement that acknowledges that the simulator is correct to *think* the problem might be an ulcer, whilst (evidentially) invoking the wider institutional concepts of *medical literature* and *science* to strengthen his own claim that the symptoms might point towards something more serious. It is entirely possible of course, to view the candidate's less assertive stance here as professionally congruent with the uncertainty of the diagnosis

at hand. And indeed, this may be a plausible explanation for the reliance on external, institutional agents of knowledge that are dialogically invoked by the candidate.

Nonetheless, as the subsequent lines (165 onwards) will attest, the candidate appears to be attempting to direct the simulator towards the idea of a more serious diagnosis by utilising a scalar implicature in which the modal *could* is used in place of a lexis of stronger probability. But whilst this mitigatory indirectness arguably has a patient-centric intent, as I have highlighted previously, indirect strategies such as this increase the burden on the hearer to correctly read the pragmatic function behind the statement. It is also worth considering that any areas of ostensible misunderstanding may also be the pedagogic infelicity of the patient characterisation.

In line 161 the candidate explicitly indexes the ongoing *states of affairs* in regard to the diagnosis – deictically signalling the uncertainty present at this point. As the simulator once again challenges to establish assurance in regard to the stomach ulcer (line 162), the candidate echoes the previous scalar implicature, presenting the ulcer diagnosis as a *possibility*, whilst introducing their own alternative diagnosis as a *thought* – epistemically modalized through the use of *could*. This mitigated claim by the candidate appears intended to presage their introduction of cancer into the diagnostic realm; here presented in an alleviated form as a *growth*. Again, however, this mitigatory and inexplicit formulation is not felicitously received by the simulator and accordingly requires the candidate to explain what they explicitly intended to convey in lines 170-172. This discord ostensibly stemming from the simulator – either by ‘in character’ disbelief or pedagogically challenging infelicity – not responding to the candidate’s patient-centric attempts to minimise the bad news at hand.

In fully explaining their use of the lexis *growth* in lines 170-172, the candidate utilises a number of epistemically focused words – *thinking, thoughts* – that demonstrate the procedural and ongoing nature of this particular diagnosis and its inherent uncertainty. This concurrent articulation of the diagnosis early in line 170 is distinct from the *states of affairs* commentary that is significantly key within the PDC and is instead more akin to the ‘front-staging’ commentary that was found to be significant within the CPC in its discursive

characterisation of the diagnosis temporally ongoing within the dyad. In comparison to the candidate's earlier evocation of *science* and *medical literature*, the *thoughts* in line 171 are as yet untethered to external evidence that would allow the candidate to discursively *confirm* the diagnosis to the simulator. In contrast to this uncertainty is the strong, epistemic – and ultimately empathic – claim that the candidate *knows* how difficult this uncertainty can be for the simulator. A further example in which a knowledge claim by the clinician is mobilised in order to create an affective mood.

In lines 176 to 185 (not shown) the simulator presents another professional identity challenge for the candidate; a direct objection to both the candidate and the healthcare institution as a whole in not preparing him for the potential bad news at hand. The candidate initially responds to this challenge with a series of non-lexical backchannels (lines 176, 178, 180, 182 and 184 – viewable in data repository transcript), Extract 4 picks up immediately following this exchange:

Extract 4 :

- 186 **CAN:** Hmm I - I can see that <0.5> you weren't expecting this and <1.0> in the ideal
187 world if your blood tests were fine we could reassure yourself we could see if
188 we can manage the symptoms and improve it but <0.5> I have to be honest
189 as a doctor I <0.5> I wouldn't be doing my duty if I if I said that to you
190 **SIM:** Right
191 **CAN:** Now
192 **SIM:** Ok
193 **CAN:** As I say we might well be dealing with an ulcer <2.0> but from what we know
194 sometimes <0.5> the blood tests and your symptoms could be mimicking
195 <0.5> a cancer or a growth underneath it <0.5> or now <1.0> moving forward
196 now have you had any ideas or thoughts as to how we could go about <0.5>
197 getting to the bottom of all of this at all
198 **SIM:** Well I mean I know you can do a scan <0.5> which would <0.5> put my <0.5>
199 mind at rest that <0.5>
200 **CAN:** Mhm
201 **SIM:** I haven't got a stomach ulcer <0.5> 'cos that's my <0.5> main

202 **CAN:** Yeah
203 **SIM:** Concern
204 **CAN:** Yeah
205 **SIM:** So <0.5> yeah <0.5> scan <0.5> if you can do that
206 **CAN:** So a scan is one option and we know that that can pick up erm <0.5> things
207 like growths and cancers they're not so good at picking up ulcers in fact now
208 what we do know from medical <0.5> literature and science is that <0.5>
209 doing a camera test where we look directly at your stomach <0.5> and the
210 surrounding organs in your upper bowel can give us a better more accurate
211 guide as to what's going on how would you feel if I was to send you to a
212 <0.5> erm a doctor who could do a camera test for you

The *I can see you weren't expecting this* phrase uttered by the candidate in line 186 further serves to underline the evaluative, epistemic component of their identity via the appraising and acknowledgement of the simulator's experiential state. The counterfactual statement then spoken to the simulator allows the candidate to express a volitive condition in which they would prefer to provide reassurance to the simulator. However, the candidate reinforces that it is their professional role and identity *as a doctor* that prevents them providing both reassurance and more favourable conditions in this instance: An overt indexing of professional identity that foregrounds that it is *my duty* that is causing the imposition on the simulator, distinct from a notion of personal identity or obligation.

The candidate's ambiguous use of *we* also returns in this portion of the consultation – moving in lines 193-197 from collectivising and jointly problematising the *dealing with an ulcer* to the candidate and simulator, to an evocation of the *we* deictically signalling the institutional medical that *know(s)* and provides specialist knowledge from which the candidate can base their judgments. As was previously suggested in Extract 2 of this dataset, pluralising a typically singular pronominal *you* for a collective *we* may not always be received as a germane or empathic gesture by the hearer.

Lines 195-197 also contains a further deployment of an ITI by this particular candidate; at this point offering discursive agency to the patient in the face of potentially very bad news. To restate an earlier point, the original research (Emerson et al. 2020) highlighted

that ITI formulations were not received favourably by simulated patients in areas of the consultation where relatively concretised diagnosis had not yet been reached. However, here the simulator chooses to progress the exchange and offers a suggestion for their future treatment.

The ongoing exchange stemming from this ITI also demonstrates once again the precarious discursive mechanics behind the lay-expert divide in medical consultations that may lead to notions of asymmetry: The ITI is a rhetorical strategy that ostensibly offers participatory decision-making and action-planning, however, if the patient's response is not congruent with a professional opinion (e.g., line 198) it must be dialogically corrected by the clinician as is the case in lines 206-212. Arguably therefore, enhancing further the knowledge asymmetry present and exhibiting only discourse-level parity between the interlocutors. And in this particular example, becoming an explicit information-giving sequence for the candidate.

Also notable from this ongoing exchange is that the candidate once again utilises the external epistemic agents of *medical literature* and *science* (invoked in the collective medical *we*) in order to create his own counterpoint to the simulator's idea. Suggesting that the external epistemic source is being used in place of a counterpoint from his own perspective, perhaps in order to facilitate a less adversarial exchange given the simulator's propensity toward challenging the candidate's assertions.

Dataset 3 (Scenario B) - Summary

The extracts from this dataset have considered an area of a consultation in which the candidate gathers data from the simulator and explores their concern in regard to their ongoing symptoms. As part of the contextual understanding of this particular exercise scenario, the analysis has taken into account a number of professional identity challenges uttered by the simulator that ostensibly confront the candidate's performance within the consultation. These challenges are not only directly to the candidate, but also to the wider medical institution which they are a representative of within the simulation. Unlike Scenario

A, in which delivery of a certain diagnosis is the primary goal of the consultation, Scenario B also presents a high degree of circumstantial uncertainty for the candidates to navigate.

Against the backdrop of these contextual challenges, this particular candidate positions their identity as a component of the wider healthcare institution; via use of the pronominal collective medical *we* and discursive indexing of institutional epistemic domains such as *science* and *medical literature*. The evocation of these wider domains then ostensibly serves to strengthen the candidate's own expert position within the dyad – particularly in instances in which it runs contrary to the simulator's own thoughts and assertions. The candidate discursively enacts a potentially contrary point of view through implicatures that connote that the simulator's ideas are unlikely to be correct; a strategy that has clear patient-centric intent but diminishes the candidate's own epistemic stance.

The management of the balance between the simulator's experiential 'lifeworld' thoughts and suggestions, and the candidate's own ideas they wish to impart is therefore an important facet of the discursive work undertaken within this consultation by the candidate: Especially as the simulator's own experiential claims are often used duplicitously to mask their underlying alcoholism in this particular scenario. From a relationality identity perspective (Bucholtz and Hall 2005) it is notable that the candidate maintains the simulator's right to *think* about what the condition could be, whilst evidentially indexing the epistemological sources behind their own implications of what the diagnosis most likely is.

Given the diagnostic uncertainty and complexity within this case, I have proposed that the candidate's diminished epistemic stance may be entirely reasonable from a professional point of view. (Indeed, in line 161 the candidate explicitly delineates the uncertainty present at the current point) The candidate navigates this inherent uncertainty within the scenario via the use of *suggests* as a recurrent evidential marker that places discursive attention on the evidence that is being presented by both the simulator and the tests. *Suggests* is utilised within implicatures that function to pragmatically guide the simulator towards the candidate's own rationale by modalizing the simulator's perceptions in a weaker possibility (line 84), as well as in response to the simulator's thoughts and ideas

that have been yielded via an ITI construction. The dialogic result of ITI use within this dataset illustrates the intrinsic asymmetry contained within the dyadic roles in question, and why I characterised ITIs as an illusory token of shared decision-making; ultimately the *suggestion* of the evidence and its professional interpretation by the candidate supersedes the experiential thoughts provided by the simulator in response to the ITI.

In this dataset there are also a number of recurrent aspects of this particular candidate's discursive identity that become apparent from the analysis: Patient centric strategies such as the *tell me* sequence, the numerous ITIs and elements of ostensible 'trained empathy' (Roberts et al. 2003) could be uncharitably interpreted as stock phraseology – especially in those instances where the portrayal of empathy is incongruent with the local context in which it sits (lines 57-58 of Extract 1 for example). Areas such as this raise questions for any analysis of linguistic professional identity, in so far as, to what extent these seemingly formulaic constructions are 'trained' patient-centrism or, are indeed an integral lexical component of professional identity. All of these aspects could be considered overt indexes of a professional identity, but without deft contextual deployment they can appear inauthentic (Atkins et al 2016, Atkins 2018) and counterproductive (Roberts et al. 2003). This demonstrates that seemingly within these exercises the portrayal of identity cannot be overt and instead must be integrated within the discursive work at hand.

Contextually, the analysis of this dataset has also revealed how institutionally appropriate responses to challenges in the dyad may be difficult for the candidate to enact – in this instance an investigation into consent not being sought for a liver test. As I suggested in Dataset 2, this may be an area where the contextual paucity of simulation makes discussion of 'outside the stage' events or processes difficult to discursively manage, potentially inhibiting a more complete performance from the candidate.

5.5 Dataset 4 (Scenario B) – *Metacommunication & introducing possibility over certainty*

The final dataset of the Perfect Day Corpus is from consultation 04B and covers a similar area of the dyad to the previous dataset, however as the various extracts, below, will demonstrate, the discursive enaction of the consultation is notably different from that in Dataset 3. Whilst the dataset remains faithful to its initial outline on the concordance plots, lines 141 – 146 have been added at the start of the dataset to give context to the foregoing discussions. Prior to the beginning of Extract 1, the candidate has begun to explore the patient's medical and lifestyle histories, culminating in a series of questions specifically in regard to the patient's drinking habits in lines 79 – 99 (not shown). Accordingly – and similar to the previous dataset – the simulator has issued a series of challenges to the candidate's professional identity; questioning why the line of investigation is relevant to the blood test results.

Extract 1:

- 141 **CAN:** I will definitely explain that I'm trying to work out the best way we can support
142 you and since you mentioned perhaps I should go into that <0.5> also do you
143 smoke at all
144 **SIM:** No <0.5> I used to but I stopped a few
145 **CAN:** Few years ago
146 **SIM:** Well no months ago about six months ago
147 **CAN:** Six months ago <0.5> was that voluntary or was that
148 **SIM:** Yeah I decided my wife kept nagging me so
149 **CAN:** Good
150 **SIM:** She nags me about drinking and smoking so I thought if I do one of them that'll
151 **CAN:** So your wife is a bit concerned about your smoke your drinking too
152 **SIM:** Well she tweets about it but I mean
153 **CAN:** Do you feel guilty about your drinking
154 **SIM:** No
155 **CAN:** No ok <0.5> do you get annoyed when someone talk about the drinking

156 **SIM:** Yeah I'm starting to now
157 **CAN:** Ahm so sorry about that <0.5> that's not what I intended
158 **SIM:** Right
159 **CAN:** I just wanted to make sure yeah <0.5> I mean the the results of your test have
160 come back and <0.5> I'll just go through it <4.0> so <2.0> you you we checked
161 your kidney function

In response to the simulator's challenges, in line 141 opening Extract 1, the candidate metacommunicatively addresses his agenda for the consultation in the commissive *I will definitely explain*. As the candidate then continues with the lifestyle questions, he conspicuously uses an *or?* tag question (line 147) to navigate another area that may be sensitive and contain the potential for an identity challenge. Here the alternative statement that would logically complete the question is omitted, leaving what might be an uncomfortable circumstance to lexicalise to the patient – i.e. that they have been involuntarily forced to stop smoking – implied rather than vocalised in the exchange: A strategy that minimises interrogative imposition on the simulator.

After a general comment on the *state of affairs* the simulator is lexicalising (line 149), the candidate deploys a pair of questions that directly address the simulator's attitudinal and affective concerns in regard to their drinking. Given the prescribed characterisation of the simulated patient (see Excerpt. 5.3, below) in line 156 the simulator issues another direct challenge to the candidate's enaction of their task, forcing the candidate to once again restate their objectives for the consultation (lines 157 & 159-161). Following this in lines 162-173 (not shown) the simulator initiates another professional challenge in regard to the unannounced liver test, similar to the one seen in Dataset 3.

Your wife thinks you drink too much and makes you feel guilty – but you have always drunk quite a lot because it stops you worrying about things (money is a bit tight on your pension). You think you ought to cut down but feel you need a drink to keep going. You get quite irritable with your partner when they go on at you (**as you might with the GP if they try to talk about this issue!**)

Excerpt 5.3 – From the Perfect Day guide for simulated patients, Scenario B (emphasis mine)

Extract 2 :

174 **SIM:** I don't why they said they were going to do that when I thought they were just
175 doing a blood test for my stomach sort of thing

176 **CAN:** Yeah it's it's still part of the stomach it's just one of the other that sit in the
177 <unclear> tummy and if you've been sick we need to do <0.5> an MOT test

178 **SIM:** Yeah ok

179 **CAN:** So that came back a bit abnormal <0.5> one of the on one of the <0.5> test
180 that we did <0.5> and also er on the full blood I'll explain everything <0.5> on
181 your full blood count too <0.5> ah the red cell the red cell which is the part of
182 blood that carries oxygen around the body

183 **SIM:** Ok

184 **CAN:** Also is a bit <0.5> larger than normal <0.5> now so we would expect them to
185 be a certain sort of <0.5> erm size but they are bigger than that size <0.5>
186 that would cause a bit of problem <0.5> ah in terms of the fact that they are
187 not what they are meant to be and the fact that the liver function is not what is
188 meant to be <0.5> now tying both together <0.5> there is a link <0.5> and the
189 link is that <0.5> and from what you've already told me is that <0.5> the
190 enzyme that is <unclear> abnormally in the liver is actually one that can be
191 raised if you're drinking a lot more than necessary <2.0>

192 **SIM:** But that wouldn't make me sick though would it

193 **CAN:** Now I'll tie this together <0.5> now with the sickness that you are getting
194 <0.5> and you did mention that you did have some specks of blood blood
195 when you've been sick when you retch <0.5> its its possible that the drinking
196 is irritating the lining of your tummy the stomach and also the food pipe

197 **SIM:** Right

198 **CAN:** So when that happens <0.5> because you've been drinking and from what
 199 you've told me its <0.5> above what your expected to be drinking <0.5> in a
 200 week because from a rough calculation of what you're taking in a day <0.5>
 201 ahm you're taking <0.5> no less than what we call twenty units a day <0.5>
 202 and the government says we shouldn't take more than fourteen units
 203 **SIM:** People can talk about units but it means nothing to me
 204 **CAN:** Yeah so what I mean by that is a glass of wine <0.5> is two units <0.5> you
 205 understand
 206 **SIM:** Right
 207 **CAN:** You take four you think about four which what you've said long time <0.5>
 208 that's about eight units and then you share a bottle of glass of wine with your
 209 wife um in the evening <0.5> so that works out to another four to six units
 210 depending on the strength of the wine that you take so you're taking roughly
 211 what is recommended in a week in a day and that's <unclear> take that
 212 everyday regularly your going over the week limit
 213 **SIM:** I know a lot of people who drink on a regular basis <0.5> and everybody's
 214 different so
 215 **CAN:** Everybody is different but <0.5> ah ah people do drink but when drinking is
 216 starting to have an effect on you on your body its <unclear> <0.5> so the fact
 217 that you're being sick <0.5> you're retching <1.0> and <0.5> also the fact that
 218 you didn't mention you need an eye opener to steady your body in the
 219 morning actually means that also the fact that it's also showing on your liver
 220 means that you're doing a bit of damage from the drinking
 221 **SIM:** Right <1.0>
 222 **CAN:** How do you feel about that <1.0>
 223 **SIM:** Well <0.5> I still can't see that its related but <0.5> but I mean if the blood
 224 tests say that they say that
 225 **CAN:** Yeah

Following the standard challenge in regard to the liver examination, the candidate conceptualises the battery of tests as a *MOT test*, a metaphorical explanation that receives dialogic accord from the simulator in the following line. Continuing this explanation, in lines 179-196 the candidate once again utilises a number of metacommunicative formulations to signpost to the simulator that this ongoing account of the blood test results will yield

relevance to the overall diagnosis. As I suggested in Chapter 4, metacommunication is an important area of discursive signposting within medical dyads and simulations especially; with Roberts et al. (2004) highlighting how it is prescribed in medical literature such as the Cambridge-Calgary model as a means to present clarity to the patient, and Hawthorne et al. (2017) illustrating how it builds alignments between the interlocutors in the dyad.

Markedly, the metacommunication here is to *link* and *tie together* the various pieces of evidence the candidate has within the consultation in order to produce a cohesive narrative of cause-and-effect explanation for the simulator, that also addresses the cogency behind the previously unannounced liver tests. If we contrast this sequence to the candidate in the previous dataset, it is notable that this candidate's increased level of certainty in regard to the symptoms means that this narrative of explication is projected from his own deictic centre, rather than via the indexing of external epistemic agents. And where uncertainty is present (for example, lines 195-196) it is integrated into the explanation, rather than left as a stand-alone statement (see line 161 of Dataset 3 for example). Arguably these differences in epistemic projection have ramifications for the level of expertise / certainty experienced by the simulator – or indeed an examiner – within the simulation. Where the institutional medical *we* is invoked by the candidate in line 201, it is only to index the technical measure of alcohol units. And when this technical term is challenged by the simulator (line 203), the candidate again employs the metacommunicative *what I mean by that* to reconceptualise the abstract, technical measure into a formulation pertaining to the simulator's own experience.

Throughout this area of the consultation in which the candidate has attempted to explain the significance of the test results to the simulator, discursive attention is also repeatedly placed upon both the simulator and their actions through the repeated *you*, *your*, *you've* and *you're* (31 instances in lines 184-220). This significant use of the second person pronoun often constructing a form of metacommunication that reports the simulator's own speech back to them – for example, *from what you've already told me* (lines 198-199), *you did mention* (line 194) and *what you've said* (line 207). Arguably, this integrates the

simulator's own narrative into the now epistemic decision-making narrative of the candidate; evidentially marking the circumstances reported by the simulator as an integral part of the ongoing advice narrative. This not only places dialogic attention upon both the simulator and the symptoms they have described, but in terms of discursive asymmetry also accords with the proposition of Kacewicz et al. (2013: 14) that 'higher status individuals focus their attention outwards, towards the person they are speaking with' via pronominal usage.

The extensive area of explanation is then followed in line 222 by an ITI construction that pertains directly to the candidate's foregoing narrative. Notably, because the ITI is contextualised to this diagnostic explanation, it meets with a level of relative accord – given the generally infelicitous stance of this simulator – and no further identity challenges. As I noted previously, it appears, perhaps particular to this pedagogical simulated context, that ITIs such as this only meet dialogic success when moored to at least some form of diagnostic certainty within the consultation. Offering discursive agency to the simulator on top of diagnostic uncertainty has produced discordant responses in most of the datasets analysed in this chapter so far, perhaps indicating that, at least in the context of these simulations, that some diagnostic work must be evidenced by the clinician before the patient reads the pragmatic intent of an ITI correctly. In this particular example the choice of interrogative itself is also significant, substituting the more information-connotative *what* (seen in all other ITI examples in this chapter) for a more affective *how*. The simulator's response to the ITI in lines 223-224 demonstrates that the candidate's strategy has been successful as the simulator accepts the evidence and ceases this professional identity challenge. Extract 3 continues directly after the end of Extract 2:

Extract 3:

- 226 **SIM:** So are you saying I need to stop drinking
227 **CAN:** There are a lot of things that <0.5> we need to do one is stopping drinking
228 which is good but I'm not going to ask you to stop drinking immediately <0.5>
229 we are going to say cut down because your body is so used to a certain level

230 of drinking that if you were to go cold turkey on it <0.5> you would have what
231 we call withdrawal symptoms like the shake you become very unwell some
232 people become muddled up and confused <1.0> but we don't want that to
233 happen <0.5> what we usually say is that you gradually reduce the amount
234 that you drink <0.5> on a weekly basis usually about ten percent <0.5> ahm
235 but even more than that there is a special drug and alcohol team in the
236 community that you could do a self-referral to <0.5> and they would be able
237 to talk through cutting down to the right amount with you but there is a benefit
238 in terms of the fact that the the the you know you did mention that the uncle
239 had an ulcer <0.5> now alcohol drinking high level of drink and can actually
240 cause an ulcer too <0.5> usually also present vomiting and some people get
241 tummy pain and <0.5> you don't go down that line because you could have a
242 bleed from an ulcer

243 **SIM:** But I haven't got one <0.5> that's ok is it

244 **CAN:** It's it's it's at the minute it's ok but you did mention that you do get flecks of
245 blood when you become sick

246 **SIM:** Not very often

247 **CAN:** Now that can be a result of the fact that when you when you be sick all the
248 time <0.5> you tear a small vessel in the food pipe

249 **SIM:** Right

250 **CAN:** Its on the <unclear> when you retch <0.5> and that may cause the bleeding
251 the other bit is that because you are being sick <0.5> continuously it might
252 just be that actually <0.5> the lining of the tummy is irritated and you might
253 have what we called <0.5> you might have um an inflammation of the tummy
254 of the stomach or you might have an ulcer but it is difficult to say

255 **SIM:** Right <3.0> not what I expected to be honest

256 **CAN:** I know I know but <0.5> I mean you've come to see me but its so that we can
257 work out the best way to support you <3.0>

258 **SIM:** Well <1.0> not much I can do if you say that's what I've got to do

259 **CAN:** I mean there are things we ought to do usually in this condition ahm given the
260 fact that you did mention that you you yourself you've not been sick but that
261 you've been sick for a couple of time and there's been flecks of blood in it and
262 things like that <0.5> I think one we need to look at that also not ignore that
263 and perhaps do a camera test to look at the lining of the food pipe and also
264 the tummy

265 **SIM:** Don't fancy that

266 **CAN:** Why is that <3.0>
 267 **SIM:** Um <0.5> anyway
 268 **CAN:** There are other things we could recommend because you're being sick <1.0>
 269 quite regularly yeah we could give you some anti sickness medication and
 270 some medication called <drug name> to protect the lining of the tummy
 271 **SIM:** Right
 272 **CAN:** So you could start that today I'll prescribe that today more importantly ahm we
 273 need to stop the drinking because if we're protecting it
 274 **SIM:** Stop the drinking
 275 **CAN:** No no no to cut down thanks for clarifying that for me <0.5> cut cut down on
 276 the drinking <0.5> and also make a referral ah to the drug and alcohol service
 277 in the community so they can help you cut down gradually <interruption> so if
 278 I see you in a weeks' time
 279 **SIM:** Ok
 280 **CAN:** And ah I'll give you contact detail and I'll prescribe the <drug name> for you is
 281 that alright
 282 **SIM:** I'll think about what you said yeah
 283 **CAN:** Thank you
 284 **SIM:** Thanks

In line 226 the simulator's own metadiscursive reformulation (*so are you saying*) of the candidate's – at this point – alluded to action plan frames the potential advice in its most deontically imposing and absolute manner. The candidate responds to the absolute presented by the simulator, by immediately addressing the action plan in the collective *we need* and the negating his own deontic action; *I'm not going to ask*. The candidate's use of the collective then shifts to the collective medical in order to deliver the advice – invoking the institutional *we* to lexicalise the metadiscursive signposting of the advice (*what we are going to say*), the technical term afflicting the simulator (*what we call*) and the future action (*what we usually say*). In the middle of this is also another evocation of the doctor-patient collective in *but we don't want that to happen*. Following this, the candidate discursively returns attention back to the simulator with the repeated use of *you* to reiterate the patient's action at the end the advisory sequence.

The difficult characterisation of the simulated patient returns in line 243 as they challenge the candidates state of affairs – presenting with certainty that (the possibility of an ulcer) which has been navigated in implicature and medical vagueness so far in the consultation by the candidate. In order to counter this finitude, the candidate highlights the temporality of the condition in line 244 to signpost throughout the upcoming exchange why the uncertainty regarding the ulcer still exists. This is emphasised in the repeated use of *might* in lines 250-254, once again modalizing the epistemic claim around certainty of diagnosis. In the face of this uncertainty, the simulator underscores their own lack of agency (*not much I can do*), ostensibly suggesting that the advice they have received has been asymmetrically dispatched and not jointly agreed upon. This echoes with Landmark et al.'s (2015: 66) findings that patients faced with a dispreferred treatment option would push back deontic responsibility onto the clinician.

However, the candidate seemingly misreads this diminished agency claim from the simulator, instead perceiving it as 'nothing can be done' in the circumstances and in turn, responding with an action plan. Returning attention back to the simulator through the repeated use of *you*, and then evoking joint action once again in the mitigated epistemic claim *I think we need to look at that...and perhaps do a camera test*. Notably, the physiological details of these procedures are presented in the lay terminology *camera test*, *food pipe* and *tummy* to seemingly engender simpler comprehension of what this course of action entails for the simulator.

After the simulator rejects the planned camera test (lines 265-267), the candidate offers an alternate action plan (line 162) and then states that simulator should *stop* drinking (lines 268-270). Markedly, this misstep by the candidate is immediately seized upon by the simulator who repeats it to emphasise the potentially absolute nature of the advice – running contrary to that given by the candidate at the beginning of this extract (line 228) – and forcing the candidate to restate the advice again in its original form. Underscoring how the portrayal of the simulated patient orients towards unambiguous certainty within the context of these pedagogic scenarios.

Dataset 4 (Scenario B) - Summary

This dataset has illustrated a candidate's extensive use of metacommunication within the consultation. Under analysis it can be seen how this discursive strategy allows the candidate to effectively navigate the undesirable circumstances behind the liver test and the accordant challenges this presents. By dialogically connecting pieces of evidence that are ostensibly disparate (at least for the lay characterisation of the patient in this exercise) via recurrent metacommunicative strategies, a narrative account is formed that evidentially indexes the candidate's line of reasoning and the accordant epistemic stance towards the advice that is being provided within the dyad (see for example, lines 184-220 for the most prominent example of this). This metacommunication also includes the candidate reporting the simulator's own speech, thus integrating the patient narrative within their decision making and dialogically affording the simulator attention throughout an ostensibly asymmetrical explanation sequence.

Importantly in terms of professional identity, this candidate's epistemic stance – similar to the candidate in Dataset 2 – is primarily projected from their own deictic centre, rather than through the recurrent evocation of the wider medical institution. When the collective medical *we* is used by this candidate, it is largely done so to either clarify technical terms (*what we call*) or to reinforce and frame in collective action a course of action that has already been lexicalised (*one we need to look at*), rather than as a primary source of certainty within the dyad. And although diagnostic ambiguity remains an important aspect of this particular scenario, this candidate integrates modal potential within a discursively signposted action plan such as in lines 250-254 and 259-264, also notably utilising the hedge phrase *difficult to say* seen throughout the PDC data. This is especially important given the simulator's orientation towards certainty in this scenario – a characterisation that replicates the predominant patient desire for certainty and the associated increased reporting of patient satisfaction this brings (Johnson et al. 1988). The relative success of this candidate's use of ITIs also demonstrates the contextual sensitivities and dynamics at play within the consultations: In this instance the ITI is modified for affective purpose and already

attached to ideas, therefore prompting accord in the consultation as opposed to the discord seen in Dataset 3. Demonstrating that such invitations for the patient to add their own thoughts, concerns and expectations cannot be employed generically.

From a contextual perspective, this dataset has also demonstrated how the professional identity challenges uttered by the simulator function to disrupt the candidate's performativity; infringing on their ability to act unchallenged as a professional. And accordingly, how the navigation of these challenges by the candidate determines the successful enaction of the consultation itself by addressing a concealed problem. In this particular dataset, the candidate overcomes an explicit challenge that threatens to disrupt the consultation (line 156) by using metacommunication once again (*that's not what I intended*) and addressing the drinking problem in the context of the unsolicited liver test through recurrent pronominal use that directs attention towards the simulator and their actions. (*N.B*; it is worth noting that there are a number of examples of consultations in the wider PDC in which a candidate does not uncover the simulator's drinking problem in this exercise)

Therefore 'talk about talk' is an explicit way for this candidate to navigate areas of difficulty or uncertainty, and – more importantly in the context of a simulated consultation – allows the clinician to lexicalise overriding discursive concepts and intentions, rather than specific details, in a dyadic context where fine grained contextual detail may be scarce. It could also be stated that metacommunication in this respect enhances the performativity of simulations themselves, allowing the candidates to discursively craft the 'credible appearance' (Atkins et al. 2016) of a clinician in a context where the dialogic enaction of ancillary administrative or procedural clinical work may be difficult.

6. Data Analysis, Clinical Pharmacy: A Discursive Pragmatic Approach

6.1 Introduction

The discursive analysis of the CPC continues the methodological approach taken in the previous chapter for the PDC. For the CPC, the keyness areas utilised in the Louw et al. (2014) method to identify areas of typicality in the data are; *Pronominal Auxiliary Contraction* (including the key lexis *you're, you've, I'm*), *Deixis (that's, your)* and *Irrealis (I'll, we'll)*. There are also differences in the data arrangement that should be briefly restated: Whereas the Louw et al. (2014) plot charts for the PDC were a randomised sample of each exercise undertaken by the candidates, the plot charts for the CPC are comprised of the entirety of the data yielded from an individual site. In other words, each research site is represented by a singular keyword plot.

Similarly to the PDC analysis, the areas of keyness typicality identified will be split into approximately three smaller extracts for a closer reading. The terminology in regard to the levels of analysis also remains constant from the previous chapter. In the transcriptions presented in this chapter, the clinical pharmacists are represented as 'CP' and the patients as 'PT' – any other participant within the consultation will display an epithet that will be outlined at the beginning of that particular dataset.

Whereas in the previous chapter I accounted for the identity of the simulator as a pedagogical construct within the PDC, in this chapter – in line with commitment to a full meso-level reading of the activity context and the notion of identity 'relationality' (Bucholtz and Hall 2005) – I also discuss how the patients potentially contribute to the professional identity being enacted by a CP in particular consultation. It is also important to note that – unlike the PDC – the clinicians under analysis in the CPC hold differing levels of experience and expertise in pharmacy. For example, the CPs in Datasets 5, 7 and 8 are prescribing pharmacists, whereas the CP in Dataset 6 is not. Additionally, the CP in Dataset 8 had undertaken a minor illnesses course which allowed them an expanded role and had worked extensively in a hospital setting, whilst conversely, the CP in Dataset 6, for example, was

predominantly a community pharmacist prior to the CPiGP pilot study. The analysis takes account of these contextual factors and will reference them wherever relevant to the data.

6.2 Dataset 5 (Orchards) – Shared decision-making & the CP advisory role

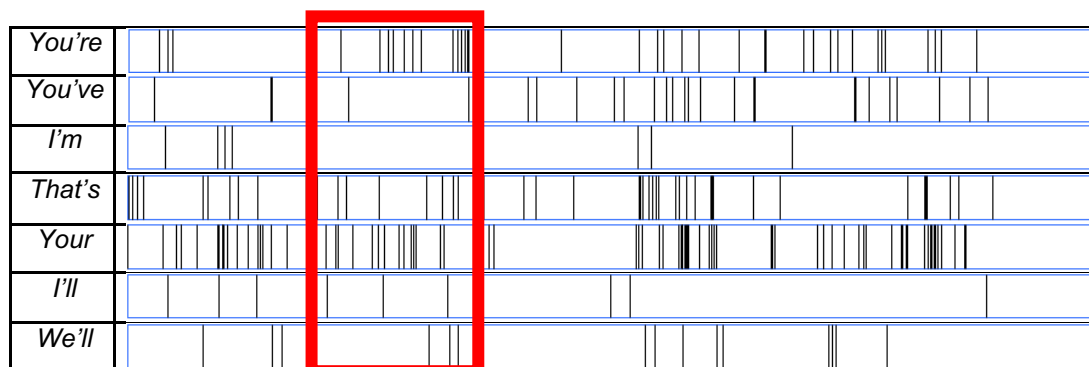


Table 6:1 – Concordance plots of the areas *Pronominal Auxiliary Contraction, Deixis and Irrealis* for *Orchards*:

This particular consultation from *Orchards* involves a patient attending the surgery for an annual review of asthma medication, in which they outline that some of their symptoms have recently worsened. As Chapter 4 Section 4.6.1 has previously highlighted, the medication review is a key role for clinical pharmacists and a significant linguistic footprint of this activity persists in the data trends established via corpus analysis. Within the CPC data 58% of the consultations could be coded exclusively as medication reviews.

The keyness dataset shown in Table 6.1, above, initially stretched from line 317 of the *Orchards* corpus file to line 443. When analysed in context, the opening of this range preceded a break between consultation two and three of the data file, whilst the end of the selection stopped just short of the end of consultation three. For this reason, it was decided to adjust the selection so that it encompassed the entirety of consultation three – rather than the closing of consultation two, and consultation three, without its own closing sequence.

Extract 1

- 1 **PT:** I thought I'll let her sleep for ten minutes
- 2 **CP:** She's gone <0.5> erm so have you had any problems

- 3 **PT:** Erm well last month I've started <0.5> most of the time my asthmas fine I don't
4 even notice I've got it erm but at night time as soon as I go to bed I'm I'm really
5 struggling to breathe <0.5> I don't know whether its like the last month since I've
6 come back off holiday ahm <2.5> I don't know whether its <0.5> just the change
7 in air a little bit ah I don't know don't know
- 8 **CP:** Where did you go on holiday
- 9 **PT:** Cypress <2.5>
- 10 **CP:** Did you just go for like a week or two
- 11 **PT:** Yeah just a week
- 12 **CP:** Yeah <1.5> and what kind of symptoms do you get at night time
- 13 **PT:** Er it's like really shortness <0.5> my chest really tight <3.5>
- 14 **CP:** And do you take a dose of your inhaler <1.0>
- 15 **PT:** Um yeah but its <0.5> it's like it's not really doing anything <4.0>
- 16 **CP:** Is it every night
- 17 **PT:** Yeah at the minute <1.5>
- 18 **CP:** And that's been for about a month did you say
- 19 **PT:** Yeah <13.0>

Although missing the very beginning of the consultation, (see Chapter 3 Section 3.4.4 on the practicalities and ethics of recording at the CP sites) in which the contemporaneous field notes document a routine introduction and tangential talk in regard to the sleeping child also present in the consultation, the CP opens the dyad with a seemingly non-specific question in line 2. Despite the ostensible vagueness of the utterance, this formulation demonstrates how medication review dyads can be dialogically distinct from the prototypical doctor-patient interaction from the very beginning: Not only is the purpose of the visit known by both participants – meaning that areas of the dyad such as ‘explanations for attendance’ are minimised and therefore not required to be responded to by the clinician – but the condition itself, and its temporal longevity, is reified around the provision and dosage level of medication. (The reification or abstraction of patient conditions via the metonymic use of medication as a substitute and the subsequent effect this creates will be returned to throughout this chapter.) Pilnick (1998: 35) observes a similar phenomenon in oncology

clinics in which there are quick moves to 'business' once greetings have taken place. In effect, the medication review dyad presents a form of closed context consultation for both participants, in which participation within the activity context is set and understood prior to the consultation. Arguably this prior contextual understanding within the management of long-term chronic conditions may allow for a more transactionally focused consultation.

The immediate on-topic response by the patient demonstrates that the specific contextual grounding of the CP's question in line 2 has been understood, and from there the patient is able to offer their own lay assessment and explanation of their condition. Although Gill and Maynard (2006: 118) refer to constructions such as the one in lines 3-7 as 'overt' explanations provided by the patient, notably this is a diminished epistemic claim as it is presaged by the mitigatory elements *I don't know* and *just* and subsequently followed with a repeated *I don't know*.

This explanation is not immediately responded to by the CP, and instead between lines 8 to 15 the CP undertakes an interrogative, data gathering sequence. Markedly, these questions are also in a closed form, specifically aligning the symptoms and actions to the patient via the repeated pronominal *you*. The transactional utility and patient-centric ramifications of open versus closed forms of questioning in medical consultations has been long debated (e.g. Ishikawa et al. 2002, Schoeb et al. 2013), but the appearance of these closed forms echoes with Murad et al.'s (2014) comprehensive pharmacist-patient literature review concluding that pharmacists are more likely to use closed over open questions (15), alongside Greenhill et al.'s (2011) findings that pharmacists tended to neglect patient centric strategies. Arguably, the effect the CP produces here is once again a transactional directness that does not immediately demonstrate any dialogic concessions to a patient-centric approach or long form exploration of the condition. Extract 2 of this dataset resumes directly after this opening sequence:

Extract 2

- 20 **CP:** So <0.5> you've got a ahm just the blue inhaler at the minute <1.5> which is a
21 reliever <0.5> erm <0.5> have you had a different type of inhaler called a
22 preventer
- 23 **PT:** No no
- 24 **CP:** So the reliever relaxes the muscle in your airway lets more air in and then it
25 wears off after like twenty minutes or so <0.5> the preventer reduces
26 inflammation and mucus and swelling
- 27 **PT:** Ok
- 28 **CP:** Erm and you take it regularly you don't take it for a symptom you take it as a
29 preventer <0.5> erm now <0.5> most of the time people with asthma have a
30 preventer sometimes they don't but you can tailor it to the time of year
- 31 **PT:** Yes
- 32 **CP:** So if you have been struggling at the moment we could start you on a preventer
33 see if that improves things <0.5> and then maybe when the seasons settle or
34 maybe after the winter you could then <0.5> come off the preventer
- 35 **PT:** Ok
- 36 **CP:** Erm so we kind of call it stepwise plan you step up onto the preventer you can
37 even increase the dose <0.5> and then you can step the dose down and step off
38 it again
- 39 **PT:** Yeah
- 40 **CP:** Yeah <0.5> erm I'd like to do your peak flow if that was ok
- 41 **PT:** Yeah
- 42 **CP:** But you'll have to put put her down her down for that
- 43 **PT:** Ok <7.5>

The discourse marker *so* used by the CP in line 20 gestures the end of the interrogative data gathering and dialogically signals a cause and effect; joining the information yielded by the patient to the CP's upcoming statement – which is itself a 'triadic' (Scott and Purves 1996) reference to the patient's official record on the computer. The patient's assertion in line 23 that they have not received a prevention inhaler previously, then prompts the CP into a declaration of specific professional expertise in lines 24-26, once again punctuated by the procedural discourse marker *so*. These advisory utterances by the CP in both lines 24-26 and 28-30 resonate with Sarangi's (2000: 18) reporting of explicit clinical information

provision taking on the form of a service encounter. In this instance the CP unequivocally assumes the educational activity of the role in order to introduce a new form of medication. Notably, within this educational sequence the pronominal use by CP discursively presents the medication as enacting upon the patient (*relaxes the muscle in your airway, you take it regularly*) which is then contrasted to the generic, collective *people with asthma* to illustrate the typicality of this course of treatment.

Once the CP has discursively outlined the role of the new medication being introduced, it becomes more explicitly aligned to the patient's own symptoms in lines 32-34 – presenting an irrealis, conditional mood for prescribing through the conjunctive use of *if*. The act of prescribing a further inhaler here is also collectively framed as *we* by the CP and also modalized through the use *could*; denoting that the act of prescription – at this point of the consultation – is not yet fully decided.

As the quantitative analysis in Chapter 4 outlined, the discursive collective is a particularly key area for the CPC; however as I have suggested, the use of *we* by clinicians can be contextually ambiguous and, in this instance, a textual reading does not make it clear if this particular usage connotes an institutional healthcare *we* or the framing of the CP and patient as a shared decision-making *we*. Naturally each of these has very different effects in terms of asymmetry and patient-centric care.

Certainly, by line 36 the pronominal *we* indexes the collective medical institution as it is used to introduce the pharmaceutical concept of a 'stepwise' medication (alleviated by the use of *we kind of call it*) plan to the patient. Again, here the repeated use of *you* by the CP maintains dialogic attention on the patient as the recipient of the medication, but also notably in this instance – in light of the stepwise context – frames them as an agent of their own treatment dosage through the emphasizing and deontic *you can even* uttered by the CP. Extract 3 resumes the consultation after the CP has administered a peak-flow test and inhaler technique test to the patient (40 lines later), the initial preamble to this section details a faulty piece of apparatus for the peak-flow test:

Extract 3

- 83 **CP:** I don't know if there's something wrong let me have a look <0.5> 'cos it
84 sounded funny at the time <3.0> ah <1.5> let's try this one <0.5> these blue
85 ones are better <4.0> ok <1.5> it's going to be off the chart now <1.0> that's
86 perfect that's fine so you have got a good technique there <0.5> so <1.0> erm
87 that won't be the issue <1.5> so we'll try you with this anyway
- 88 **PT:** Umhuh <2.0>
- 89 **CP:** One puff twice a day at the moment see if that helps <0.5> it'll take a few days
90 to kick in
- 91 **PT:** Yeah
- 92 **CP:** And if that does do the trick then you can keep going with it till you feel
93 comfortable enough to try maybe stopping it and doing the blue one again <0.5>
94 a good rule of thumb would be to carry on with it if you need to use the blue one
95 three times a week or more <0.5> if <0.5> you start the brown one which we call
96 the preventer and your salbutamol use goes right down for a good <0.5> few
97 weeks <0.5> that's ok you probably might not need it continuously but if you
98 keep taking and your salbutamol use is still three times a week or more continue
99 and even consider putting the dose up a bit to two puffs twice a day
- 100 **PT:** Ok
- 101 **CP:** I'll put a little summary of that in here <0.5> so it's called Clenil <0.5> and it's
102 brown <1.0> and we'll do one puff twice a day to start with <2.0> and you're
103 using the blue one every day at the minute aren't you
- 104 **PT:** Yeah
- 105 **CP:** So we want to try and bring that down to three times a week <0.5> that's blue
106 <0.5> you can have one puff whenever you need it <0.5> so you don't it's not
107 that you're not allowed to take it but we're aiming for better control so you don't
108 have to take it <0.5> so that's where we'll start you off <0.5> if it's not really
109 working and you're getting worse you can take the preventer up to two puffs
110 morning and night
- 111 **PT:** Ok
- 112 **CP:** And you can use the blue one again as much as you need to <0.5> and then if
113 you're still not really getting anywhere still on that come back and see us
- 114 **PT:** Ok
- 115 **CP:** If you're out of breath and you can't really talk you're ringing the ambulance in
116 an asthma attack so you've got the three zones
- 117 **PT:** Yeah yeah

118 CP: Do you want me to send the new erm <0.5> inhaler to Boots
119 PT: Yes please
120 CP: OK
121 PT: Mostly I don't use it at all <0.5> but it's just <0.5> I noticed that I suffer from
122 allergies at this time of year as well
123 CP: Yeah so there are different kinds of trees that set off at different seasons and
124 PT: Yeah
125 CP: And a lot of people are effected by the change in the weather and the air and
126 the stuff like that so
127 PT: Urhuh
128 CP: If you have got a little bit of a cold as well that's not going to help <11.5> so I'll
129 send that straight over to Boots <0.5> one puff twice a day should last you
130 nearly two months
131 PT: Ok
132 CP: But you can just order one again if you're getting on with it we can give you
133 another one see how you go <0.5> erm with that <0.5> but if it's not working
134 just come back <4.5> so that's gone to Boots for you <2.0> all right
135 PT: Thank you very much
136 CP: Thank you bye

Following the admission of the inhaler-technique test, in lines 85-87 the CP enacts a further element of expertise in the affirmational *that's perfect so you have got good technique...that won't be the issue* utterance. Areas of discursive judgement such as this are not as prominent in the CPC as in the PDC (in which they constituted the key category *candidates indexing states of affairs*) but markedly the professional ratification here is aligned to a specific, procedural part of the CP role rather than as an evaluation of the patient's condition or symptoms as is generally the case in the PDC.

A further instance of the collective, institutional medical *we* is utilised in line 95, delineating between lay, patient conceptions of medication (inhalers known by their colours) and the technical, functional name used by the healthcare institution (*which we call the preventer*). Once the new medication is introduced in this metonymically simplified manner by the CP, the blue inhaler – already in use by the patient – is referenced by its

pharmaceutical name, Salbutamol, which accords with Pilnick's (1998) illustration of patients with long term conditions becoming comfortable using technical or pharmaceutical terminology.

In lines 101-103 the CP begins to utilise emphatic front staging (EFS) constructions; indexing their own action to enact a summative irrealis sequence to close the consultation. Here they also reintroduce the pharmaceutical name for the new medication (the term *Clenil* had also been used during the patient's peak-flow test, prefaced as *something called Clenil*). That the CP manages the introduction of the technical, pharmaceutical name for the brown inhaler in this gradual manner arguably demonstrates an attempt at promoting a shared understanding of the medication and its function. Conferring with point 40 of the Calgary-Cambridge model of consultation in regard to aiding patient understanding; 'uses concise, easily understood language, avoids or explains jargon' (Silverman et al. 2005: 24). However, as Chapter 4, Section 4.6.3 previously suggested, where such 'textbook' examples occur, it is worth considering that a potential observer's paradox may be at play within these consultations as the data was being recorded.

The summative irrealis EFS beginning at line 101 also collectivises the action associated with the new medication through the CP's use of *we'll do one puff*. As this progresses, the joint future action of the new treatment plan becomes contrasted against the current treatment that singularly points towards the patient in the tag question *you're using...aren't you*, and by line 105 it's not only the action, but also the intention behind it that becomes collectivised by the CP in the desiderative *we want*. This deictic pronominal switching also ascribes agency to the patient (*you can have one puff whenever you need it*) and negotiates the non-absolute nature of the CP's advice (*it's not that you're not allowed to take it*).

Whilst this minimisation of hearer imposition could be ascribed to notions of negative politeness, instead, I argue, this strategy has an explicit identity function; being deployed by the CP in order to facilitate a minimally didactic professional identity within the dyad. One that promotes the idea that the treatment is jointly reasoned and agreed between both

participants – ultimately to promote accord with the plan. Whilst co-constructions of patient narratives have been studied previously (for example, see Gwyn 2002: 150), this utterance suggests the co-construction of future action. Giving the discursive impression that this has been a negotiated process, in which a collective deontic stance has been taken towards the treatment that is in part, participatory for the patient.

A cursory scan of both the transcript excerpts from this consultation, and the initial concordance plot (Table 6.1) illustrates how this consultation is not only marked by recurrent pronominal attention towards the patient (alongside a paucity of the CP indexing themselves during the consultation), but also how the patient's responses are largely limited to affirmative backchannels with very little exposition. It is possible therefore, to characterise this as an ostensibly very asymmetrical consultation in both the traditional discursive sense of lay contributions (e.g., Mishler 1984, Waitzkin 1991, Wodak 1996), as well as via the framework of deictic pronoun use I have adopted in this thesis – thus rendering the negotiated process of future treatment truly illusory.

Returning to a consideration of the specific activity context informed by 'thick participation' (Sarangi 2006) however, a number of contextual details are relevant within this consultation that may influence its apparent asymmetrical nature: Firstly, to reiterate an earlier point, because this is an explicitly framed medication review consultation, it engenders a more closed context and therefore less exploratory approach than we might otherwise expect from a clinical dyad. This means that certain discursive tasks, such as narratives of symptom discovery, are generally extraneous to the immediate goal of the consultation. Additionally, the asthma medication review remains an annual obligation for the patient (via the UK Quality and Outcomes Framework), rather than being a consultation initiated by the patient to address a specific problem.

That this patient attends the consultation with a small child may also be a contextual aspect to take into account when assessing their relative dialogic passivity from merely the quantity of utterances and exposition they entail. Whilst these elements cannot claim to be definitive explanations for the unfolding of talk within this consultation, they do provide a

richer account of the circumstances in which this consultation exists; facets that are not immediately apparent from the language data itself.

Dataset 5 – Summary

In returning to notions of a professional identity to close the analysis of this dataset, I have proposed here that the particular consultation at hand, as a predesignated asthma review, presents a closed context in which the clinician adopts a more focused and transactional professional identity. This performance foregoes open-ended and exploratory modes of consultation – often deemed to be the hallmarks of a patient centric approach (Ishikawa et al. 2002) – in favour of a mode that utilises conventions that Sarangi (2000: 18) has previously characterised as a ‘educational service encounter’.

But whilst Sarangi – in reference to genetic counselling consultations – notes that this transactional style isn’t what we might expect from a ‘mainstream doctor-patient interaction’ (ibid), given the recentness and increased prominence of the CP role within UK primary care, we might question if indeed this remains the case. Or, whether this emergent form of advisory, non-exploratory consultation may become increasingly prevalent as primary care services are directed away from general practitioners. As I highlighted in Chapter 4, Martin (2014: 496) refers to these discreet discursive activities as ‘routines’ that structure and determine expectations within the consultation. However, whilst a ‘mainstream doctor-patient interaction’ (Sarangi 2000: 18) might consist of a series of these tasks in order to arrive at a diagnosis or treatment plan, the medication review is a dyad solely consisting of one of these routines – often pertaining to a singular course of medication for a long term, chronic condition.

Whilst performative, consciousness raising utterances are integral to the epistemic stance taken by the CP in this consultation, there is also a strong sentiment of collective decision making and action throughout the dyad. I suggest that in this particular instance, notions of the dyadic co-operative exist as a variously invoked floating collective by the CP, in which ambiguities in the use of *we* (for example, lines 32-34) frame forthcoming actions as

a joint achievement and convey tenets of professional authority through reference to the wider healthcare institutions.

Whilst Bucholtz and Hall (2005: 604) illustrate how discursive ambiguities in pronominal use can promote institutional power, in this instance the exploratory analysis has revealed a specific piece of identity work by which the CP diminishes their own perceived professional agency within the dyad to facilitate the notion of shared decision-making (line 101-110). In this respect, the CP's discursive professional identity is primarily concerned with the aforementioned conscious raising and lifestyle advice facet of the role – the epistemic component – whilst the deontic aspect, in which there are prescribed actions to be undertaken by the patient, is lexicalised collectively and therefore has the appearance of a co-authored agency.

I have suggested that this exhibits a co-creation of practical action that is distinct from the co-creation of experiential patient narrative often found within doctor–patient dyads. And in the emphasis this discursive strategy places on patient agency, this appears to be a key discursive component of promoting shared decision-making within this particular consultation – however illusory this ultimately may be. Indeed, as Joosten et al. (2008) highlight, the notion of shared decision-making is particularly important to consultations involving chronic conditions such as asthma.

A wider contextual reading including the ethnographic detail of this consultation recording has given the analysis a remit to consider how aspects such as restricted contexts, obligatory attendance and even the presence of dependent children may also contribute to the CP's professional identity, and – in this particular dataset – a dyad looking ostensibly highly asymmetrical from mere lexical contributions alone. This perceived asymmetry contrasts against the various markers of patient-centrism deployed by the CP, such as a mitigated deontic stance, an emphasis on the patient's agency and the gradual introduction of technical lexis.

These details suggest that any reading of professional identity and interactional asymmetry are complex and highly context dependant, thus according with Gill's (1998)

notion that asymmetry is not 'imposed unilaterally' and is instead a 'collaborative achievement' within the dyad.

capacity to act'. Negotiations of agency are also an overt instance in which the lay-specialist distinction is dialogically traversed within the consultation. Consequently, I hypothesised in Chapter 3 that it would be linguistic areas such epistemic and deontic stances that would play a significant role in the conveyance of expertise and the subsequent mediation of agency between the interlocutors.

Following the initial talk in regard to the operation at the start of the consultation, at the beginning of Extract 1 the patient outlines to the CP that she has made a decision to reduce her prescribed painkiller medication:

Extract 1

- 49 **CP:** Ok but you're still getting some pins and needles <1.0>
50 **PT:** Yeah
51 **CP:** Ok <0.5> erm <6.5> ok you may benefit from a different type of painkiller added
52 on to it although <0.5> they've already put you on amitriptyline but <0.5> you're
53 reducing it are you doing that of your own accord
54 **PT:** Yeah
55 **CP:** What why are you doing that exactly
56 **PT:** There was a few reasons one reason is that effected me heart <1.0> and I got
57 slightly worried you know
58 **CP:** Yeah
59 **PT:** The other reason is <0.5> er <0.5> I'm putting on too much weight <0.5> and I
60 know for fact that amitriptyline makes you hungry <0.5> and even on a diet I've
61 been on a diet now for years <0.5> you know on and off and its driving me crazy
62 so
63 **CP:** Ok
64 **PT:** I'm coming off them
65 **CP:** OK ahm <14.0 – CP typing> ok ah it's meant to be a good <0.5> ahm painkiller
66 for neuropathic type pain so when you're getting pins and needles as you come
67 down on the dose of that you may find that any neuron inflammation ahm the
68 pins and needles may get a little bit worse on that side <1.0> yep if that's the
69 case then it's really unbearable let us know we may need to put you on
70 something called gabapentin and then that might help

In accord with the requirements of the medication review, the CP establishes the temporal continuation of the patient's complaint in line 49 (*still getting*), and when the patient affirms this, the CP offers a low epistemic commitment to new medication through the modal *may benefit*. The deictic *they've* and *you're* within this line locates the potentially antagonistic elements of agency within the dyad – in this case with *they've* (the GP team within the same practice) being offset against *you're* as a referent to the patient. Notably the CP does not use the institutional *we'll* here to refer to the GP team; they are deictically separate from both the CP's speaking position and the consultation. The CP maintains dialogic attention on the patient and their action through the repeated *you're / you / your*, placing 'on record' that the medication reduction has come from the patient rather than the institution, culminating in the un-mitigated question found in line 55 (it is also worth noting for analytic purposes that the *what* to begin line 55 is a speech misstep, rather than a marker of exclamation).

After the patient responds to this question (lines 56-62), ending with the declarative *I'm coming off them* in line 64, the CP counters this realis statement with an irrealis sequence; one that is modally hedged by the dual use of *may*, but provides the patient with a conditional outline of the potential consequences of their action. The CP then reifies this hypothetical mood by stating *if that's the case* and providing the patient with an alternative treatment plan. Significantly, this sequence illustrates a dichotomy that is recurrent throughout the consultation and akin to Mishler's (1984) clashing of lifeworld and medical voices; the patient's agency claim is experientially based (*effected me heart, driving me crazy*), whilst the CP's response is largely biomedical in character and does not address the patient's experiential concerns. Arguably the utterance starting at line 65 is a crucial juncture at which the CP could assert a strong epistemic stance within the dyad in addressing the patient's experiential complaints and the requirement to continue the treatment. However, the formulation of expertise in the irrealis such as this seemingly minimises a sense of obligation for the listener, instead echoing Billig et al.'s (1988) notion of modern expertise as a 'hunch shouldered authority'.

The dataset resumes approximately 30 lines after the original extract, during which time the CP and the patient have discussed dosages of the pain killer medication – amitriptyline – and are now considering how the patient’s dose of quetiapine may also be bringing about unwanted side effects. In line 103 the patient proclaims that, should the side effects continue, she will also cease use of this medication:

Extract 2

- 103 **PT:** Oh that’ll be next if it’s not settled
- 104 **CP:** But but <0.5> again you’re on a very low dose of that one ahm but the problem
- 105 is that its maintaining your able to communicate you er ah appear to be fine at
- 106 the moment <0.5> then its ah then they keep you on lowest possible dose you
- 107 can get away with <0.5> we reduce it and then some of the side effects of erm
- 108 the er mental health problems and they would all come back in again <1.0> so
- 109 you just have to balance it
- 110 **PT:** Oh
- 111 **CP:** But most important also is it would be better if you do it under supervision of er
- 112 the GP or er do you have a
- 113 **PT:** Yeah but they won’t my psychiatrist won’t let me <0.5> reduce stuff
- 114 **CP:** Mmmm
- 115 **PT:** Er yeah it’s my body I’ll do what I want
- 116 **CP:** Er yeah ok <0.5> concern would be is that <1.5> mustn’t do it very quickly
- 117 otherwise you get rebound reaction <0.5> and ahm it would be better if <0.5>
- 118 you say to them this is where I want to go so how I want to do it and they’ll say
- 119 ok <0.5> we don’t advise but let let us supervise you er withdraw you from it so
- 120 at least they look after you <0.5> at the moment you are doing it on your own
- 121 and if there’s a rebound reaction then there’s nobody over seeing that <0.5>
- 122 yeah so <8.0>
- 123 **PT:** I mean I’ve been on ‘em fifteen sixteen years
- 124 **CP:** Umhuh
- 125 **PT:** It’s too long <9.0>
- 126 **CP:** Ok since er I’ve given this from the discharge so what I’ll do is I’ve made a note
- 127 and I actually won’t do it myself but I’ll ask one of the GPs if they’re happy for
- 128 me to do it first and then I’ll ah make these changes so they’ll probably say yep
- 129 that’s fine and they’ll probably <0.5> send a note or something to the

130 psychiatrist <0.5> so that he is aware that this is what's happening <0.5> yeah
131 <0.5> so that the erm right hands talking to the left hand otherwise we could end
132 up with reading different to what the records are saying to what everything else
133 is

The CP's response to the agency claim in lines 104-109 modulates between a strong epistemic declaration within their specific area of expertise (*you're on a very low dose*) to the diminished *you appear to be fine* in evaluation of the patient's current, holistic condition – arguably a domain of GP expertise. The non-specific *they* spoken by the CP is a reference to the hospital psychiatry team and therefore identifies treatment agency outside of the dyad. This external agency is then directly contrasted to the collectivised CP and patient joint action of the subsequent *we reduce it* utterance. Significantly, this is again presented in the irrealis – exhibiting to the patient a dispreferred conditional mood rather than any gradation of a directive speech act.

Whilst there are arguably identity and rapport concerns at play in formulating advisory sequences as dispreferred consequence rather than directives, in this particular instance it appears to impair the CP's deontic authority leading to deontic incongruence (Stevanovic and Peräkylä 2012) within the dyad as the on-going exchange will attest. This strategy taken by the CP echoes Nguyen's (2006: 41) notion of 'implied advice' in which the pharmacist provides no explicit instruction and instead the consequences are highlighted through exposition of the problem.

The speculative irrealis mood is continued by the CP in line 111 with the use of the modal *would be better if* in aligning the patient's intentions with the external professional supervisory authority of the GP team. As line 115 demonstrates however, this discursive tactic of illustrative hypotheticals to mediate conflicting ideas around treatment – in its diminished deontic authority – leaves the advice-giving sequence open to a bald on-record agency claim from the patient. Contextually, this is similar to Pilnick's (2000) reporting of patients resisting alignment to the role of 'advice recipient' in extended consultations with

hospital-based pharmacists. Here, however, the rejection of advice is much more explicit than misalignment and perhaps indicates that – in presenting professional advice as merely counterfactual – both the epistemic stance taken by the CP towards the potentially detrimental side to the patient's action, as well as the deontic stance taken in view of getting the patient to accept the advice, has not been explicit enough within the discourse.

Verstraete (2005) makes the point that modal deontic expressions do not yield scalar implicatures in the same manner an epistemic modal may; primarily because the utterance contains both a modal source (in this case the CP) and a modal agent (the patient). In this particular instance this results in the ostensible failure of the irrealis *would be better if you...* suggestion, as the weak modal *would* is not understood by the patient as a legitimate piece of advice for their future action.

Nonetheless, the CP continues this dialogic irrealis in lines 116-122 (*concern would be / it would be better*), this time introducing a technical phrase (*rebound reaction*) and a further external agent – the hospital psychiatry team. Notably, rebound reaction as medical concept is not explained to the patient at this point, rather this occurs approximately 25 lines after this sequence. The CP also invokes a propositional action that Leppänen (1998: 224) calls an 'allowable or requested alternative' advisory sequence. In this example the CP outlines how the patient should approach the psychiatry team in regard to the patient's wish to reduce her medication, including the formulation of conjectural dialogue to accompany this, in which the CP adopts the patient's deictic pronominal centre.

The utterance in lines 126-133 arguably marks the beginning of the CP discharging their own professional agency within the consultation in deference to the wider institutional remits of the GP and psychiatry teams. Initially punctuating the sequence with the discourse marker *so*, the CP utilises EFS to firstly outline future action (*what I'll do*) before modulating to the past-tense (*I've made a note*) to evidence action already undertaken for the patient in this closing sequence. Following this, the CP formulates himself as a passive agent (*I actually won't do it myself...*), both narrativising the institutional procedure required to oblige

the patient's requests and foregrounding the authority and epistemic stance of the external GP team required to make the requested changes over his own.

Dataset 6 – Summary

This particular dataset has examined how a CP dialogically manages a medication review in which a patient makes strong claims for control of their own treatment. In light of Ahearn's (2001) definition of agency as 'socioculturally mediated', this example arguably demonstrates this capricious mediation taking place within a clinical dyad: The claim for agency by the patient is discursively formulated in terms of their experience, and whilst these experiential claims are uncontested by the CP, the CP's responses are framed around tenets of professional expertise in creating an undesirable, biomedical irrealis mood contextualised against the wider, institutional healthcare system external to the dyad. This hypothetical mood ostensibly serves as a transactional substitute to the use of directives or imperative moods within the dyad; an indirect strategy of compliance that may have roots in a patient-centric approach to promoting empowerment.

As such the CP's performative professional identity is ostensibly one that is unobtrusive, allowing the patient requisite treatment agency against a background of institutional disapproval. The avoidance of any explicitly didactic utterances by the CP could be potentially due to the uncertainty behind the CP role and the full extent of its professional remit at the time of the recording – especially given that this patient is also under the care of a number of other clinicians.

It is notable how the discursive strategy of irrealis 'implied advice' (Nguyen 2006) differs from the seemingly transactional irrealis of the EFS also utilised by the CP to close the consultation (however, the appearance of both demonstrates why the grammatical future was found to be significantly key in Chapter 4). Whilst in this particular dyad it is easy to highlight how the implied, dispreferred irrealis is unsuccessful, data from the CPiGP focus group demonstrated that this particular CP's use of shared and non-didactic decision-making strategies have otherwise been considered effective:

“You can go to people that talk about diets, lifestyle; ‘you should do, you must do...’ this sort of thing, with <CP name> it is done in a more gentle way. With me, he led me to a point where it is something you know you have not done, so made me think about it. He doesn’t say; ‘you will do this, or you should do that’...in the end, you make the decision.”

Excerpt 6.1: Focus group patient testimony - Foxhole

This particular dataset, however, demonstrates how a professional diminishing their deontic stance in order to promote a convivial decision-making atmosphere can lead to dyadic misalignment. Ultimately in this exchange the CP’s advice is not taken by the patient, meaning that the CP has no other option but to refer the patient’s request onwards.

Alongside Verstraete’s (2005) ideas in regard to the non-scalar quality of deontic modals, Orasanu and Fischer (2008: 38) have suggested that the use of indirect strategies places an increased pragmatic onus on a hearer to interpret an utterance correctly. Meaning that whilst construing advice in this manner promotes a non-didactic mood between the interlocutors, it also heightens the possibility that the recipient will misunderstand the speaker’s intent. In this particular sequence the deontic quality of the irrealis mood is either rejected or misunderstood by the patient as a non-critical statement.

In terms of asymmetry, it should also be noted that despite the CP’s prominent use of technical and medical lexis within this consultation, this does not appear to engender the type of alienation or misunderstanding suggested by Wodak (1996) (even where a pharmaceutical term such as *rebound reaction* requires explanation); here the patient is seemingly comfortable discussing their treatment in these terms.

Indeed, thematically, this is also borne out in the wider CPiGP project focus-group data in which a number of patients stated that conceptualising their condition in terms of its medication and management with the clinical pharmacist was reifying and preferable to the – at times – abstract nature of discussing their condition with a GP. Again, as I noted in the summary of the prior dataset, this yields the notion that asymmetry and how a clinician

navigates it in terms of their discursive identity is more complex than a simple ascription of lay-expert terminology within the interaction. Whereas the definition of an 'expert patient' (Shaw and Baker 2004) I detailed in Chapter 2 oriented around potential lay claims to previously exclusive medical information, a patient with a chronic condition such as in this dataset, can be viewed as a discursive expert in regard to their treatment. Thusly requiring a dynamic adaption in professional identity to both claims of agency and expertise, rather than a homogenous application of discreet discursive consultation techniques.

6.4 Dataset 7 (*Ashbourne*) – *Triadic consultation*

<i>You're</i>	
<i>You've</i>	
<i>I'm</i>	
<i>That's</i>	
<i>Your</i>	
<i>I'll</i>	
<i>We'll</i>	

Table 6.3 – Concordance plots of the areas *Pronominal Auxiliary Contraction*, *Deixis* and *Irrealis* for *Ashbourne*:

The dataset of *Ashbourne* is unique in the CPC, in that it comprises of only one and a half (approximate) consultations. This is in part due to the particular means by which this practice approaches the CP role; meaning the CP is only responsible for medication reviews, the majority of which are undertaken by telephone. As Section 3.4.4 of the methodology outlines, for ethical reasons these telephone consultations were not documented for the research. Accordingly, only two in-person consultations could be recorded at *Ashbourne*, the first of which was beset by audio problems. Due to the paucity of data at this site, it was decided to undertake an analysis of the entirety of the complete consultation from this site, rather than to highlight an area of keyness typicality.

Table 6.3 above, nonetheless, demonstrates how keyness is distributed throughout the dataset for *Ashbourne* – with the full consultation illustrated by the red box and the incomplete consultation in the grey box. As the transcript extracts will illustrate, this particular dataset is also unique due to significant areas of minimal talk other than backchannels from the CP. The reasons and ramifications of this will be discussed throughout the subsequent analysis in this section.

The consultation in question concerns a patient who is attending for their annual medication review regarding a number of conditions. As mentioned above, in this practice the CP's remit is restricted to medication reviews and during LiPP's visit to the site, the practice manager reported that a robust triage system was in place that ensured appointment requests were directed to the appropriate clinicians. In effect, therefore, the CP's consultations within this practice are generally homogenous as activity contexts. Of further analytic interest to this particular consultation is that the patient is a healthcare professional. This was acknowledged in the pre-amble and the patient also attended the consultation wearing clinical fatigues, this is therefore, an intra-professional dyad. The first extract from this consultation begins with the CP undertaking a routine identity check:

Extract 1

- 1 **PT:** <date of birth>
2 **CP:** And your address
3 **PT:** <address>
4 **CP:** Lovely so you've come for a medication review today have you
5 **PT:** Yes
6 **CP:** Yep <0.5> so you saw the nurse at the beginning of the month
7 **PT:** Er last week actually
8 **CP:** Erm had your blood pressure done yeah
9 **PT:** Blood pressure
10 **CP:** Yep your blood pressure's ok and you've had some blood tests done haven't
11 you as well
12 **PT:** Yeah they came back fine
13 **CP:** Yep lovely so your kidneys are fine <2.5> so your kidneys are fine liver's fine
14 and your cholesterol levels they were <0.5> pretty good actually
15 **PT:** I know I was quite surprised I do nothing but eat cheese so I was quite surprised
16 about that want it
17 **CP:** So we should do your <0.5> your risk <0.5> or I'd imagine it to be quite low due
18 to your age so <2.0> yeah so when we've got your cholesterol levels or when
19 you've got high blood pressure that can increase your risk of heart disease erm
20 having high cholesterol levels further increases that and a family history can as

21 well <0.5> so that's all taken into consideration along with your blood pressure
22 your age your weight and your gender erm it says that you smoke is that right
23 **PT:** That's right yeah
24 **CP:** Ok so that all goes into a table it comes up with a ten-year risk ok so yours is
25 two point three which is very low ok <0.5> anything over ten we'd offer treatment
26 with statins which lower your cholesterol level
27 **PT:** Yeah
28 **CP:** So you're a way from it
29 **PT:** I'm a long way away from it
30 **CP:** Yeah you are <0.5> so erm as you get older that risk will increase if you blood
31 pressure was erm higher then again that increases your risk if your cholesterol
32 levels go up that increases your risk er weight has an effect as well so erm
33 <0.5> any plans to stop smoking at all

In line 4 the CP utilises a tag question – a rhetoric strategy identified as significant in the keyness trends of the CPC – in order to establish the agenda for the consultation. As I previously established, tag questions can serve an affective discursive role (Holmes 1984) and in this particular example, the rhetorical nature of the tag question accords with Rodhe's (2006: 135) notion that rhetorical questions function to 'synchronize discourse participants, confirming their shared beliefs'.

Whilst the question itself has a contextually obvious answer to both participants (and therefore sharing the requirements for a rhetorical question as per Ilie's (1994) comprehensive taxonomy, also at meso level, we are aware that a medication review is all that this dyad this *can* be. In lines 10-11 the further tag question – this time a reverse polarity tag question – checks the patient's interaction with the wider institutional healthcare functions, and arguably forms an implicature that invites the patient's endorsement of the CP's reading of the electronic patient record (EPR).

The evaluative language uttered by the CP in lines 13-14 is also anchored to this procedural checking of the EPR: As I mentioned previously in the analysis of Dataset 5, evaluative statements such as this are not an area of keyness significance within the CPC (unlike the PDC), and whilst in that extract the CP's evaluations were tied to the procedural

enaction of a peak flow test, here, notably, they are aligned to the affirming of the official patient record. This is therefore, a triadically-based epistemic stance that is taken by the CP – akin to Swinglehurst et al.'s (2014: 4) conception of an EPR as a further 'institutional voice' in the consultation, that 'contributes to defining what is important medical knowledge'.

The irrealis / jussive joint action then uttered by the CP in line 17 refers to a standard NHS health check – a preventative programme designed to assess early risk factors for heart disease, strokes and dementia in patients over 40, and for some sites within the CPC, a routine part of the medication review. Although in this instance the procedure is framed purely in terms of its risk-quantified output, the CP initiates an explicitly educational sequence (lines 17-33) to outline what the process means. At the end of line 22 the CP's question in regard to the patient's smoking is also based around reference to the EPR: Arguably this formulation (*it says you smoke*) allows the interrogative mood to be discursively detached from the CP, not requiring them to formulate a question from their own deictic speaking position (into what might be a particularly sensitive or face threatening matter), but instead frames the request as reported speech from the EPR as an official record. The use of the EPR therefore, is also an aid to the deontic status of the CP in the dyad; permitting questions to be asked based upon the official record, rather than as a perceived product of the CP's own standalone agency or judgement.

Following this section of the dyad, the patient outlines the reasons they haven't stopped smoking, which is punctuated by frequent, minimal backchanneled responses from the CP such as *yeah* and *right* (not illustrated) – a pattern that is also recurrently found in this consultation. These frequent backchannels without explication deserve attention as there is potentially a number of ways in which they could be read relating to the concerns of this thesis: Firstly, as Heinz (2003: 1114) notes, backchannels generally accord with Grice's (1975) co-operative principle in terms of a conversational contribution 'such as is required' in the specific context. And therefore, in light of concerns around paternalism present in healthcare delivery, these formulations could be viewed as allowing the patient to take the floor and elaborate their own concerns in a patient-centric approach. Alternatively, in terms

of the work of Zimmerman et al. (2013) minimal responses such as these could be viewed as a dialogic inattention to the patient within the consultation.

Being present at the site allows a more contextually based reading, in which I suggest that this discursive phenomenon is more a symptom of the practical enaction of a triadic consultation that is heavily based around reference to, and completion of, the EPR. Swinglehurst et al. (2014: 4) note how computer use can lead to an 'orderliness' within the consultation that is emergent from the 'template' of the official record on the computer, rather than from evolving dialogue within the dyad. An orderliness of this manner certainly seems to be apparent within this consultation as the CP follows the structure of the prescriptive health review structure via the computer. The extract resumes after the patient has noted that she mainly uses cigarette breaks to take a break from her own patients at work:

Extract 2

- 57 **PT:** So much easier I'm just going for a cigarette
58 **CP:** Yeah
59 **PT:** Rather than <0.5> I'm going to get away from you because you're doing my
60 head in
61 **CP:** Yeah <laughs> doesn't sound quite as good
62 **PT:** Don't sound quite as good no it damages your relationship a bit
63 **CP:** Yeah erm <0.5> if we just did put that as ex-smoker then that sort of further
64 reduces it
65 **PT:** Further reduces
66 **CP:** Your risk so that
67 **PT:** I've cut down a lot
68 **CP:** Yeah <0.5> so there is support available as well I'm sure you know
69 **PT:** Yeah
70 **CP:** If you want to stop and you want some support with that but as I say <0.5> erm
71 risk wise you're sort of well away from statins so keeping your weight under
72 control keeping your blood pressure under control erm <0.5> diet that <unclear>
73 exercise that'll help you keep risk down
74 **PT:** I've not had much exercise recently but touch wood ahm er adopting a dog in
75 <unclear> I lost my dog in April and I haven't really done much since then

76 CP: Oh right

77 PT: So hopefully in a couple of weeks I'll get back to dog walking across the moors

78 CP: Yeah what dog are you getting

The patient's explicit mentioning of her own patients and associated professional tensions in this sequence (line 50 - not shown - to line 62) appears to be a move to promote congruence within the dyad between the locutors, via the alignment of discursive identities, whilst also pragmatically conveying the identity of an expert patient (Shaw and Baker 2004) to the CP. By indexing in-group professional allusions such as the toils of patient care, the patient specifically aligns herself with the CP as a healthcare professional and minimises her lay identity within the dyad. Dialogically, this aligns with Bucholtz and Hall's (2005: 599) idea of the 'adequation' of speaker identity, in which alignment between speakers need not be exact, but 'must merely be understood as sufficiently similar for current interactional purposes'. Here, the sufficient similarity between the CP and patient is understood as the interlocutor's membership of the same wider healthcare institution.

Consequently, in lines 63-64 the CP hedges the advisory action formulating the implied advice of smoking cessation as a reduction in risk. Arguably the metonymic conceptualisation of detrimental lifestyle areas – such as smoking – as a quantified risk score on the EPR allows their discussion to be broached more easily within the consultation by the CP. Although the CP's use of the collective *we* here is once again another ambiguous example within the CPC (I suggest that it could be viewed as a potential reference to joint action of smoking cessation, or as an institutional collective constructing the official record on the EPR) the hypothetical mood used by the CP presents a conversational implicature to the patient that suggests that the action at hand should be undertaken.

The identity alignment work undertaken by the patient is acknowledged by the CP in line 68 in the crediting of the patient's expert, in-group status in the dyad. This is then followed in lines 70-73 by a non-didactic piece of advice that emphasises the patient's agency in the repeated, desiderative *want* which is then further moderated by the self-referencing,

reported speech of the CP reiterating that the patient is at no serious risk. Following this sequence, the CP and patient engage in tangential talk that lasts approximately 40 lines of the transcript. Immediately after this tangential talk the patient will also explicitly index her previous experience as an addiction worker in order to convey concerns around ongoing painkiller use:

- 121 **CP:** Anyway <0.5> where we were we
122 **PT:** Yeah sorry
123 **CP:** Medication wise is there any problems
124 **PT:** No problems with my medication <0.5> I'm a bit concerned that I'm taking more
125 codeine than used to that my pain has increased
126 **CP:** Right <0.5> ok
127 **PT:** Erm <0.5> I'm having to order it every month now
128 **CP:** Yeah
129 **PT:** I'm not having more than two a day
130 **CP:** Ok
131 **PT:** Erm because I used to be an addiction worker so
132 **CP:** Right
133 **PT:** So I hate the stuff

Much of the subsequent exchange involves the patient exploring their condition and medication with the CP's responses limited to backchannels as they contemporaneously complete the EPR. Therefore, the analysis of the selection resumes towards the closing of the consultation:

Extract 3

- 237 **CP:** Yeah the Senna can be good sort of if you need to go sort of really quickly but
238 sort of long term it's not the best
239 **PT:** Not the best
240 **CP:** So I'll I can give you some Lactulose just to loosen it <15.0> so I've added that
241 onto your repeat for you
242 **PT:** Thank you

243 **CP:** The citalopram how are you <0.5> doing with that

244 **PT:** Brilliant <0.5> brilliant actually I did er I was on one twenty which is er the

245 standard dose I did wonder whether with everything that's gone off if I need an

246 increase but <0.5> I'm managing really well

247 **CP:** Yeah that's good

248 **PT:** I'm happy to just carry on with that so <0.5> and I don't want to come off it we've

249 agreed that's that

250 **CP:** Yeah yeah

251 **PT:** <unclear>

252 **CP:** Ok have you tried to come off it perhaps

253 **PT:** Lots of times in the past

254 **CP:** Yeah

255 **PT:** Its never ending never ending <1.0> the agreement is that I stay on twenty if I

256 struggle I can increase <7.5>

257 **CP:** Have you tried a ten at any point at all

258 **PT:** No I've only ever had twenties the lowest I've been

259 **CP:** It might be worth at some point in the future considering a ten milligram erm and

260 just seeing how you that might be enough to control your symptoms <0.5> if

261 you've had a lot of stress recently then lets continue with the same for now but it

262 might be just something to consider in the future if you've had a period where

263 you've sort of been well for a long time <0.5> then we can always trial it and see

264 how you go that's just something to think about for the future

265 **PT:** <unclear>

267 **CP:** But yeah erm the gabapentin <0.5> is that something you want to <0.5> try or

268 do you want to try the physio first

269 **PT:** Try physio first

270 **CP:** Yeah

271 **PT:** I'd rather try it than <unclear>

272 **CP:** Yeah

[Not shown – concluding exchange]

The extract resumes with the CP offering an alternative medication to the over-the-counter medication currently taken by the patient. Much like the instances seen in *Foxhole* previously, in line 240 this is presented in the irrealis, with the pronominal self-reference of the EFS foregrounding the 'CP as a provider' temporary identity role in the dyad, whilst also

evidencing the consultation work as concurrent and ongoing, therefore fulfilling a transactional function within the consultation.

The dialogue in regard to Citalopram in lines 243-264 illustrates how a potentially sensitive and face threatening condition (clinical depression) can be discursively navigated when conceptualised in terms of medication. Initially, the discussion is literal and pertains to the medication (lines 243-258), but arguably moves towards a more general appraisal of the condition from line 259 onwards. Accordingly, this metonymic reference allows both interlocutors to conceptualise the severity of the patient's symptoms without explicit dialogic reference to them – for example lines 261-262.

This area of the consultation also presents a further instance of a patient claiming agency by invoking a healthcare practitioner external to the immediate dyad. Although alluding to a change in circumstances that might affect their dose (lines 245-246), the patient subsequently asserts that *we've agreed that's that* in regard to maintaining the same dose, an utterance that deictically identifies the authority of an external clinician. After the CP questions whether there has been any previous modification of the dose (line 252), the patient further reinforces that this decision-making process exists externally in line 255's *the agreement is that*.

This exchange exemplifies a tension I alluded to in the summary of Dataset 6, and that was expressed in interviews by this particular CP and others throughout the data collection for this study and the wider CPiGP project: That, because the CP role is still relatively new and amorphous within the primary care context, the boundaries and remit of the role are still being established by each individual CP – both within their own workplace context and intra-professionally against the remits of other clinicians. For example, as I noted to begin this dataset, this particular CP is restricted by the practice to only undertake medication reviews, whilst other CPs within the CPiGP cohort were able to manage minor ailments. Given the variability and newness of the role, there are times within the data (i.e., Dataset 6, line 127) that a CP – faced with an issue inappropriate or external to their remit – must either triage onwards or signpost the most relevant institutional caregiver (in part,

accounting for the keyness significance of the *CP indexing the collective* within the dataset). Accordingly, the advice ultimately provided by the CP (line 259 onwards) is hedged as the modal *might* and is formulated as the irrealis *in the future* twice, so that it doesn't impinge on the external advice pre-established.

Dataset 8 (Ashbourne) – Summary

The consultation comprising Dataset 8 is unique to the CPC in that it features a Clinical Pharmacist consulting intra-professionally with a fellow healthcare professional. This appears to have an influence on the patient's performative identity within the dyad as they index a number of in-group professional motifs throughout the extracts. Accordingly – in line with Bucholtz and Hall's (2005) notion of 'relationality' within dialogic identity – this seemingly inflects the CP's own discursive identity, as they utilise hedging, implicatures and overt reference to the EPR within their lifestyle advice and engage in lengthy tangential talk to manage the discourse with an expert patient.

The CP's heavy use of the EPR in a triadic form of consultation also warrants its own discussion, in that it forms a procedural basis from which the CP dialogically enacts the structure of the consultation. As I noted, this lends a 'orderliness' (Swinglehurst et al. 2014) to the undertaking of the dyad, and in terms of Martin's (2014) conception of clinical 'routines' that manifest dialogically from the necessity of certain areas of medical work, this consultation arguably presents a 'routine' being enacted in its most procedural discursive form. Again, it is worth considering whether this is due to the newness of the CP role in primary care sites, or indeed whether the presence of a researcher in the clinic engenders a more procedurally correct enaction.

The EPR in this dataset also forms an official record from which the CP can project an epistemic stance, thus diminishing the CP's own requirement to enact explicit judgement or obligation within the dyad. Whilst the notion of officially recorded, quantified 'risk' throughout the consultation is referenced by the CP as a proxy for an explicit deontic stance in the face of lifestyle advice that may be challenging for the patient to hear. The use of

these strategies of mitigation is important to note given the intra-professional and therefore 'expert' status of the patient who indexes their in-group professional identity throughout the dyad.

Overall, the most remarkable element of the CP's discursive identity within this dataset is how minimal it appears to be: The percentage of talk in this consultation favours the patient (54% total words) with many (52%) of the CP's turns appearing as backchannels with little exposition. This procedural enactment of the consultation accords with Pilnick's (2003: 841) observation of certain pharmacy-based dyads as a 'tightly focused' 'service encounter', but whilst in Pilnick's example this dialogic minimalism stems from a lack of acknowledgment of the patient's identity and potential knowledge, in this example I suggest that it is a product of the relative nascency of this form of consultation, in which areas such as EPR use and concurrent consultation have not yet been codified in a similar manner to that of a GP consultation.

Similarly, whilst the eliding of areas such as lifestyle advice, or its metonymic replacement in terms of risk or medication could be viewed as problematic in view of a patient-centric approach (see for example, Reisfield & Wilson 2004), as I highlighted in the summary of the previous dataset, patients from the CPiGP focus groups reported that talking about their condition in terms of medication or risk factors was seen as a practicable, discursive concretisation of an illness that may otherwise remain somewhat esoteric and conceptually abstract.

The disregarding of the experiential domain in this manner, however, could be viewed as a dehumanising discursive strategy in view of the traditional critiques of the clinician-patient dyad I outlined in Chapter 2. And indeed, whilst this may be true for some patients, consideration should be given to whether obligatory, 'closed' activity contexts propagate a transactional discursivity that is contextually pragmatic. As researchers committed to 'reflexivity and relevance' (Sarangi and Candlin 2003) in the discipline, merely importing the analytic expectations of other primary care consultations into a novel activity

context such as clinical pharmacy should be questioned; especially as these findings and recommendations pertain to the professionals we collaborate alongside.

Extract 1

- 1 **PTM:** It started with a tickly cough I'll tell you now he's a smoker
- 2 **CP:** Right ok
- 3 **PTM:** Which he shouldn't be you know one of them but he started with a tickly cough
- 4 on Monday <0.5> now an then the coughing between smoking an <unclear> but
- 5 it's got really really bad where he's been waking up in the middle of the night
- 6 you know
- 7 **CP:** Ok
- 8 **PTM:** An an
- 9 **CP:** How long how long have you been smoking for
- 10 **PTM:** A year now a year
- 11 **CP:** Yeah right ok so it's not just recent smoking
- [not shown: PTM & CP discuss character of cough – areas of file distortion]*
- 31 **CP:** Do you feel you're struggling to breathe at all
- 32 **PT:** Sometimes 'cos when I breathe I cough
- 33 **CP:** Cough ok
- 34 **PTM:** He's been wheezing quite bad when he walking around <>
- 35 **CP:** Right ok and whilst climbing stairs do you kind of feel a bit more tired
- 36 **PT:** Yeah
- 37 **CP:** More than normal <4.0 – CP prepping spirometer> are you on any inhalers at all
- 38 **PT:** No
- 39 **PTM:** To be truthfully honest I was going to take mine up last night <0.5>
- 40 **CP:** I'll pretend I didn't hear that
- 41 **PTM:** I know I know but I never I never thought
- 42 **CP:** Any pain in your ears at all <0.5>
- 43 **PT:** Er no
- 44 **CP:** No <0.5> in your throat
- 45 **PT:** Yeah
- 46 **CP:** Yeah you want to open wide for me <5.5 – examination> let's have a feel
- 47 around your chin <8.0> is it sore at all
- 48 **PT:** Yeah <8.5>
- 49 **CP:** Ok so the coughing is it worse at night time
- 50 **PT:** Yes <3.0>
- 51 **CP:** Do you want to take your jacket off and I'll have a listen your <0.5> wheezing
- 52 **PTM:** Yesterday <unclear>

53 **CP:** So take your coat off <4.0> I'll get you to stand up as well if that's alright and
54 turn and face your mum <3.5> deep breaths in and out <58.0 – listening to
55 breathing> ok sit back down again for me <0.5> so there's no signs of any
56 infection <0.5> that I can hear on his chest um his upper chest sounds a bit
57 squeaky
58 **PTM:** Yeah

To open the consultation in line 1 the parent begins the narrative of her son's symptoms by foregrounding the temporality of the condition. Notably, this initial statement by the parent also contains the revelation of undesirable information directly related to the condition at hand – *I'll tell you now he's a smoker*. That this confessional statement is then immediately evaluated by the parent in line 3, perhaps demonstrates that it functions to propagate epistemic alignment between the interlocutors; pre-empting the information being yielded and evaluated by the CP's own questioning. Halkowski (2006: 113) identifies information presentation such as this as 'working at being a reasonable patient' by exhibiting a doctorable identity to the medical professional – and in this case, providing a discursive acknowledgement that an undesirable lifestyle choice is present.

Similar to areas of the PDC discussed in the previous chapter, that this initial area of the consultation is monopolized by the parent isn't contextually surprising – even if it is atypical for the CPC: As an exploratory consultation in which the reasons for attendance must be outlined by the parent (line 5), the CP remains relatively passive until asking a series of focused, transactional questions in regard to the nature of the patient's cough (lines 12-25, not shown here due to partial sound distortion). These questions are followed up by the CP addressing the symptoms twice as experientially based *feel you're struggling to breathe* (line 31) and *feel a bit more tired* (line 35). The use of the experiential *feel* in these instances arguably allows the patient to address the symptoms in their own domain of experience – the 'lifeworld' (Mishler 1984). If we compare these instances of questioning in lines 31 and 35 to the invitation to input (ITI) constructions found in the PDC in which patients are asked to comment on *what* symptoms might mean, or *what* the course of action

should be (i.e., being asked to adopt the 'voice of medicine'), the patient-centric intent of the strategy adopted by the CP here is clear.

In line 39 the parent adopts a further 'confessional' stance in admitting to the CP that she was going to give the patient her own inhaler. The humorous response by the CP in line 40 echoes an idea by Heritage (2013: 371-2) that subtle epistemic claims in discourse can maintain expert identities. In this instance, for example, the CP's response is an implicature of the CP being able to issue a professional, deontic rebuke against the parent's actions. This utterance, therefore, fulfils an indexical-pragmatic component of the Bucholtz and Hall (2005) model by indirectly highlighting the inherent claims on knowledge in the lay-expert divide.

As the consultation progresses towards an examination of the patient, the notion of the CP holding assumed deontic rights over the patient is also illustrated in lines 46 and 51, with both requests appearing unmitigated and without a presaged metacommunicative act to signpost the request in advance. Contextually, it could be argued that this is partly due to the age of the patient and that the CP would perhaps be less didactic with an adult patient, nonetheless, an element of mitigation is present in the request for the patient to stand up for the examination (line 53).

Immediately following the examination, the CP utilises the discourse marker *so* (line 55) to demarcate that they are about to deliver an epistemic evaluation of the symptoms, evidentially indexing the basis of the assertion as *that I can hear*. Markedly, as Chapter 4 illustrated, this nature of construction is uncharacteristic for the CPC, and is instead more akin to the *states of affairs* keyness found in the PDC. Extract 2 of this dataset picks up the consultation immediately following Extract 1:

Extract 2

59 **CP:** So that's kind of like the wheezing <0.5> noise there so I think the smoking's not
60 helping <0.5> that's making it worse <0.5> an I think what its more likely to be is
61 a bit of a viral infection

62 **PTM:** Yeah

63 **CP:** On his on his lungs is causing the cough and then the smoking is just <0.5>
64 made it that bit worse <0.5> so I think what I'm going to do <1.0> have you used
65 an inhaler before

66 **PT:** Er

67 **PTM:** No

68 **CP:** No <0.5> so he doesn't need any antibiotics <0.5> I'm going to give him the blue
69 inhaler

70 **PTM:** Yes

71 **CP:** Salbutamol <0.5> erm <0.5> how old are you fifteen <0.5> what I'll do as well is
72 I'll give you a chamber <1.5>

73 **PTM:** <unclear – distortion>

74 **CP:** Its better if you use the chamber 'cos its not about kind of how he uses it

75 **PTM:** <unclear>

76 **CP:** Its like a a ahm cylinder

77 **PTM:** Oh right <unclear> thing yeah

78 **CP:** I'll get you a picture up <2.0> ahm <1.0> and what it does it just helps the erm
79 because sometimes when you breathe it in with the inhaler it just hits the back of
80 the throat whereas with this you haven't got to do the hand and mouth co-
81 ordination <0.5> so that's what they look like <1.5> those

82 **PTM:** Me daughter's got that one

83 **CP:** Yeah this is the old version of that one so

84 **PTM:** Yeah

85 **CP:** The inhaler goes in one end and mouth goes in the other <1.5> spray into the
86 chamber <0.5> and then you've got time then to breathe it in <0.5> you haven't
87 got to do it all in one go <2.0> and obviously <0.5> 'cos what you're only fifteen
88 aren't you

89 **PT:** Yeah

90 **CP:** And we need to kind of get you off the cigarettes

91 **PTM:** Yeah

92 **CP:** As well

- 93 **PTM:** I've been to his school actually school nurse you know to get some support an
94 stuff but <unclear> so I'll carry on getting on to him
95 **CP:** Yeah

The CP explicates the lay conceptualisation *squeaky* in line 59 in order to align it with the wheezing the parent has reported early in the consultation. The CP then makes a further pair of evaluative statements utilising the epistemic verb *think*. It is important to note however, although *think* is an obvious marker of an epistemic mood or stance within the dialogue, its use here is in a hedged construction (*more likely to be*) and therefore forms a scalar implicature indicating that the diagnostic assertion by the CP is provisional and temporally ongoing.

Again, this discursive activity is distinct from that seen in the previous CPC datasets within this chapter, thus demonstrating the current variability in the remit afforded within the role. Wherever *states of affairs* commentary have been operationalised by CPs in the data so far, it has been in order to affirm a procedure (e.g., an inhaler test), whereas the instances at this particular site precisely match those in the PDC in their evaluation of symptoms and conditions as they are presented within the consultation.

Nonetheless, in line 64 the CP utilises a highly typical EFS construction to lexicalise the upcoming action based upon the provisional diagnosis. As I outlined in the corpus analysis of Chapter 4, the transactional irrealis character of this type of EFS formulation is distinct to the metacommunicative strategies found in the PDC. Whilst the discursive analysis of Dataset 4 of the PDC further highlighted how metacommunication within the PDC allowed a clinician to lexicalise their overriding intentions or conceptualisations within the consultation, here the emphatic front staging is a discursive token of progression within the dyad; evidence of the resultant action from the 'routines' (Martin 2014) of questions or examination that have taken place.

This transactional discursive quality is further seen in line 68, in which the CP adopts the temporary discourse identity (Bucholtz and Hall 2005) of 'CP as healthcare provider' (identified as a key component of CP identity in Chapter 4) through the self-referential *I'm*

going to give him. This is also repeated in line 72 (*I'll give you a chamber*) which demonstrates how the primacy of self-indexing 'talk as action' in the EFS, and indeed, why professional self-reference is much more key in the CPC than the PDC.

Consideration could be given to whether the discursive transactionality of the EFS is a remnant of a clinical service that has been traditionally shop-based. Although, it is important to note, that in this new professional context, the EFS is not a register emergent from task-orientation as has been the traditional conception of transactional discourse (for example, McCarthy 2000), but rather, it is performative aspect of professional identity that reifies expert medical work into a transactional – and therefore reciprocal – exchange for the patient. As I argued in Dataset 6 of this chapter, the evidencing of transaction in discourse such as this may in part contribute to the high levels of patient-satisfaction recorded by the initial CPiGP project.

In a similar manner to Dataset 5, the CP initially conceptualises the medication in lines 68-69 in a visually apparent, lay representation rather than in terms of its pharmaceutical name. Significantly, in both this example and the one in Dataset 5, the move from the metonymically simplified *blue inhaler* to the drug's pharmaceutical name functions to introduce the inhaler as a new treatment in a patient-centric manner. As Lakoff and Johnson (1980: 36-7) suggest, the use of metonymy in this respect aids cognitive comprehension of the world – by conceptualising a novel item in a universally understood manner for the hearer; therefore, functioning in as an aid to patient-centric understanding.

A further dimension to the discursive management of a 'triadic' consultation can be seen in line 62, in which the CP utilises the computer to visually illustrate the use of the inhaler in conjunction with the chamber. Here the computer is operationalised to reify explanations and concepts; rather than becoming a component of an epistemic or deontic stance towards treatment as previously seen, it instead forms an auxiliary element of the consultation that is utilised to maintain engagement with the consultation process as Swinglehurst (2014: 21) suggests.

Following the illustration of the inhaler technique and apparatus, the CP begins to deliver lifestyle advice to the patient (line 87), in which notably, the evidential basis of the upcoming request ('cos *what you're only fifteen aren't you*) is indexed as a tag question prior to the statement itself. The statement, whilst in the strongly deontic *need*, is mitigated via the imprecise *kind of* and collectivised as the joint action of all participants in the consultation. The parent once again responds to this advice with a doctorable identity that shows accord with the CPs advice and evidences their own action (lines 93-94), similar to their utterances at the beginning of the consultation. The final extract from this dataset continues immediately following the end of Extract 2:

Extract 3

- 96 **PTM:** <unclear> let him have one of them <0.5> electronic fags
97 **CP:** The e-cigarettes
98 **PTM:** Yeah you know what they're like at this age he's always smoked fags though
99 **CP:** Yeah I think the jury's still a bit out on the e-cigarettes its yes its <0.5> hasn't
100 got all the rubbish in it and the gunk but it's still got that nicotine and addictive
101 stuff so <0.5> the ideal thing would be to get off them all together <0.5>
102 otherwise by the time you come <0.5> by the time you hit thirty you're going to
103 be on tablets and inhalers and struggling to breathe <0.5> and you'll be kind of
104 getting COPD
105 **PTM:** I've got that
106 **CP:** I'd expect yeah <0.5> so it's better to try and nip it in the bud now before it then
107 gets worse
108 **PTM:** I think with most kids its boredom isn't it so more with the gym that's where he
109 needs to go
110 **CP:** Yeah <0.5> so I'll give you that that's an inhaler do two puffs do it up to four
111 times a day and before you go to bed as well <0.5> erm steam inhalation in the
112 meantime to try and get rid of all of the gunk off your lungs <0.5> does it feel
113 quite thick as well yeah <0.5> yeah that'll be the cigarettes as well they'll be
114 kind of contributing to that <0.5> so steam inhalation either when you're in the
115 shower or get a bowl of hot water
116 **PTM:** I've got some of that sss oil stuff at home

117 **CP:** Yeah Olbas Oil yeah all of that <0.5> and when and when you go to bed extra
118 pillow just to support the head in the bed bit more upright to help with your
119 breathing
120 **PT:** Yes
121 **CP:** Is that alright <0.5> so if it gets worse struggling to breathe <0.5> get yourself
122 down to the hospital
123 **PTM:** Yeah
124 **CP:** Over the weekend or if it's not improved over the next couple of weeks then
125 come back and see us <0.5> alright
126 **PTM:** See you
127 **CP:** Bye

The parent's adoption of a doctorable identity continues at the start of Extract 3, with the suggestion that they have attempted to introduce e-cigarettes to the patient in lieu of actual cigarettes. In order to manage this well-intentioned admission that nonetheless appears to go against health guidance, the CP invokes an abstract and external epistemic source (*the jury*) and presents a preferred irrealis (*the ideal thing*) to outline the deontic action required that the patient ceases all forms of smoking – later reinforced in line 106's *it's better to try and nip it in the bud now*.

This is followed by a dispreferred irrealis sequence (line 102 onwards) similar to those uttered by the CP in Dataset 6 in order to outline the potential consequences of not taking the advised action. Notably, in this instance the discursive projection of the dispreferred irrealis is temporally bound (*by the time you hit thirty*) and isn't simply 'implied advice' (Nguyen 2006) as the example in Dataset 6, as it is intertwined with the CP's explicit presentation of advised action throughout and overt deictic attention on the patient via repeated *you / you'll / you're*.

Whilst in line 110 it appears the temporary identity role 'CP as healthcare provider' returns through a recurrence of the *I'll give* construction, in this instance a contextual reading yields that this is practically orientated around the action of the CP handing the prescription to the parent. Another atypical *states of affairs* construction occurs in line 113, in which the CP takes a causal epistemic stance towards the nature of the patient's symptoms.

Following the discourse marker *so*, in line 114 onwards the CP begins a recap of advice resulting from the consultation. West (2006: 409) has demonstrated that general practitioners initiate the closing of dyads by marking arrangements such as this, thus establishing a discursive ‘continuity of care’ beyond the consultation. In both Chapter 4 and the analysis of Dataset 5 within this chapter however, I observed that the EFS often played a role in closing clinical pharmacy consultations by either foregrounding action to be taken by the CP, or the CP and patient jointly as part of an agreed action plan.

In this extract – arguably more akin to West’s conception of GP closings – instead the recapping of advice is deictically projected out towards the patient’s obligations. Viewed through the framework of research into pronoun use I outlined in Chapter 3 and how this can provide insights into social hierarchy, the difference between concluding the dyad via *you* and *your* obligation to follow advice, versus obligation *I* have, and *I’ll* undertake, has clear implications for the perception of asymmetry within the dyad.

Dataset 8 (*Greenheath*) – Summary

This dataset has demonstrated that, when unconstrained from a closed activity context, the discursive enaction of CP identity can ostensibly appear similar to the performance of a stereotypical GP consultation. Within this consultation there are multiple clinical ‘routines’ (Martin 2014) being enacted by the CP – for example, history taking, examination and diagnosis of the condition. The latter of these is especially atypical for the CPC as I have noted throughout, utilising *states of affairs* epistemic stances in exactly the same manner as the junior doctors of the PDC, which then manifest into didactic advisory utterances.

Contextually, this extended performance can be accounted for by this particular CP holding both the credentials for a prescribing pharmacist and one qualified to manage minor illnesses; alongside *Greenheath*’s organisational approach to the CP role as I noted at the start of the analysis. I have also argued within the analysis that the patient’s age and the critical nature of underage smoking cessation might have led to the CP adopting a more unequivocal approach to that seen in previous data. Nonetheless, it would be remiss to

suggest that the enactment of this consultation is entirely uncharacteristic – although the exploratory consultation is a differing context to that faced by other CPs, there are after all, areas of CPC keyness utilised within, such as the EFS and dispreferred irrealis moods.

Returning to the ‘thick participation’ aspects of the data for this particular site however, there are other notable factors contributing to the performativity found in this dataset, that also illustrate both; the mutability of the role at this point and the tension between current clinical communication theory and the practical discursive enactment of the role. In the second interview with the CPiGP team, the CP remarked:

“...you are always taught like to use open questions, ask the patient what can I do for you, how can I help you? [...] So I started doing that, how can I help you, knowing it’s for a medication review. Then because they are in a doctors’ surgery, they think that we are GP’s and can sort out anything. They start talking about all their problems and everything but their medication. [...] and you go ‘ooh I am only sorting out your tablets’ so very quickly you go against what you should do for a consultation and use very closed questions. [...] And start to lead the conversation more and let the patient answer rather than using ‘is there anything else you would like to discuss’, ‘any other problems’ because I knew it would be out of my remit and I wouldn’t really know what to do.”

Excerpt 6.2: A CP interview extract from Greenheath 16/09/16

In the follow up interview five months later the CP reiterated this point again:

“In the books you are meant to use open questions [...] I found that I was doing that and it was just opening cans of worms because there were problems that were completely unrelated to the idea of the consultation. So now it is very direct questions, almost like answering for them. Rather than saying, ‘do you know what tablets you are taking?’ and they sit there 5 minutes and try and think of all the names, you know when you put words in their mouth and you say ‘oh you take this’.”

Excerpt 6.3: A CP interview extract from Greenheath 10/02/17

There is evidence therefore that this particular CP has developed a more didactic professional identity in order to manage the particular challenges of the CP role at this site. Indeed, in the semi-structured interview I administered in conjunction with the data recording at this site, I asked the CP about the demographics of the patients attending the practice and how frequent 'expert' patients were. The CP commented that whilst patients from an affluent area of the city (approximately 30% of the demographic) often wanted to know why certain medication was being advised over other medications they were aware of, that with patients from a more socio-economically deprived area of the city (approximately 70% of patients) a more direct approach was taken, in which the emphasis was on the act of provision itself.

The data from this site therefore illustrates how – in a role that has yet to be fully codified – the enactment of professional identity is a dynamic and emergent discursive undertaking, resultant from a number of contextual considerations and practicalities.

7. Discussion

7.1. Introduction

This thesis initially set out to answer the following series of research questions:

- 1) How do discursive professional identities manifest in the Perfect Day and clinical pharmacy datasets?
- 2) How do clinicians discursively enact professional expertise in the consultations?
- 3) To what extent does interactional asymmetry manifest within the data – does it play a significant role in these particular consultations?
- 4) Can a useful, practicable methodology be developed for external collaborators that combines corpus and discourse analysis with aspects of ethnography?

In the corpus analysis of Chapter 4 I established areas of significance used by speakers within both the Perfect Day and clinical pharmacy datasets. These findings were then applied to Bucholtz and Hall's (2005) identity model to give this thesis a working understanding of how salient lexical components exist in the enaction of discursive professional identities. In Chapters 5 and 6 I then utilised a discursive pragmatic approach in order to examine how these notable areas of speaker identity manifest in specific interactional contexts within the data. The analysis within Chapter 5 and 6 also employed elements of ethnographic detail gleaned from the data collection in order to augment the context-based examination of the data – providing an aspect of 'thick participation' (Sarangi 2006) to the data.

The analysis of these two datasets has ultimately revealed how distinct the discursive enterprises within the consultations are; despite their ostensible clinical, dyadic similarities. And accordingly, that professional identity is performed in lexically divergent manners by the specialty registrars of Perfect Day and the clinical pharmacists of the CPiGP

project. Evidence has also suggested that the navigation of asymmetry between the locutors and the conveyance of expertise is also discrete between the two corpora.

This discussion chapter, therefore, is structured to account for the overriding themes yielded from the three data analysis chapters in answering the initial research questions directly. Section 7.2.1 will illustrate how, for the candidates of the Perfect Day Corpus, professional identity is comprised of a system of evaluative moods, epistemic stances and affirmations that also function discursively as an integral part of the enaction of an expert identity. In Section 7.2.2 I explore how the overt navigation of asymmetry – a specific area of professional identity work – was largely unsuccessful for the candidates and explore the reasons for this. Finally, for the Perfect Day Corpus, Section 7.3.3 will discuss how the contextual frame of these specific simulations impacts the candidates' performance of professional identity.

For the Clinical Pharmacy Corpus, Section 7.3.1 describes how CP professional identity is one that is largely transactional, leading into Section 7.3.2's discussion of how the prominent use of irrealis moods by CPs formulates emphatic front staging (EFS) – a discursive strategy emphasising work being undertaken by the clinician in the dyad, that also demonstrates expertise and locates the CPs' identity as a healthcare provider. In Section 7.3.3 I consider how medication reviews present a closed context for the CPs currently, how this impacts both the CPs' professional identity and consultations, and how this also foreshadows perhaps a more modular approach to primary care.

Although, as I stated in Chapter 3, a direct comparison of the two datasets was not a specific intention of this study, Section 7.4 will explore areas that are common to both datasets; the indexing of external epistemic domains and use of the institutional, medical *we* as an identity component. Whilst Section 7.4.3 examines the findings in context of the changing UK healthcare landscape. How the findings pertain to professional practice they examine is discussed in Section 7.5, in order to address the final research question. This chapter concludes with an appraisal of the methodology taken; reflecting on both applied linguistics collaborations and the methods used within the research.

7.2 Perfect Day

7.2.1 Enacting credible evaluation – observable, performative professionalism

This thesis primarily set out to uncover how professional identity was enacted within the Perfect Day and clinical pharmacy datasets. The corpus analysis undertaken in Chapter 4 evidenced that in the Perfect Day consultations there were two overriding lexical themes; firstly, a commentary on the *states of affairs* within the dyad, characterised by the provision of evaluation, affirmation and epistemic stances towards diagnostic evidence in the grammatical present. Secondly, a direct indexing of the simulator via various *you / your* pronominal constructions that served to establish the temporality and detail of the simulator's narrative – often to augment the candidate's own reasoning and judgment. In concluding Chapter 4, I proposed that these two areas of significance fulfilled the indexical-epistemic component of Bucholtz and Hall's (2005) model of identity.

Chapter 5's discursive analysis then illustrated how the pragmatic achievement of an evaluative professional identity in context is multifaceted; existing as both ostensibly mundane evaluative backchannels such as *that's good*, to comprehensive metacommunicative strategies that evidentially present discursive reasoning throughout the consultation. Thus fulfilling Mushin's (2001) notion that epistemic stances are contingent on pragmatic use of language in context, rather than just specific formal properties.

Chapter 5 also demonstrated that epistemic stances can be reinforced or diminished by a candidate invoking the wider institutions of the medical profession via the pronominal *we* as they react to the performativity of an infelicitous interlocutor. It also showed how pragmatic elements such as implicatures and ITIs are deployed for patient-centric intent – these will be fully discussed in Section 7.2.2. Accordingly, I propose that the professional identity evident within the Perfect Day Corpus can be characterised as one of credible evaluation – observable performative professionalism. Furthermore, this amalgam of realis moods, epistemic stances and deictically external pronouns creates a system by which expertise is enacted by this cohort of junior clinicians. This echoes Sarangi's (2006) notion of healthcare language as an 'expert system'.

Throughout the analysis of the Perfect Day data I have contended that any examination must account for the pedagogic environment in which these professional identities are being performed. The clinicians within these dyads are not going about their daily business in a surgery, but rather, they are specialist registrars undertaking a training exercise in which their emerging consultation skills face professional scrutiny. As such, the high significance of performative evaluation within this data may indeed stem from the activity context (pedagogic simulation) as it does the speech event (clinical interviews) itself.

I have purposefully adopted the epithet 'credible' to characterise the enaction of identity within Perfect Day as I believe that this orientation towards performative evaluation most closely echoes Atkins et al.'s (2016: 7) notion of success in simulations being determined by the 'ability to voice a credible appearance of [...] communication'. As I noted in the conclusion to Chapter 4, there is evidence of candidates orienting towards the positional, local identity (Bucholtz and Hall 2005) conventions of the 'good doctor / good trainee'. As such, it might be that an explicit, evaluative performativity is yielded in order to demonstrate the perceived requirement of good clinical skills – resonating Hodges' (2012: 27) view of an overreliance on 'performance discourse'.

The notional requirement to maintain an evaluative epistemic stance of 'knowing' is seen in instances in which candidates are not sufficiently equipped to provide an immediate answer to the simulator. In both Datasets 1 and 3 of the Perfect Day Corpus the candidates deictically locate institutionally-adjacent epistemic domains outside of the dyad to fulfil the perceived requirement to provide certainty to the simulator. As I noted in those examples, the hallmark of a more experienced medic is more likely to be the measured discursive presentation of uncertainty (Buckman 1984). Indeed, Gordon et al. (2000: 62) note that measured expressions of uncertainty correlate with a wider body of discursive behaviour associated with high reports of patient satisfaction.

Given the high level of discursive agency the simulators claim within these dyads, alongside the pedagogic challenges they enact, the Perfect Day scenarios would appear to accord with Hanna and Fins (2006) notion of a reversed asymmetry. By which, the dialogic

infelicity – as I have called it throughout this study – is a product of a patient for who the consultation is, unrealistically, inconsequential. Nonetheless, the approach I have proposed within this thesis integrates the findings of social psychological research on pronouns to provide a novel means of uncovering how asymmetry exists within medical consultations. That the candidates recurrently index the simulator, their actions and their narrative, accords with the findings of Kacewicz et al. (2013: 13) that locutors of ‘higher status’ (defined in Chapter 3 as a higher knowledge status in line with principles of attendance at any clinical consultation) are more likely to deictically project outwards towards their interlocutor. Indicating that even in consultations in which the patient is extremely challenging, there is an underlying asymmetry that is predicated around discursive attention inherent in the task at hand.

Kacewicz et al. (2013: 14) contend that the non-conscious use of pronouns by speakers (Chung and Pennebaker 2007) provides a relatively unbiased principle by which the understanding of hierarchy is illustrated within the interaction. Or, as Gonzales et al. (2010: 14) assert a ‘pure measure of social dynamic’. As such, this finding would reinforce Pilnick and Dingwall’s (2011: 1374) notion that asymmetry ‘lies at the heart of the medical enterprise’ – given that a significant component of the professional discursive identity is the deictic projection of attention towards the lay interlocutor, a sense of asymmetry may be inevitable. The implications for this are that, whilst previous research has suggested that it is areas such as disparate voices, knowledge claims, or turns at talk that exemplify the asymmetry in medical dyads, unconscious pronominal use reveals the architecture of social order that is inherently predicated around the axiomatic roles each locutor inhabits.

Nonetheless, this is predicated upon the assumption that pronominal usage is largely unconscious per Chung and Pennebaker (2007); however, in adopting this framework for the analysis, in Chapter 3 I noted that this in itself could be considered a contentious assumption. Accordingly, within the discussion of usage of the institutional *we* by clinicians in Section 7.4.2 forthcoming, I propose how unconscious deictic use of pronouns in

discourse may differ from use that seemingly indexes a collective group identity for a particular discursive outcome.

The analysis within this thesis has also uncovered an unanticipated facet of clinician professional identity that has so far gone largely ignored within the subject literature: That an evaluative, epistemic stance towards evidence by the clinician within the dyad may have affective functions for the patient, rather than just reinforcing knowledge asymmetries. In a comprehensive review of clinical reassurance, Pincus et al. (2013) identify 'cognitive' ('providing explanations and education' – similar to what I have termed throughout this thesis as epistemic) and affective modes of reassurance. They conclude that, whilst the discursive performance of affective or empathic reassurance has notable short-term effects (for example, satisfaction and reduction in patient anxiety), cognitive or epistemic reassurance has a broader range of tangible patient outcomes both immediately (increased knowledge and belief change) and in the long-term (compliance, acceptance, lessened impact of health problems on life generally) (Pincus et al. 2013: 2414-2415). Reassurance and the epistemic claims it entails, therefore, could be characterised as an element of 'functional asymmetry' as per the conception of Pilnick and Dingwall (2011).

Pincus et al.'s (2013) conclusions not only have ramifications for traditional notions of paternalism or asymmetry in healthcare, but also introduces the importance of temporality and longevity of care into the debate. This is particularly important to simulated consultations in which reoccurrence or temporal longevity of care is another layer of illusion that must be maintained by the participants. Consideration could also be given to how the role and dialogic form of discursive reassurance may change with an increase in more informed expert patients in primary care.

Within the analysis of the Perfect Day data a number of recurrent formulations were evidenced that could be categorised as stock or formulaic language. That elements of formulaic language should be found within simulated consultations is not in itself a new concept (see for example; Roberts et al. 2003, Hawthorne et al. 2017). Notably, numerous pieces of advisory literature for the RCGP's Clinical Skills Assessment explicitly warn

against the use of formulaic language. I suggested in the analysis of Dataset 3 however, that the issue remains to what extent these constructions can be dismissed as merely formulaic or are indeed an integral linguistic component of a professional clinical identity. For example, Wray and Perkins (2000: 15) highlight how formulaic language functions to ‘short-cut’ processing time in discourse – a function that would have clear application to time-constrained contexts such as real and simulated medical consultations. They also note that formulaic language functions socially to indicate a group identity (14) – similar to the point I made at the conclusion of Chapter 4 that stock phrases were markers of indexical, group structure (Bucholtz and Hall 2005) identity.

Indeed, research considering metrics of success in simulated consultations has shown that formulaic sequences of language are used as much by successful candidates as they are by unsuccessful candidates; indicating that it is the ability to modify, reformulate or contextualise phrases that determines their acceptance in the discourse of the consultation (Roberts et al. 2014, Atkins 2018).

In Dataset 3 I highlighted a prominent example of a candidate uttering a formulaic statement of empathy that appeared detached from the exchange that preceded it. With simulated patients reporting their primary metric of a candidate’s quality as the appearance of being listened to (Russell et al. 2012: 394), decontextualized empathy such as that in Dataset 3 perhaps presents a token of discursive logic not being followed or reciprocated, in favour of an opportunity to utter gestural empathy. Additionally, an examiner or educator may surmise that stock empathy is an overt index of group identity; its prominence within the discourse illustrating the explicit performance of affective discursive work, rather than a contextually appropriate usage.

7.2.2 Navigating perceived asymmetry

The analysis I have presented within this thesis has proposed a number of linguistic means by which the Perfect Day candidates navigate the perceived lay-expert identity asymmetry within these consultations. The most prominent of these discursive strategies being 'invitation to input' (ITI) formulations in which candidates attempt to elicit thoughts, concerns and dialogic participation from the patient (Emerson et al. 2020). The regularity of ITI constructions within the data suggest that they could be considered an element of formulaic language in line with the previous section – appearing as a discursive means by which the candidate orients towards a positional, local identity (Bucholtz and Hall 2005) in the performance of attentive patient-centrism.

The recurrent rejection of ITIs within this data, however, demonstrates that they are similarly sensitive to appropriate contextual use. Instances in Datasets 1 and 3 for example, illustrate that asking patients to comment on undeveloped concepts, or to propose extensive actions in the context of these consultations may be ultimately detrimental to the professional identity the candidates are attempting to convey. Whilst in part this may be attributable to the infelicity of the simulators, Toerien et al. (2011: 319) contend that offering patients choice – or in the case of this thesis, the discursive agency 'to input' – is a more complex endeavour than much medical literature suggests. Or furthermore, that the offer of autonomy itself may be counterintuitively burdensome for the patient (de Haes 2006: 295 for example, cites Schwartz's 2004 notion of a 'tyranny of choice').

This echoes the point I made in the analysis of Dataset 4, suggesting that ITIs are more effective when presaged by an epistemic, diagnostic narrative from the candidate that will ultimately frame the input the patient is being invited to make. The presentation of an ITI in its most affected form with no contextual modification seemingly leads to incongruence that undercuts professional identity. Nonetheless, the caveat must be made that this is how ITIs succeed and fail within this particular pedagogic environment, with patients who are both challenging and infelicitous. In a non-simulated GP consultation – given that it is highly consequential for the patient – it could be argued that a patient would be more inclined

acquiesce to the intent of the clinician in order to progress the consultation towards the goal of diagnosis or treatment.

Analysis of the Perfect Day Corpus also highlighted how the candidates routinely operationalised implicatures to navigate the often-delicate subject matters within the scenarios. The candidates' use of implicatures – frequently, for example, expressing covert disagreement or introducing the possibility of a more serious illness – would suggest that this is patient-centric, discursive identity work being undertaken to alleviate imposition on the simulators; serving to subtly guide them towards a likely diagnosis or course of action without didactically imposing a doctor-centric perspective.

However, in a similar respect to ITIs, this strategy was largely rejected or seized upon by the simulators. Given that vague language is an enduring feature of healthcare interactions (Adolphs et al. 2004), I believe it would be insufficient to ascribe these implicature failures as a simple need for clarity from the candidate. The findings of Winefield et al. (1995) demonstrate that in more complex consultations the adoption of a patient-centric approach by a clinician lessened reported patient satisfaction. Given the inherent complexity of both the scenarios in Perfect Day, it may be that an unambiguous discursive performance would be more appropriate. Once again, highlighting the importance of an appreciation of context for the candidates, in which alleviatory strategies are used dynamically, rather than homogeneously throughout the consultation.

As I have noted in this thesis, whilst implicatures may elide uncomfortable areas of the consultation for the clinician, they do so by forcing the simulator into more interpretative work in order to glean the pragmatic intent behind the utterance. Furthermore, as the analysis has illustrated, implicatures were often used (for example, in Dataset 3) by the candidate to manoeuvre around an ITI that had yielded an unwanted answer from the simulator; functioning to indirectly correct the simulator without explicitly stating they were wrong. That in these instances the candidate then had to 'scale up' bad news by using implicature, demonstrates how contextually detrimental this discursive strategy can be – causing, in effect, a diminishment of professional identity.

As such, both ITIs and mitigatory implicatures are discursive strategies that ostensibly seek to enhance the ‘adequation’ component of the relationality principle of identity (Bucholtz and Hall 2005); signalling to the patient that knowledge, decision-making and modes of knowing are understood in an egalitarian manner by both interlocutors in the consultation. Nonetheless, in the context of these pedagogic scenarios these are strategies that are incongruous with the characterisation of these particular patients.

7.2.3 Contextual fragility of simulation

Despite analytic concerns over the artifice of simulated consultations (Seale et al. 2007), the data yielded from the Perfect Day Corpus has demonstrated how dynamic and varied candidate performativity and approaches can be in these interactions. Because of the pedagogic, scripted nature of Perfect Day, I outlined in Chapter 5 that I view the activity context as twofold; the circumstances of the consultation itself, alongside the designed performativity of the simulator. To begin the Perfect Day analysis, I noted that the characterisation of the simulators was one that ran contrary to ideas of a ‘doctorable’ (Heritage and Robinson 2006) patient identity, and as such, was infelicitous in its dialogic approach – a pedagogic function of the exercises to ostensibly challenge the candidates.

With much of the literature on simulated consultations questioning the realism of such exercises (for example, Hanna and Fins 2006) the accordant validity of such infelicitous and undoctorable discursive performances by the simulators could be called into question. In the previously noted illustration of vague language for example – despite its erstwhile typicality in medical dyads – areas of vagueness were primarily occasions in which the simulators challenged the candidates in Perfect Day.

Nonetheless, I believe that a holistic appreciation of the activity context should be adopted when dealing with pedagogic simulation; one that takes account of the initial intent of the educators who designed the scenario. Be it as an exercise to refine a particular area of consultation skills such as breaking bad news, or, as in the case with Perfect Day, to introduce Self-Regulation Theory to the candidates.

My colleagues and I previously noted (Emerson et al. 2020) that the simulators in Perfect Day do not fulfil the remit of an expert patient characterised by Shaw and Baker (2004). Rather, a case could be made that the simulators represent avatars for increased patient agency – characterizing ‘worst possible’ scenarios for the candidates to manage. Indeed, in their perhaps excessive and infelicitous agency, the simulators challenge the candidates’ straightforward enactment of a professional identity as I noted in Dataset 4; forcing a more attentive consultation style that accords with the notion of Self-Regulation Theory, whilst not necessarily presenting objective realism. For a clinical educator however, it is worth considering that – as with the example of vague language – the performativity of the simulator can be challenging to the candidate in ways that are otherwise atypical from real-life consultations. Indeed, as I suggest in Section 7.5, forthcoming, perhaps a more mundane and less assertive challenge could also prove valuable.

Throughout the Perfect Day analysis, I have also attempted to comment on instances in which the context of the simulation itself appears to have had a bearing on the discursive identity performance of the candidate. Primary amongst these contextual concerns are the confined temporality of the dyads and the paucity of contextual detail contained within them. Chapter 4 revealed the significance of the grammatical present within the Perfect Day Corpus – a stark contrast to the significance of irrealis moods found in the Clinical Pharmacy Corpus. A focus on the immediate context might suggest that, in these particular scenarios, discursively manifesting hypothetical future action is difficult for the candidates. Which, in turn, may account to some extent for the unexpected lack of deontic projections within the data in outlining a course of future action for the simulators.

To attempt to account for this, I return to the notion of credible performativity proposed at the start of this chapter: It has been shown that the act of consulting in a simulated environment is difficult for some clinicians, with embarrassment, observation anxiety (Nestel and Tierney 2007: 5) as well as socio-cultural differences (Ragg et al. 2015: 380) being levied as the main reasons for diminished performance. Whilst discursive reference to the immediate, realis context is straightforward – for example commentary on

the *states of affairs* or symptom narrative the simulator is presenting – those elements ‘out of frame’ may be harder for candidates to index. In these off-stage instances, I suggest that the simulation moves beyond a performative endeavour for the candidate, to one that requires creative actualisation.

At several instances in the Perfect Day data I have emphasized that the omission of certain contextual details within the simulations appears to force the candidates into more onerous discursive work in order to account for their environmental absence. Key amongst these areas were the lack of an EPR to refer to histories or details, difficulties actualising responses to complaints, and integrating out of frame family members into patient recommendations. The ambiguities surrounding the opening and closings of simulations has already been noted by Roberts et al. (2000) and Thomassen (2009) for example, but I propose that the absence of this further detail moves the candidate beyond the performativity of the task at hand, to a creative indexing of out of frame or incomplete detail.

In essence, these consultations represent a minimalist activity context that is purely dialogic, which may indeed be the intent given the goals of Self-Regulation Theory. There are also a number of practical and educational design constraints around any simulated programme such as Perfect Day that potentially make the addition of extensive contextual detail unfeasible. Nonetheless, it is again worth considering for any educator that these contextual elements may be an unappreciated component of any candidate’s discursive performance. As Roberts et al. (2014: ix) report, that successful simulation candidates used metacommunication extensively illustrates that this may be one strategy by which the candidates can navigate this paucity of environmental detail – as demonstrated by the candidate in Dataset 4; relying on concepts and intentions within the dyad rather than being mired in detail.

7.3 Clinical Pharmacy

7.3.1 A new, mutable professional identity

For the clinical pharmacy consultations, the corpus analysis of Chapter 4 foregrounded four areas of lexical significance; the first of these illustrated the lexical footprint of the medication review – the primary form of consultation found in the CPC data. Demonstrating how the CPs indexed patients via *you're you've* contractions to check and endorse medications or symptoms. Frequently, this was achieved in conjunction with the EPR as a triadic epistemic source within the consultation.

Notably, the CPs self-referential use of first-person pronominal constructions featured in two of the areas of key significance uncovered by the corpus analysis, functioning in broadly similar manners to evidence medical work to the patient. Collocational examination then showed how present and past tense constructions (*I'm, I've*) outline the CP's action and responsibilities, whilst irrealis formulations (*I'll*) highlighted work to be undertaken or being concurrently done. The final area of significance in the clinical pharmacy data illuminated how the CPs invoked the lexical collective to promote shared decision-making and grounded their own decisions and actions in the scope of wider healthcare institutions.

I argued that these pronominal functions operated as emphatic front staging (EFS) – a concept that borrowed the Goffmanian (1959) dramaturgical concept of a front and backstage to describe the contemporaneous discursive foregrounding of work being done.

To conclude the clinical pharmacy area of the corpus analysis I proposed that the CPs were evoking the indexical-overt component of the Bucholtz and Hall (2005) model in three ways: In their indexing of the patient for medication reviews, their self-reference in the foregrounding of their roles and work, and in their collective allusion to the wider healthcare institution. Meanwhile, I argued that the CPs self-reference in the outlining of concurrent and future medical work constituted an indexical-epistemic component of identity and that their evocation of the collective for shared decision-making purposes was an indexical-pragmatic

element of identity. As this wider array of findings suggests, the variation and dynamism of tasks and real-life data ostensibly makes identity more complex and volatile.

The discursive approach to clinical pharmacy data in Chapter 6 built a multifaceted analytic picture of the CP professional identity that demonstrated both discursive execution and contextual enaction of this role was not always comparable between the datasets. Unlike the controlled environment of Perfect Day, it is perhaps unsurprising – as the corpus results suggest – that it is far more difficult to characterise a central theme of identity within the Clinical Pharmacy Corpus. This is in part attributable to the varied approaches and professional remits afforded to the CPs by their employing practices, alongside their individual statuses as either a prescribing or non-prescribing pharmacist; detail that was available for this thesis via the ‘thick participation’ (Sarangi 2006) ethnographic involvement in the wider CPiGP project.

A further point of relevance from the ethnographic detail is that there are no senior role models in comparable positions for these CPs due to the nascency of the role – the CPs within this data were either mentored by GPs or nurse practitioners prior to their appointment. That the remits and procedures around this role are not fully professionally codified at this stage, also means that the CP in one practice may largely see a different profile of patients to another. Accordingly, the CPC data documented the establishing of a professional identity with no set precedent.

Nevertheless, a recurrent finding from the data was the transactionality of the clinical pharmacy consultations; by which, the predominant identity finding from both the corpus and discursive analysis was one in which the action and transaction of deontic moods was favoured over evaluative, epistemic moods. This was exemplified by the use of the EFS – the persistent discursive indexing of ongoing action. Below, I attempt to account for why pronominal self-reference is a key area of CP data, and subsequently in Section 7.3.2, I discuss the EFS in detail, considering the singular irrealis aspect in the first half of the section and the collective irrealis component in the second.

Given their status as potential language-based proxies for identity (Vaughan and Clancy 2013), the prominence of pronominal self-reference is a significant feature of professional identity in the clinical pharmacy data. In adopting the same social psychological principles of attentive pronominal asymmetry used for Perfect Day, the higher significance of CP first-person pronouns within the Clinical Pharmacy Corpus may indicate that these consultations are more egalitarian – with discursive attention shared between both locutors and a more personal discursive presence from the clinician in the dyad.

Indeed, Zimmerman et al. (2013: 223) propose that extensive use of first-person singular pronouns may function as a social strategy designed to evoke empathic responses in interlocutors. If indeed there are elements within these consultations that require a level of social understanding from the patients, or provoke discursive self-attentiveness from the CP, it is in the newness of the role, which – as the wider CPiGP project and interview data for this thesis documented – often required clarification in regard to its limits.

A more prosaic explanation, however, might lie in the recurrent medication review activity itself. Whilst, as I noted at the start of this section, medication reviews are often undertaken in a variety of different manners because the conventions are not yet codified into the dyad, this form of consultation is often a closed context; fulfilling the notion of a singular medical ‘routine’ (Martin 2014), rather than a series of routines. (The specifics of a closed context to CP identity performance will be discussed fully in section 7.3.3, below). Those consultations that relied upon the EPR heavily (for example, Dataset 7) demonstrate most explicitly that this is a singular routine of procedural action, unlike the Perfect Day consultations which are predominantly evaluative over narrative states of affairs presented in the dyad. Accordingly, the CPs dialogizing their own discursive identity into the consultation seems an inevitable mechanism to evidence a reciprocal exchange of procedural checking and accordant action to be undertaken.

7.3.2 Talk as work, talk as action – transactional irrealis moods

In Chapter 4 the corpus analysis illustrated the importance of irrealis moods in creating the emphatic front staging (EFS) seen throughout the CPC data. In this section I discuss how use of the EFS in context can be broadly distinguished between the pronominal singular (*I'll*) to its plural, collective functions (*we'll*).

The importance of the EFS to professional identity is seen in the discursive evidencing of work being concurrently undertaken, or to be undertaken, foregrounding the 'provider' aspect of the CPs' positional, professional identity. The basic notion of medical talk as medical work in itself has previously been addressed by Iedema (2006), however whilst Iedema focuses on the bureaucratic aspect – in that it is discursive work mandated by institutional processes – within the clinical pharmacy dataset I have contended throughout the analysis that the narrativization of medical work is primarily interactional and transactional in its purpose: The CPs' projection of the irrealis, evidentially accounts for, and discursively reifies, the temporal continuation of care, therefore fulfilling aspects of patient satisfaction.

Whilst projections of the grammatical future have not received a large amount of analytic attention in clinician-patient interactions, in an analysis of radio talk-show therapy Gaik (1992) illustrated how irrealis modality can have an affective function to the hearer via the evocation of possibility. Given the focus on the immediate medical work at hand, whilst the EFS may also have an affective function related to possibility, more ordinarily its use arguably signals the completion of the dyadic transaction. This was demonstrated by the summative effect use of the EFS achieved in the closing portions of dyads (for example, see Dataset 6), according with conversation analysis work on closings such as Schegloff and Sacks (1973) as well as work on pharmacy interactions such as Nguyen (2012). An interesting parallel therefore exists between the EFS and metacommunicative strategies seen in *Perfect Day*; whereas metacommunication can be an overarching discursive framework that evidences a candidate's line of reasoning or agenda within a consultation, the transactional irrealis of the EFS indexes the action that is taking place, or resultant from

the consultation for relational / transactional purposes. In both strategies there is a meta-functional intent in directing the unfolding discourse within the dyad.

The question remains, however, why emphatic front staging is such a significant area of CP identity. As I outlined in the discursive analysis of Dataset 8, the abundance of transactional modes could possibly be a remnant of the traditional purview of the shop-based pharmacist, in which advice precedes the 'delivery of tangible goods' (Nguyen 2012: 54). In line with the previous section, EFS may stem from the necessity to dialogize remit as the clinical pharmacist role begins to move away from this more traditional, 'service provider' aspect into one that fulfils elements of primary care traditionally undertaken by a general practitioner. Indeed, this accords with Graf's (2011: 144) findings that forms of meta-commentary are more prevalent in activities in which there is not a comprehensive shared understanding between the interlocutors. That the majority of these consultations are obligational in the management of long-term, chronic conditions could also play a part; with the CPs reinforcing the necessity of the consultation itself.

Ultimately, I argue that it is the long-term temporality and obligative nature of chronic care management that engenders the EFS as a transactional form of patient-centrism, discursively foregrounding the process and outcomes of the consultations as paramount. As Zgierska et al. (2012: 2) note, in chronic healthcare management the expectations of the patients often shape the encounter itself, with 'fulfilment of patient expectations' – often by means of the offer of a prescription – resulting in higher patient satisfaction. Throughout the discursive analysis of the CP data, I noted that recorded patient satisfaction was high within the CPiGP project and that, contrary to research such as Wodak (1996), patients reported the reification of their condition in terms of medication was beneficial to their own conception and understanding of their illness.

Whilst it would be remiss to attribute high reporting of patient-satisfaction solely to the CPs' use of EFS, the ongoing discursive evidencing of the enaction and fulfilment of the dyadic transaction may accomplish a comparable function to MacDonald's (2016) claim that elements of nursing expertise resides in ostensibly mundane small talk. In that, by

dialogizing the medication process, the treatment and condition is made more tangible for the patient, less conceptual and less abstract. In this instance, the dialogic ‘expert system’ (Sarangi 2010a) is the recontextualization and reification of complex professional work and discourses into a reciprocal transaction within the dyad. Clearly this has implications for clinical training; the notion of patient-centric care in chronic conditions, as well as how modern healthcare delivery is conceived – these ramifications will be discussed further in Section 7.5.

The analysis also illustrated that the use of the pronominal singular irrealis in the EFS also frames the CP identity as one of healthcare provider in which medication is *given* by the CP. For example, Chapter 4 illustrated that *give* was the fourth highest collocate of *I’ll* in the data. Arguably the use of the lexis *give* has a discursive effect distinct from if medication is otherwise *prescribed, provided or recommended* – suggesting instead, an informally transactional mood. Notably, whilst this was seen more prominently in the datasets containing prescribing pharmacists (Datasets 5, 7 & 8), forms of the provider identity were also present in Dataset 6 whereby the CP foregrounds their immediate future action (*what I’ll do is*) in requesting a change of dose from the psychiatrist providing care to the patient.

In conceiving of the CP identity as a gatekeeper role, I argue this positional identity work represents an instance of Nguyen’s (2006: 157) demarcation between discursive *expertness* and expertise itself: If in Perfect Day the identity of a professional expert comes from evaluation over *states of affairs*, an aspect of CP *expertness* is conveyed by discursively evidencing that a professional decision has been made via the fulfilment of the transaction in question within the dyad. As I noted above in regard to the EFS generally, it could be argued that the ‘CP as healthcare provider’ identity is a discursive remnant of a more traditional form of community, shop-based pharmacy. If the CP primary care role is to be expanded to a more extensive remit beyond this traditional conception, the predominance of these forms that reinforce the inherent transactionality of the role should be taken into consideration.

The second component of EFS involved the CPs *indexing the collective*, a keyness finding that was notably distinct from the Perfect Day data. Throughout the analysis I noted how the collective is invoked to several effects within the CPC; to collectivise both interlocutors in the dyad in joint action, or to index the wider healthcare institution, with some usage blurring this boundary over the course of a single utterance (see for example, Dataset 5). The CPs indexing of the medical collective will be discussed separately in Section 7.4.2 of this chapter, whilst here I focus on the shared action aspect of the EFS.

The use of the collective in future action, predominantly as shared decision-making strategy, presents a deontic aspect that is also largely unseen within the Perfect Day data. As I argued previously in Section 7.2.3 of this chapter, this is perhaps due to the enclosed temporality of simulation making the dialogising and projection of future acts more difficult in simulation than in real life contexts.

As Farr (2005: 216) notes, *we* is generally a socially inclusive pronoun and its key significance within this data concurs with the prototypical use of the collective in Skelton et al.'s (2002) three-part pattern; 'patient – I suffer, doctor – I think, we will act'. Critically for the idea of shared decision making, examining the CPs' collective irrealis use in line with the principles of pronominal attention taken within this thesis indicates that firstly, discursive attention is not simply focused on the patient, and secondly, that agency for future action is not just projected deictically from the CP.

Conversely, the analysis in Chapter 6 illustrated how the idea of shared decision-making via the pronominal *we'll* can be a discursive illusion, occluding professional discursive agency that resides only with the CP. In Dataset 5 for example, the collective action mixed with other ambiguous uses of the lexis *we*, under examination revealed a collective that was heavily led by the CP's expert direction and contained little by way of contributions from the patient. In that particular instance I suggested that the use of the collective irrealis of the EFS concealed any sense of didactic imposition by the CP in deciding a course of future action.

Therefore, the collective irrealis element of the EFS appears to be a means by which asymmetry – and perhaps more importantly for the Clinical Pharmacy Corpus, agency – between the locutors is addressed. The nature of these consultations dictates that agency is as important, or arguably more important than notions of professional-lay asymmetry, given that they involve chronic conditions in which the continuity of care is paramount. Notably, it is often in circumstances in which the advice provided by the CP may impinge upon the agency of the patient that future action or planning is conceptualised jointly.

A prime example of this is demonstrated in how the CP in Dataset 8 manoeuvres from repeated singular *I'll* use of the EFS to the collective *we'll* form when levying smoking cessation advice to the patient. Indeed, this example demonstrates the primacy of the singular *I'll* to convey the in-group expertness fulfilling the transaction, with the collective *we'll* mediating the deontic requirements resulting from the consultation. Thus illustrating how the discursive occlusion of professional agency is undertaken via relatively minor moves such as pronominal modification.

As I proposed in regard to the singular form of the EFS, looking at the activity context of the CP consultations also offers practical, contextual reasons for the recurrent use of the collective irrealis EFS: That the majority (3 out the 4 consultations analysed in Chapter 6, and 11 out 18 of the consultations in the entire CPC) of these consultations are under the auspices of the management chronic conditions means, inevitably, that the patient is required to take a more active role in future action (Montori et al. 2006, Ariss 2009). Whilst the notion of shared decision-making itself has been shown to be more effective when it involves long-term decisions for the patient (Joosten et al. 2008). The implications being that in chronic conditions, the relational identity work undertaken by the CPs must not only account for the immediate asymmetry within the dyad, but also the long-term management of legitimate agency and epistemic claims from patients. Whilst this may not be dissimilar from the dialogue in a real-life GP consultation, it is however, easy to see how this discursive work is highly distinct from that of Perfect Day in which the evaluative *states of affairs* stances unfold in enclosed temporality.

As the contentious example in Dataset 6 highlighted, dialogic management of agency is not a straightforward exercise for the CP in which the sharing (or perceived sharing) of agency via the collective is uncontested: The patient in that particular dyad invoked both her own strong experiential agency, as well as introducing the external agency of other medical professionals ostensibly more senior to the CP to reject the advice being offered in the consultation. This was also seen more subtly in Dataset 7. I argue, therefore, that the greater requirement to accommodate patient agency in chronic conditions is a further reason why the consultations within the CPC are enacted transactionally by the CPs operationalising the EFS. Furthermore, as Section 7.4.1 will detail, this may also account for the heavy reliance on the electronic patient record in triadic epistemic stances.

7.3.3 Closed context consultations – modular healthcare delivery

The discursive analysis of the clinical pharmacy data proposed that medication reviews represented a closed context form of consultation in which there is a prior understanding of the intent of the dyad by both locutors prior to it taking place. This immediately sets the agenda of the consultation, allowing moves straight to ‘business’ (Pilnick 1998), with the medication review usually only fulfilling a singular clinical ‘routine’ (Martin 2014). This form of consultation is in opposition to more exploratory forms such as the consultations of both Perfect Day and Dataset 8 of the CPC, in which the explanations for attendance are explicated concurrently to the clinician during the consultation. Nonetheless, as I suggested at the start of Section 7.3.1, the organisational variations in remit experienced by the CPs means that the discursive performativity of these medication reviews is nevertheless dynamic and procedurally varied over the course of the three dataset selections analysed.

That these consultations exist as closed contexts is, to some extent, an indicator of how the various primary care organisations have conceived of and utilised the novel CP role. Data gathering visits to the CPiGP sites revealed that practices largely allocated consultations (medication reviews) that took advantage of the CPs’ specialist knowledge and removed that consultation type from the GPs’ workload in the organisation. Interviews with

the practice managers also highlighted that staffing deficiencies, perceived risk and trust in the individual CP affected the type of consultations they would undertake. Indeed, the specialisation of roles is not necessarily a new concept, with nurse practitioners assuming responsibility for minor ailments and triage since the 1990s (Offredy 1998). In addition, the promotion of the practice-based CP role has been synchronously joined by other supporting primary care roles such as primary care-based paramedics. I believe that the development of these roles represents a trend towards the modularisation of primary care into specialist functions in order to alleviate the service demands of a facility that is increasingly affected by retirements, recruitment shortages and a progressively aging population.

In the previous section I discussed how the chronic nature of the cases found in medication reviews may influence the performance of professional identity towards more transactional modes that explicitly foreground work and shared agency for relational purposes. Similarly, the modular, singular routine of the medication review with a pre-established agenda may also contribute to the use of language forms that appear ostensibly clinician-centred (EFS, closed questions) in order to streamline what is, an obligatory activity for the patient. I suggested in Section 7.3.1 that the pronominal significances found in the CPC could imply that these are more hierarchically egalitarian consultations, and indeed as I have reiterated throughout this thesis, reported patient-satisfaction was largely positive in this mode of focused consultation.

The closed nature of these particular dyads may present, therefore, an instance in which less elucidatory language is contextually appropriate (Nguyen 2006, 158). As applied linguistics researchers, we should be cognizant that specific consultation types or activity contexts such as this potentially have locally normative conventions, that – due to the newness of the role – are still being established and perhaps do not conform to our initial preconceptions of what these encounters ‘should’ be. This is of course true for any external professional environment the researcher finds themselves working in. With that said, it is likely, however, that the CPC dataset as it appears in this research, represents clinicians

learning and establishing the role contemporaneously, and as such, the consultations, remits and professional identities associated with both are likely to change further still.

7.4 Comparability within the datasets

7.4.1 External epistemic domains

An unexpected finding in the data, unaccounted for in the hypothesis of this thesis and common to both datasets was the clinicians' adoption of epistemic stances that relied upon, or deictically pointed at, sources that were external to either themselves as the speaker, or to the consultation itself. In Perfect Day this existed as reference to either *the letter* – a simulation prop replacing the EPR within the consultation – to the wider medical institution of secondary-care consultants, or to the wider corpus of medical literature. Whilst in the clinical pharmacy data, the third-party allusion was a more clear-cut reliance on the EPR in the room containing the patient's medical records and history.

Despite there being a body of healthcare research on the phenomenon of triadic consultations, generally, applied linguistics research has not considered how externalities are utilised by medical professionals to construct or reinforce their own evaluations. Instead, viewing the interaction as de-contextualised and the knowledge claims as the product of an autonomous expert locutor (indeed, Atkinson 1995 & 1999 notes the overreliance on singular clinicians to the detriment of the wider analytic context), despite evidence demonstrating that EPRs are now ubiquitous within UK primary care (Jha et al. 2008).

The very nature of a healthcare system based upon the principles of evidence-based medicine, however, implies that professional expertise is under constant renewal and non-finite, or as Fox (1980: 1) states, that progress has only revealed 'how ignorant, bewildered and mistaken we still are in many ways about health and illness'. In this study, the data indicates that the discursive evocation of external epistemic domains generally exists as a mechanism to manage areas of uncertainty within the dyads. In Perfect Day, this manifests as a deictic reference to external knowledge when the simulator challenges the certainty of an ambiguous diagnosis (Scenario A), or, to reinforce a diagnosis that is ostensibly uncomfortable for the simulator, and again, uncertain at the point of the consultation (Scenario B). In the Clinical Pharmacy Corpus, the triadic utilisation of the EPR as an epistemic source external to the interlocutors is more prosaic; providing a procedural

framework for a relatively new form of medical consultation (for example, as is the case with Dataset 7), or an official record from which an epistemic stance or deontic request can be based.

Because the management of uncertainty is often integral to the overall success of a consultation from a patient perspective (Gordon et al. 2000), this has subsequent ramifications for how knowledge areas external to the dyad are discursively indexed and utilised by the clinician in order to address uncertainty. In the case of genetic counselling for example, Sarangi and Clarke (2002) have demonstrated how the discursive management of uncertainty is a marker of professional expertise itself. Accordingly, how a clinician implements an external source as part of their own epistemic stance appears to be a critical area of professional identity, and can either be a hallmark of experienced expertise itself (Buckman 1984) or can be immediately detrimental to evaluative credibility of the professional – as evidenced in Dataset 1 of Perfect Day. Thus, like many of the discursive strategies discussed within this thesis, the critical element becomes a deft contextual reading of the immediate unfolding discourse.

A pedagogical environment such as Perfect Day might be a more critical arena in which this dialogic mediation of external knowledge exists as I intimated in the opening of this chapter. The analysis demonstrated that candidates tended to operationalise external knowledge domains to maintain an overall epistemic stance of professional knowing within the dyad; potentially to fulfil a perceived requirement to deliver certainty to the patient. As nascent professionals, Blanch et al. (2009: 304) have shown that for trainee clinicians' expressions of uncertainty can be especially problematic, highlighting that the types of uncertainty they portray often revolve around their own personal knowledge gaps rather than ones that exist in the body of medical knowledge more broadly.

Indeed, given the demarcation of these two distinct types of uncertainty, the issue may be one of making candidates aware of what type of uncertainty they are portraying by indexing external epistemic domains – as Atkinson (1995: 122) states, to precisely 'locate

the sources and nature of doubt' which are causing the epistemic stance to be modified to evoke an external source of information.

In clinical pharmacy there are different concerns to consider, as I established in the previous section, many of the patients seen by CPs are chronic, long term conditions. Which is in part due to how the CP role itself is conceived by primary care services. Accordingly, CPs are likely to consult with patients that have increased levels of knowledge regarding their condition, greater agency over their treatment and a number of other healthcare professionals who have long-term involvement in their care. Therefore, the modular aspect of the CP role (as it is currently conceived) may make external deictic projections and triadic consultation a commonplace and indeed, necessary, component of professional identity.

Arguably, as a professional with a discreet, specialised clinical role, there may also exist less pressure to project overall certainty towards the patient, given that – as Dataset 6 demonstrated – a number of other clinicians potentially provide this for the patient. As Candlin and Candlin (2002: 16) observe, in these cases expertise is not just drawing on professional knowledge but navigating institutional 'frameworks of authority'.

Across both corpora, the indexing of external epistemic domains highlights that professional identity is not a singular, self-authored phenomenon. But instead contains a complex mediation of the known and unknown in a particular field of specialist knowledge, that ultimately relies on deictic reference to other fields and specialists within the broader institution. For instance, the CPiGP project reported how a number of general practitioners responded positively to the placement of CPs within their practice because it gave them access to an on-site pharmaceutical expert. This exemplifies the otherwise unacknowledged 'complex division of labour' noted by Atkinson (1995: 34) within which professional identity is instantiated in relation to and reliant upon other professionals. In terms of identity, this is a clear use of the 'relationality' principle (Bucholtz and Hall 2005) – establishing the professional as distinct and in accord with other professionals by the demarcation of particular areas of epistemic entitlement.

7.4.2 The collective, institutional medical ‘we’

Somewhat related to the notion of external epistemic domains, is the evidence of both sets of clinicians indexing the wider medical institution as a collective via the lexis *we*. However, unlike the previous section, this general referent to an institutional collective is not exclusively for the means of adopting an epistemic stance within the consultation. Rather, invoking the notion of an institutional-based collective via pronominal usage represents a significant identity positioning (Bargiela-Chiappini and Harris 1997: 175) as I have stated throughout the analysis of both corpora. Whereas the irrealis form *we’ll* promoted collegial inclusion and joint action in the Clinical Pharmacy Corpus, the collective medical *we* promotes institutional in-group identity associated with professional membership.

The analysis uncovered that the use of the collective medical existed in two predominant functions across the datasets: Firstly, an endorsing strategy that often gave credence to actions or recommendations taken by the clinician. For example, in constructions such as *we are going to say cut down* (Dataset 4) – that, in effect, obscure the clinician’s own personal projection of agency. Positioning recommended actions as the product of a collective, rather than a singular voiced agency, that carries with it the professional prestige of the institution. Secondly, was a clarifying function that located the clinician’s use of technical or medical concepts or terminology and then elucidated it for the patient; *which we call the preventer* (Dataset 5). Again, identifying the technical lexis as distinct to the clinician’s identity as a member of a professional in-group.

Positioning the clinician as a member of a professional in-group via the pronominal collective represents an instance of indexical, overt and group structure identity work (Bucholtz and Hall 2005). However, the discursive establishment of the clinician within an in-group could infer the patient as a member of an out-group – as such, conceiving the collective medical as a discursive tactic that is exclusionary as far as the patient or simulator in the immediate dyad is concerned. And therefore, reinforcing the traditional expert-lay asymmetry.

Nonetheless, as the analysis over both datasets has demonstrated, most instances in which the collective medical is utilised have ostensibly patient-centric intentions. Serving to mitigate deontic action or explicate technical into lay terminology. Whilst the alignment of a clinician with a dialogic collective accords with findings suggesting that more frequent use of *we* is associated with higher status interlocutors (Cassell et al. 2006, Sexton and Helmreich 2000), reflecting that they are ‘more collectively oriented or other-oriented’ (Kacewicz et al. 2013).

Use of the collective medical *we* also demonstrates the synecdochic relationship professional identity within these corpora has to a wider intuitional context. The specificity of this wider context, however, is often left unclear with examples in the data deictically indexing either the clinician’s surgery, the NHS or a professional in-group oriented around the particular role of either GP or CP. I argue however, that the deictic imprecision of the collective medical *we* is largely unimportant. Instead, this collective form of identity is a discursive tool that allows the clinician to invoke tenets of institutional regard in scenarios where it is required – for example, in Dataset 3.

In Chapter 4 the adoption of an institutional identity was specifically seen in the Perfect Day candidates’ assumption of responsibility for apologising on behalf of their simulated GP practice. Thus, it would appear that the capacity to invoke, align membership to, and apologise for, a wider institution can be a key area of discursive professional identity. Echoing therefore, the point I made in the previous section that professional identity is not construed alone, and instead, is contingent upon the indexing of a wider institutional group membership – a further evocation of the relationality principle (Bucholtz and Hall 2005) of identity.

In concluding this section regarding utilisation of a collective medical, it is worth noting that the idea of a selective choice of the first-person plural for identity purposes contradicts the assertion that pronoun use is not conscious (Chung and Pennebaker 2007) frequently applied in the social psychological examination of pronouns. As I outlined in the methodology, it is beyond the remit of this thesis to fully explore this debate. However, I

believe that the data at hand illustrates a distinction in usage that might be useful for that particular discussion: Whilst pronouns that are used interpersonally and deictically between interlocutors might be said to be non-consciously applied by a speaker, those which index group membership (that is external to the concurrent dialogue) are seemingly more consciously chosen. This is not a distinction made by the current literature.

7.4.3 Changing landscape of healthcare provision

The introduction to this thesis outlined how the underlying backdrop to the research was one that finds primary care delivery in the UK in a period of change due to demographic, political and economic pressures. In Chapter 2 I also made the case that emergent factors such as medicalisation and the advent of the expert patient (Shaw and Barker 2004) may have produced cultural and societal circumstances distinct from those in which previous studies of clinician-patient interaction have taken place. The two corpora examined for this thesis epitomise the changing nature of service provision: Perfect Day is a training program designed to attend to potential consultation deficiencies in GP trainees, in order to address the increased numbers required to maintain service provision. Whilst the Clinical Pharmacy Corpus documents the adoption of a new and innovative primary care role in a select number of pilot practices.

I contend that it is the changing circumstances underpinning – what is an otherwise off-researched professional context – that renders the clinician-patient dyad a still relevant site of investigation for applied linguistics. Furthermore, because of these constantly evolving set of societal, cultural and institutional changes, that progressing and innovative methods should be sought to investigate the modern medical interview. In this thesis I have attempted to address this via the introduction of elements of ethnography to the enduring partnership of corpus linguistic and discourse analysis, as well as by proposing a novel way in which asymmetry can be conceived of. Peräkylä (1998: 317) observes that the nature of political and societal changes does not necessarily render previous work on doctor-patient interactions inaccurate, merely that they can only be said to characterise professional dyads

within that particular timeframe. This principle, of course, will also, ultimately, be true of this research, in which many of the findings around professional identities will likely be superseded as the landscape of primary care develops even further.

In both the analysis chapters and throughout the discussion in this chapter, this thesis has illustrated how the contextual circumstances surrounding the interaction at both a meso and macro level influence how the professionals are able to enact a discursive professional identity. Indeed, Wilson et al. (2013: 372) observe how technological and cultural changes render professional identity a 'constantly evolving and shifting construct rather than simply a set of attributes or goals to be achieved'. Accordingly, as I previously noted in Section 7.3.3 of this chapter, as researchers we may begin to rethink what the pertinent questions are surrounding clinical dyads. An increasingly modular approach to primary care may propagate dyads far removed from those conceived and researched by Freidson, as well as expert-lay relationships enacted far differently than those studied by the likes of Mishler etc.

Similarly, as the cultural and political circumstances around primary care change, researchers aligned in research and consultation 'on and for' (Cameron et al. 1992) other professionals bear responsibility to ensure that the recommendations and literature provided to research partners is likewise contemporary and contextually relevant. For example, the RCGP's guidance for postgraduate trainees' adoption of patient-centric care utilises Mishler's (1984) original conception of opposing voices within the consultation. Following Peräkylä (1998), I argue that the findings of this thesis demonstrate that these binary conceptions do not fully account for the modern variables and influences at play within contemporary healthcare dyads. The prominence of triadic consultations in the Clinical Pharmacy Corpus, for example, demonstrate an instance of how the discursive enactment of aspects of primary care are now centred around the EPR as a centralised, institutional epistemic source, rather than a reliance on a singular authoritative expert locutor. And whilst it may be difficult to draw any broad conclusions from the Perfect Day Corpus as an exemplar of modern general practice, it is pertinent to note that even in simulation it depicts

themes of stronger patient agency and the increasing trend towards locum-based care (GMC 2018).

7.5 Ramifications for applied professional practice & future directions

As the analytic findings and foregoing discussion attest, there are a number of potential practical applied linguistic ramifications resulting from this research. I will address the main findings of this thesis here in terms of their potential applications; however, this is done so whilst acknowledging that this is not necessarily a straightforward process, with potentially a number of political, organisational and practical constraints (Brown et al. 2006: 23). The recommendations are also undertaken in the ethos Sarangi (2010a: 192) suggests, as 'analytic insights for reflection' rather than didactic instruction. In line with Roberts and Sarangi's (1999b) notion of 'recontextualization' of findings, this section will conclude with the applications distilled into bullet points summarising the reports that will be delivered to the Perfect Day programme and the School of Pharmacy. The approach taken within this section will be broadly to answer the following questions:

- How can the results of the Perfect Day linguistic analysis contribute to the programme or help improve GP simulations more broadly?
- How can the analysis of the Clinical Pharmacy Corpus help establish a communications-based training package for clinical pharmacists?

Firstly, for Perfect Day, a tendency towards evaluative performative professionalism as a 'performance discourse' (Hodges 2012) is not surprising. Discursive forms of demand characteristics have been previously been observed in medical simulations (Hanna and Fins 2006, Seale et al. 2007). However, the nature of how this was shown to exist as an orientation towards evaluative / epistemic stances should be borne in mind by educators in

the design of such simulated scenarios. If, like in Perfect Day, the simulated training is a remedial program to address perceived issues in consultation skills, this tendency towards a particular means of consultation becomes even more important. Not least because expressions of uncertainty can be a problematic area for medical trainees to address (Blanch et al. 2009). As such, educators should be aware that indexical, epistemic identity work (Bucholtz and Hall 2005) is potentially being foregrounded by the candidate in place of a measured discursive approach to portraying uncertainty. Subsequently, the explicit teaching of the integration of uncertainty into discursive professional identity should be considered – allowing for consultations that rely on the deft indexing of external epistemic domains or the space for the candidate to practice outlining where uncertainty lies.

Invitations to input (ITI) emerged as a dominant means of expressing shared participation and accordant patient centrism within the Perfect Day data. I highlighted within this chapter that, in their recurrence and contextual disharmony, they could be considered an aspect of formulaic language – a measure of ‘trained empathy’ (Roberts and Sarangi 2003) learned to discursively evidence the perceived patient-centric requirements of the consultation. Nonetheless, ITIs yield a wider argument about the use of formulaic language within simulations more generally and its perception by medical educators. Whilst formulaic sequences are seen as inherently negative by examiners, their use by both successful and unsuccessful candidates (Roberts et al. 2014) suggests that it is the context in which they appear that is being assessed.

Educators and examiners should be aware therefore, that formulaic sequences have legitimate discursive application as I outlined in Section 7.2.1 and indeed, that their successful usage is governed by a seamless integration into the candidate’s overall performativity within the dyad – as is the case, for example, in Dataset 4. For candidates and trainees, it would be advisable for their communications skills curriculum to highlight that – whilst elements of formulaic language are an inevitable component of professional identity – homogenous and decontextualized use of discursive strategies such as ITIs signals a notion

of overt performativity to both patients and examiners that is likely to impinge on their professional credibility.

This also, therefore, brings about a wider question of how language assessment criteria exists in the GP curriculum. Alongside the potential success and failure of aspects of stock language, strategies that could be perhaps viewed as 'doctor-centric' under assessment – such as unmitigated epistemic claims – also ostensibly can perform a reassuring affective function. Indeed, the point could be made therefore, that a broader understanding of what constitutes the discursive enaction of empathy, rapport, expertise practically entails should be considered. And accordingly, that any focus on these areas should foreground their dynamic contextual enaction rather than the explicit performativity of 'doing empathy' or 'doing rapport'.

This study has also highlighted the importance of contextual detail for the discursive enactment of professional identity within the data; as such, a recommendation stemming from this research would be for medical educators to provide as much real-life contextual features as possible within the simulation. If this is not practicable, the absence of detail such as simulated EPRs should at least be accounted for in the assessment criteria of the simulation. Educators should be aware that seemingly mundane contextual aspects can significantly aid the candidates' construction of a professional identity, such as the conveyance of certainty or authority. And that by omitting this, there may be deleterious ramifications on the candidate's ability to function as a professional – forcing them into more creative discursive work. This is especially pertinent in light of the increased modern use of the EPR.

The results of this study suggest that greater scrutiny should be given to the role played by and the effects produced by the characterisations of simulated patients. The infelicitous simulated patients of Perfect Day challenge the candidates via their belligerence, disbelief and reluctance to engage with service provision, as well as by challenging the candidate's knowledge as a professional. Accordingly, an argument could be made that, faced with this type of patient, an orientation towards establishing certainty within the dyad is

inevitable. That is not to suggest that this patient characterisation is unrealistic, but rather, that a balance should be sought in any simulation that aims to provide a variety of discursive – and clinical – challenges for the candidate. For example, creating a dyad that simulates the increasing numbers of elderly patients visiting GPs for a predominantly social function (Stokes-Lampard 2017) would instead challenge candidates to enact their professional identity with a patient that was highly doctorable and non-confrontational.

Given the nascency of the CP role in primary care, there are a number of findings that might be of interest to medical educators in the establishment of a training curriculum for postgraduate pharmacists. As I noted at the start of Section 7.3.1, this element of the research is especially important for the Clinical Pharmacy Corpus because there is no direct archetypal identity associated with the primary care pharmacy role given its relative inception. Therefore, the intention of these recommendation is to provide educators with a picture of what the CP role – in this very early iteration – looks like from an interactional perspective, in order to inform the direction of a training package. An element of this activity has already taken place in the feedback reports I completed for LiPP’s involvement in the CPiGP project; using the pre-existing interview transcripts to illustrate language themes stemming from the data prior to our visit to the site. Notably, in these reports I highlighted that closed questions were observably frequent in the data. The data gathering visits, however, elucidated how such closed questions served practicable, contextual purpose – as the analysis in Chapter 6 and the propositions around the EFS in this chapter have advanced.

The first practical insight from this research would be that, in this current incarnation, the discursive enaction of clinical pharmacy dyads echo the transactional nature of traditional pharmacy service encounters. This should be of interest to both pharmacy educators as well as service providers, given that the service was perceived and utilised as a proxy, ‘GP-lite’ consultation by some practice managers in the CPiGP project. Consequentially, for educators, this means a homogenous approach – for instance, by

importing a GP-based model – to communication skills is not advised. Because this study would suggest that, despite ostensibly dyadic similarities, these two enterprises are significantly distinct.

Nonetheless, this advice should be caveated with the acknowledgement that this is the CP role as it appears in its pilot iteration. As the role becomes more established within primary care, it may possibly develop so that the activity becomes more exploratory and less closed and procedural. As I noted in Section 7.3.3, the data gathering visits to the CPiGP sites revealed that the CPs' remit were largely dictated by the perception the organisation had of the role, as well as potentially staffing shortages. Accordingly, much of the work establishing a package of training for CP dyads might initially identify areas where the current curricula do not address the communication skills requirements for extended and enclosed dyadic consultations. The need for such aspects of training has been identified as far back as Pilnick's (2000) observation of an increased advisory role for pharmacists, and indeed was mentioned in the informal interviews that took place with the CPs during data gathering. However, I argue that service demands are likely to dictate that the CP role moves beyond Pilnick's original advisory conception, to a mode of consultation which, much like the one seen in Dataset 8, is almost indistinguishable from a GP-based dyad.

Beyond the basic requirement for a set of initial extended, dyadic consultation skills, the programme should also consider how the key differences that appear to discursively set the CP role apart from other extended dyads should be approached. As this discussion chapter has argued, elements such as patient-centric care exist in different incarnations within the CP consultations; requiring the consideration of legitimate agency claims of patients into professional identity. Therefore, what is commonly conceptualised as the traditional, clinician-patient asymmetry should not be assumed in the training for these dyads. As the data has shown, they are often a negotiation between informed, high-agency patients that also involve the input of a number of healthcare professionals. This is notably distinct from the notion of a GP-based model of patient-centric care which assumes an inception point of an individual, high-status expert mitigating their professional power (see

for example, RCGP 2019). Accordingly, discursive strategies for disagreements and misalignments should be incorporated into any training, as well as skills to manage the inherent requirement the role has for inter-professional communication with other clinicians within an organisation. This, in particular was emphasised by the CP at *Orchards* who acknowledged that the conventions of interprofessional communication was an area that postgraduate training had not addressed and accordingly was learned in an ad hoc manner on the job.

That triadic consultation appears to be such an integral part of CP consultations should also be addressed in any training. The appropriate use of the external epistemic source the EPR provides not only has ramifications for professional identity as this thesis has proposed, but also potentially has consequences for patients feeling valued and listened to (Swinglehurst 2014: 24). If, therefore, simulated training that incorporates a 'live' EPR can be operationalised, its integration within the consultation could be used a marking criteria. Indeed, to echo a recommendation for Perfect Day, part of this should also include guidance on how to discursively approach areas of uncertainty within the dyad.

Summarised recommendations:

- PD1: Simulation candidates appear to orient towards stating what they know, which in turn impacts their performance when conditions arise which they are less confident in explaining to a patient. Candidates should be encouraged to explore how they vocalise their own uncertainty to a patient, and indeed, where uncertainty may lie around a condition generally.
- PD2: 'Stock phrases' are an inevitable part of medical discourse in the consultation. Consideration should be given to develop awareness in candidates to use stock phrases or requests dynamically and not homogenously – by being aware of the unfolding conversation
- PD3: The performance of a candidate – especially those not familiar with simulated training – may be contingent on a simulated environment as close to a 'real'

consultation as possible. By allowing them to refer or defer to sources such as an EPR, a creative performance aspect is removed from the simulation.

- PD4: Consider whether simulated patients are challenging in a manner that will have a positive educational outcome for the candidate. Rather than characterising a hostile or boisterous patient to stress test consultation skills, a more rigorous test of consultation management might come from an ostensibly banal patient who doesn't want to leave the consultation.
- CP1: Clinical pharmacy consultations, currently, look very similar to traditional pharmacy encounters from an interactional perspective. If the role is likely to become more exploratory as the CPs take on more clinical responsibility, a set of extended training skills should be developed that focus on enclosed, one to one consultations with patients.
- CP2: This communication training programme should not be based off a GP model – the CP role appears to require increased negotiation with long term patients and as such these communication skills should be foregrounded. Similarly, the training should also encompass the significant requirement of inter-professional communication in the CP role.
- CP3: The integration of EPR use into consultation skills should also be a priority, not only is it an increasingly important component of healthcare delivery, but its use by a clinician also has knock-on effects for a patient's experience of the consultation.

7.6 Methodological appraisal

In this section I will address the methodology adopted within this thesis. In order to echo the structure of the initial methodology chapter, this section is comprised of two distinct areas: Firstly, a reflection on the process of applied linguistics as a collaboration with external partners and research sites, and secondly, a critical examination of the means of analysis taken within the research in order to answer the final research question and address the contributions this research makes to the applied linguistics discipline.

7.6.1 Reflecting on applied linguistics collaborations

The process of this study reflects both the strengths and inherent challenges of academic research collaboration with external organisations. Indeed, the final direction of the thesis was established following the breakdown of an initial project with the School of Pharmacy to investigate inter and intra-professional communication within GP practices in light of the establishment of the CP role. This early collaboration was conceived as a series of ERDF-based consultations with both community pharmacies and GP practices, delivering linguistic insights into professional communication for the practices, whilst also affording LiPP the chance to gather data for corpus-building and further research.

However, the professional contact groups and local professional networks, and later LiPP's own promotional effort, yielded only one sign up for the consultations – a Clinical Commissioning Group: an organisation that fell outside of the ERDF's SME parameters. Thusly, illustrating that in Cameron et al.'s (1992) maxim of 'research on and for', it is the process of convincing collaborators that the 'for' is worthwhile in the first place, that is often the most critical aspect in allowing the 'on' to take place.

The level of clinical, institutional data access available for the study would arguably not have been possible without the research being grounded as part of the LiPP business unit. Access to the Perfect Day consultations – in its full form an extensive and potentially very sensitive dataset – was predicated via pre-existing working and research relationships

within LiPP. Similarly, eventual access to the CPiGP sites in 2018 was made possible via connections through LiPP's aforementioned early collaborative work with the School of Pharmacy. The data collection on the CP sites was also aided via its integration with follow-up interviews for the CPiGP project led by an interdisciplinary researcher who had been based in the pharmacy school and had conducted the initial project. This arrangement not only opened up access for my own data gathering, but also gave a level of credibility to the research visit as my colleague was perceived as a 'known entity' or a disciplinary insider to the practices.

Accordingly, the research for this thesis represents external collaboration in two distinct manners. Perfect Day, although a secondary data sample and not without its own access complications, epitomises a collaboration that is relatively research friendly: The medical educator behind Perfect Day had not only previously collaborated with LiPP, but was also concurrently collaborating on a discursive politeness chapter with the team and had based the principles of Perfect Day on academic research into Self-Regulation Theory.

Therefore, not only were aspects such as pedagogical intent of programme accessible throughout the research, but the nature of the prior relationship with LiPP meant that the practical value of linguistic analysis – as an external discipline – to GP training had already been established. The value of this pre-existing relationship cannot be understated in regard to access to highly sensitive datasets. Indeed, my own research relationship with the programme facilitator also developed over time, meaning that by the time of writing Chapter 5 of this thesis, my overall knowledge and contextual understanding of the underpinnings of Perfect Day and decisions taken by the educator team, were far higher than at the time of writing our initial collaborative chapter on the programme (Emerson et al. 2020).

Given the real-world focus of the data, as well as the multiple organisational layers involved, perhaps unsurprisingly, the CPiGP element of this thesis was a far more complex undertaking. For instance, a practice who had initially taken part in the original pilot had had a poor experience with their CP, another was suspicious of the clinical commissioner's intent

behind the project. Other practices initially resisted our visit, citing time constraints and staffing pressures. *Foxhole*, meanwhile, was in the process of being closed down during my data-gathering visit. Others however, had fully embraced the CP role and were happy to welcome us for the return interview and were open and forthcoming about their experiences. Because of these various considerations, our approach to the visit and the request to gather data had to be handled dynamically.

Interactions with the CPs themselves were otherwise very positive, with most welcoming any research that would bring linguistic insights to the role because of the erstwhile paucity of communication training available during training. During the visits I did not receive any requests for 'hot feedback' (Clarke 2003), but as I noted in Chapter 4, an argument could be made that, at times, best practice was being followed intimating a potential 'observers' paradox' (Labov 1972). The primary challenges of data gathering during the consultations proved to be the integration of the ethics debrief into the early part of the consultation. Again, this was affected by a number of practical issues such as CP workload, consultation timing and the efficacy of the system in place for appointments. For example, in *Greenheath* the process was fairly straightforward – the CP would meet the patient in the reception, explain that a researcher was in the room en-route and I would explain the ethics and present the sign off sheet as I was introduced to them in the room. However, in *Foxhole* (undergoing closure) the process was beset by the CP running late to the clinic, introducing me whilst also starting the consultation and two instances of patients walking into the consultation room without being called.

Thus, adaptability was required to explain the ethics form swiftly but comprehensibly, so as not to interfere with the consultation and its overall length. Accordingly, following the first site visit, I formulated a series of quick answers for likely questions the patients might have so any queries could be answered without affecting the consultation. Interestingly, from a researcher identity perspective, I was variously introduced to the patients by CPs as a 'PhD student', 'from a language expert team investigating what we do here', 'from the university', 'from the University of Nottingham' or as 'an observer'. Notably, this was another

example in which the institutional framing of myself as a researcher from the University of Nottingham, the LiPP team or as part of the ongoing CPiGP project appeared to help my integration into the consultation. Being able to explicate the wider research activity of LiPP to patients who were curious, also helped ground my research in a wider context, affording it a tangible institutional grounding. The 'culture of observation' (Clarke 2003) of medicine also certainly helped in this respect – out of the 25 consultations I observed (both in person and by phone) I was only asked to leave the room once. I believe some personal aspects also helped this; having previously worked in medical education I had some awareness of what the environment might entail and what aspects might be a challenge. Similarly, I had a pre-conceived idea of how to dress and present myself at the practice. My prior work experience in the NHS also helped develop a rapport with the CPs themselves during the ad-hoc, unstructured interviews between consultations and with the practice staff we encountered during the feedback interviews.

A further challenge within clinical dyad research is the interaction the researchers might face with the patients themselves. Whilst most patients generally ignored my presence during the consultation (indeed, a number of the patients appeared non-plussed by an observer indicating that the culture of observation similarly applies to long-term, chronically ill patients), a minority sought to engage my attention whilst consulting with the CP. I found myself navigating this interaction in a similar way to how Clarke (2003: 380-381) advocates – by being engaged at a low level, offering backchannels without extensive replies, to maintain a balance between not interrupting the consultation and not appearing unnaturally silent or unresponsive.

Given that these collaborations exist in different forms, ultimately the means of feedback will also exist differently. For Perfect Day the feedback report will be delivered directly to the lead educator of the programme. Whilst, due to the numerous organisations involved in the CPiGP project, and because a number of the CPs have now moved on to other sites, the feedback report will be delivered to the School of Pharmacy to potentially inform their communication skills curriculum for undergraduate and postgraduate students.

7.6.2 Methodological critique and disciplinary contributions

The final research question for this study was an examination of whether an amalgam of the recurrent methodological partnership of corpus linguistics and discourse analysis, with the addition of elements of ethnography could produce a useful methodology for these datasets. Both answering the research questions within the thesis, as well as providing findings that were useful for external collaborators. In this area I will address this final question, by examining each of the methods employed, the value they added to the research and any disadvantages encountered. In this section I will also reflect on the contributions this research makes towards applied linguistics as a discipline.

The primacy of corpus techniques in this thesis was as a means of entry to the data in two distinct manners. Firstly, to offer a preliminary entry point to the data in identifying the salient aspects of professional identity being enacted, and secondly, by utilising the Louw et al. (2014) method, to impartially target areas for discursive analysis. The advantage of the initial corpus analysis is, I believe, illustrated in how this approach provided distinct identity profiles for each of the datasets instantiated around disparate moods, pronouns and deixis used by both sets of clinicians, as well as in its identification of recurrent discursive activity such as medication reviews in the data. Whilst the trend towards larger and larger corpora has been evidenced in applied linguistics (Koester 2010), the approach taken within this thesis also illustrates the advantages of small corpus studies in which the findings can be explored in their full context.

That this study made the distinct choice to include functional language, and indeed, made it an area of significant focus, also requires addressing in the appraisal of the methodology. Although not without precedent (for example, Weninger 2010, Pearce 2014), the inclusion of functional items in the analysis due to its keyness could bring about claims of inevitable significance, given their centrality to spoken language. Nonetheless, with respect to the clinical nature of the data, this keyness inevitability could also be levied at technical or medical content lexis in the corpora. Indeed, the overall keyness results of both this thesis and the pilot study of 2017 illustrate this point.

The methodological choice to include functional language, I argue, uncovered areas of significance that illustrate discursive identity at its most fundamental level – revealing how the professional positions themselves deictically in relation to both their interlocutor and the work at hand. Allowing these functional areas to then be scaled up in wider analysis via collocational and expansive discursive analysis to build a rich picture of professional identity. Concentrating on purely content lexis, I believe, would have not uncovered areas of identity such as the emphatic front staging for which pronominal irrealis constructions are key, and indeed, would have been more akin to previous studies that have critically examined clinicians' use of jargon or technical terms.

In section 3.5.3 of Chapter 3, as well as throughout the analysis, I have highlighted the advantages of a small corpora approach; namely the ease and thoroughness with which contextual readings of results can be made. It is worth noting however, that this is not a methodological view shared universally and small corpora have inherent disadvantages. Indeed, Sinclair (2004: 189) has vociferously argued against smaller corpora as a 'limitation', instead claiming that patterns of language use are more reliably discerned from as large a dataset as possible. There are of course problems of generalisability with any small, specialised dataset. With these critiques acknowledged, I maintain that the small corpora approach is appropriate for this particular study; primarily because of the focus on specific areas of nascent, professional practice from which large-scale generalisations are not sought. In this respect, the corpora remain representative of the professional activity contained within and indeed – given the repetition of tasks contained within the corpora – any scaling up of the data may only reveal the 'closure' (McEnery and Wilson 2001) of lexical variety in each task.

The second aspect of corpus-based methodology in this thesis was to drive the focus for the more exploratory discursive pragmatic analysis of Chapters 5 and 6. In this respect, the adoption of the Louw et al. (2014) method represented an attempt to locate areas of the data in which discursive identity were being performed 'typically', whilst also avoiding the researcher biases in selecting extracts for extended analysis. Whilst the Louw et al. (2014)

process largely achieves this aim, it is not without complication. The blind selection process it offers can be challenging when applied to a dataset containing multiple speech events such as this study. Requiring the initial area be adjusted to account for breaks between consultations or yielding the selection of data that might have little ostensible analytic value; for example, upon the presentation of data where there is little to no clinician speech. Accordingly, this process cannot claim complete impartiality.

Plotting out datasets visually also does not account for the differing levels of lexical density apparent in a spoken language corpus. This is apparent in the high density of Dataset 3 of the PDC which required extensive analytic attention and conversely, the sparsity of Dataset 6 of the CPC, in which many of the turns were single word backchannels from the CP. The Louw et al. (2014) method also undoubtedly leaves interesting data unanalysed; the CPC for example, contains a consultation in which an expert patient consults with the CP and negotiates her ongoing treatment from a position of highly informed professional experience. However, due to the atypicality of the distribution of the three areas of significance for the CPC (*pronominal aux contraction*, *deixis* and *irrealis*), this consultation was not featured in the discursive analysis. This in turn brings about a wider argument of whether identifying areas based around corpus typicality is itself valuable. An argument could be made that this principle merely narrows the focus even further, rather than allowing atypical or interesting data to be analysed. As a riposte to this, I return to the methodological underpinning of the research outlined in the first half of Chapter 3 – as a collaborative endeavour, this research was inclined to produce findings that produced practicable results by giving an analytic overview of the data. Accordingly, the consultation with an expert patient may provide the academic researcher with interesting data, but at the same time the atypicality it represents may be of little interest to the external collaborator.

With these criticisms made, I still believe that the Louw et al. (2014) method provides a valuable means to add elements of objectivity to qualitative data selection. Whilst in its current state it is not perfect (an observation made by the authors themselves in their conclusion), there is scope to build upon this initial iteration of the technique. For example,

this procedure could be coded into existing corpus software to target samples of data that conform to keyness parameters and are of a certain sample size – thus removing any researcher biases. This would also illustrate a further level of objective disciplinary rigour for external research collaborations. As I noted in the methodology, corpus techniques already provide applied linguistics researchers with a credible empiricism on which to base findings to external collaborators (Brookes et al. 2018: 109). In concluding this evaluation of the Louw et al. (2014) method, from my experience using the method within this thesis I would also argue that, by merely presenting areas of data that are not ideal – for example, a decontextualized final area of a consultation – that it challenges the researcher to ensure that methods and frameworks are being applied rigorously in the analysis.

At this point, the partnership of corpus linguistics with forms of discourse analysis is a well-established methodological approach. This mixed-methods approach proved advantageous to this research as close readings allowed significant, key lexis to be analysed in their full context, as well as identifying recurrent discursive strategies (for example, ITIs) that are not identifiable from corpus analysis due to variations in speaker formulations. In this study, a decision was made to conduct the discursive analysis at a meso-level, in which the consultation data was viewed as an ‘activity context’ (Linell and Thunqvist 2003). Analysis at this level provided an informed contextual reading of each piece of data, bringing in elements yielded from on-site data-gathering or candidate reflection in a way that wouldn’t necessarily be possible via a strictly granular approach such as pure conversation analysis. A discursive approach also allowed the ‘relationality’ aspect of the Bucholtz and Hall (2005) model to be explicated from the data, to augment the indexical elements yielded from the initial corpus analysis.

An argument could be made for the application of a communities of practice (Lave and Wenger 1991) framework to this data. However, this was ultimately rejected because only the Perfect Day candidates could be said to represent a coherent professional community – a cohort of junior doctors in the same training locale. Given the nascency of the CP role as it appears in this data, identifying them as a CofP is far more challenging;

existing only as a very loosely aligned professional community (as members of the CPiGP pilot study), instead, acting as commissioned specialists with varied remits, experience and abilities to prescribe.

The ethnographic, 'thick participation' (Sarangi 2006) aspect of this research was integral to the effectiveness of the findings. Its combination with an initial corpus approach allowed the study to determine prominent trends in identity performance, and then fully elucidate their discursive use in context at a level of detail that would otherwise not be possible with standalone data. This also brought an innovative aspect to the methodology. As I highlighted in the first half of this section, the nature of the collaboration and detail available for each project was unbalanced (for example, in the CPC I was able to converse with a CP immediately following a consultation, whilst in the PDC I have relied on debrief interviews to yield speaker intention) which could be considered a limitation of the study. This is why a direct comparison between the corpora was not an explicit aim of the research questions. However, I contend that any disadvantages such as this are arguably negligible in comparison to the high level of contextual value the 'thick participation' component of the study offered.

This study makes a number of contributions towards applied linguistics as a research discipline. Firstly, the research charts a specifically-pedagogic area of the doctor-patient dyad. In this respect, despite being a typically dyadic interaction, the research fulfils Atkinson's (1995: 34) appeal that more research should focus on the backstage areas of medical discourse. That the study also examines a brand-new role in its first professional iteration is also a contribution to applied linguistics; in doing so it demonstrates modern, modular healthcare and identities that are not yet codified around a central principle, nor institutional pedagogical notion of what they 'should' be discursively.

By focusing on functional lexis and pronouns in particular, this research also presents a new route for discourse analysts to consider professional asymmetry by a framework based upon research principles adapted from social psychology. And in doing so,

by demarking interpersonal deictic indexing from group membership indexing, this study has suggested an addition to the debate of whether pronominal use is conscious or not.

8. Conclusion

This study set out to examine how clinicians conceived of their professional identities in discourse – how they presented themselves as experts and navigated the inherent lay-expert asymmetry produced. The two datasets under analysis characterise the current demographic and socio-political changes in U.K. primary care. Four research questions were formulated in order to interrogate the data. To address these research questions, an innovative mixed-methods approach was taken that paired the recurrent coupling of corpus linguistic and discourse analysis with ethnographic detail yielded from ‘thick participation’ (Sarangi 2006) within the research environments. This methodology was not only designed to rigorously interrogate the corpora, but also to provide practicable, contextually bounded findings for research collaborators.

8.1 Professional identity as an expert system

The analysis within this thesis detailed discursive professional identities in both corpora as a complex amalgam of moods, pronominal usage, epistemic and deontic stances that index the clinicians’ judgement, institutional positioning as well as work being undertaken. Fulfilling a number of areas of Bucholtz and Hall’s (2005) identities model, these components all serve the central purpose of establishing the speaker as a credible expert in a particular professional context. Such is the inextricable link between identity and expertise in these clinical datasets, it could be stated that to talk about professional identity is to talk about an expert identity. Nonetheless, these datasets in particular have also demonstrated that the expert-lay distinction exists as a cline rather than dichotomy. Both sets of clinicians under examination fulfil Nguyen’s (2006) notion of ‘novice experts’ as opposed to ‘experienced experts’. And as such, professional identity could be said to be the performance in discourse of the expertise held *at that point* by a professional – whilst identity and expertise are separate, mutable concepts, in a professional discourse context they are inextricably linked.

In this respect, I believe that Sarangi's (2010a) notion of the 'expert system' discussed in Chapter 2 and referenced throughout this thesis provides the clearest conception of what is dialogically being enacted by professionals in healthcare encounters. The findings of this research have shown how the components of discursive identity when utilised in their particular context are 'laminated with expertise and authority' (Sarangi 2010a: 192). Additionally, I contend that the conception of an expert system can be extended to conceive of healthcare dyads themselves as 'complex systems' of interaction and language use in line with Larsen-Freeman and Cameron's (2008: 161) introduction of this concept into applied linguistics and discourse in particular. (It should be noted that 'complexity' in this notion refers to the dynamic interplay of the various components of a system, as opposed to the inference of a complicated process.)

The analysis within this study has demonstrated that the establishment of discursive identity by a professional (and the discussion thereof) is inextricably linked to the context, activity, interlocutor and dynamics they produce in the ongoing discourse. Viewing professional identity as an expert system, enmeshed in a dynamic, complex system (healthcare dyads) forefronts the importance of the initial contextual conditions, or activity context (Linell and Thunqvist 2003), as an analytic starting point as the findings of this thesis have suggested (see Larsen-Freeman and Cameron 2008: 34-35). Although the interconnectedness of the performance of identity with the immediate context in which it sits is the most prescient example for this thesis, it is possible to envisage that other features of complex systems bear relevance to professional dyadic interactions – the principles of adaptation and emergence for example.

From here, a pedagogical programme for healthcare communication becomes a tool to navigate discursive complexity, as opposed to an attempt to teach a perhaps nebulous concept such as empathy or rapport (often from non-linguistics basis) as I proposed in the previous chapter. As such, giving healthcare-based undergraduates and postgraduate clinicians tools to deal with the dynamic and ever evolving medical dyad. Indeed, the

pedagogic application of a dynamic systems framework for second language acquisition has already been advocated by Dörnyei (2014) for example.

I noted in Chapter 2 that this study was primarily concerned with the discursive enaction of expertise rather than the quality or effectiveness of that expertise – matters of professional competence that I argued would be difficult for a non-clinician to appraise. Whilst I still believe this to be the case – and that an interdisciplinary collaboration might be the only way to fully answer questions of how the issues of discursive expertise raised relate to professional competence – I argue that the findings strongly indicate that contextual deployment of expertise is an integral component of professional competence. That a competent performance of ‘expertness’ (Nguyen 2006) is dependent on how and when certain aspects of discursive professional identity are enacted.

If clinical professional identities are intimately linked to a sense of expert identity, then the innovative adoption of social-psychological pronoun research into the methodology for this study has reinforced the notion that asymmetry remains a resultant ‘enduring aspect’ (Pilnick and Dingwall 2011) of interactions between expert and lay identities. Arguably the research findings within this thesis have only necessarily scratched the surface of both the implications and applications regarding the use of the pronominal framework to chart hierarchies or asymmetries within discourse – primarily examining pronoun use as a facet of identity. From a research perspective, additional investigation in this area could potentially take the framework further into a discourse analytic realm in a number of workplace contexts in which egalitarianism and collaboration is sought. Or indeed, provide insights for either clinicians or other professionals engaged in dyadic interactions as to how asymmetries can covertly manifest in discourse through the functional mechanics of language that is often thought of as mundane and not worthy of analysis (Pearce 2014).

8.2 Limitations

There are of course limitations to the findings presented in this thesis; primarily that both datasets are small, specialised corpora and accordingly generalisations into the wider professional healthcare populace are hard to make: I noted in Chapter 5, that ITIs for example, were a recurrent strategy for navigating asymmetry likely specific to this data. Because the participants in Perfect Day are trainees identified as potentially 'at risk' in regard to their consultation skills, it is probable that strategies such as ITIs are more overt within the discourse of the consultation in this particular dataset. For a more experienced GP, it is possible that this strategy would be highly integrated within their ongoing discursivity – similar to the less overt instance of an ITI in Dataset 4.

For the clinical pharmacy a similar point stands – the consultations comprising the corpus are not construed for representation nor generalisation, with a variety of experience apparent in each pharmacist and the number of consultations per site not consistent – as tends to be the case with an ethnographic 'opportunity sample'. Arguably, with the nascency of the primary care CP role as it appears in this data, it would be inadvisable to seek any generalisability from the findings, rather, what the findings provide instead is an analytic picture of what this first wave of clinical pharmacists in general practice looked like from a discursive identity perspective. This inceptive picture, I contend, is important in of itself given that many more supplementary primary care roles such as this are being introduced nationally.

8.3 Future directions

I outlined in Chapter 3 that Perfect Day was a large dataset (sampled in this thesis to match the size of the CPC) containing within it a wealth of dyadic data, alongside post-hoc debriefs, and a corpus of diagnostic background interviews for each candidate. This thesis then, represents just a potential starting point for a significant level of enquiry possible with this rich dataset.

Whilst the clinical pharmacy dataset is more modest in its overall size, there are – as I noted in the previous chapter – a number of consultations that have not received any in-depth analytic attention due to the necessary size constraints of the study. For both datasets I believe that an exclusive analytic focus on the performativity of the simulators and patients would be an interesting point of analysis, also serving an important pedagogical value – especially to investigate the discursivity of patients when faced with a relatively new primary care role. Indeed, the corpus analysis for both of these non-clinician areas was undertaken at the same time as the analysis of the candidates and CPs, but due to the focus of the research and space constraints within the thesis, it was not appropriate to reproduce these results in their entirety.

The research collaboration with the School of Pharmacy stemming from this thesis has already continued with the documentation and eventual analysis of their simulated Pharmacy Leadership and Management (PLM) module over a single cohort in 2019. PLM is relatively recent development in pre-registration pharmacy, and even in its very early stages has identified a number of pedagogical challenges in regard to the teaching and uptake of basic level consultation skills amongst the undergraduate cohort. The involvement of LiPP within the PLM module brought about a novel means by which the consultations were recorded – via GoPro cameras body-mounted to the simulators as they walked between each simulated pharmacy. Thus allowing the educator team to upload the consultation files for each student to reflect upon their performance.

Although I noted in Section 7.4.3 of the previous chapter that studies such as this can find themselves contextually grounded to a particular social and political context, I argue that this demonstrates the requirement for a continuing analytic spotlight to be shone on the clinician-patient dyad in all its evolving forms. If – as I suggested in Chapter 7 – primary care becomes increasingly modular in its delivery, the role of the general practitioner may also become increasingly specialised towards complexity in primary care. Necessitating a further shift in how this profession is discursively enacted. Alongside clinical pharmacists, new specialised roles such as primary care-based paramedics are already being established,

presenting yet another clinical profession for which the enactment of the medical consultation may take on a much different discursive shape than the standard GP, primary care prototype.

An increased number of discreet specialists within primary care will likely see interprofessional communication become more important, with triages and debriefs increasingly taking place in multi-disciplinary practice teams. These emergent areas will all be fruitful lines of enquiry for applied linguistics researchers. Whilst this thesis hypothesised that 'expert patients' (Shaw and Baker 2004) might have an effect on the delivery of the consultation, what it found instead in the CPiGP data was that in modular, specialised areas of primary care, patients have different expectations to what is perhaps the received wisdom gleaned from just considering a GP-based approach: Reporting satisfaction with the reification of their condition as medication dosages and the non-exploratory modes of consultation. This may also be influenced by underlying cultural, social and economic trends. If so, it demonstrates that not only could notions of contemporary patient-centrism change, but also that, as researchers we should keep abreast of emergent discursive forms where they occur and not simply critique them for not ascribing to the current literature.

As this thesis has intimated regarding the use of the EPR, technology is also undoubtedly to play a central role in the mediation of healthcare communication in the future. A number of surgeries now offer online consultations, whilst NHS apps such as myGP provide accessibility to a range of primary care services via a smartphone. Developments such as this may streamline and transactionalize GP consultations further in modifying the dyad for an online space; not only changing the experience and expectations of the patients, but also the constitution of professional identity for the clinician. Once again, developments such as this provide an abundant area of research for applied linguistics as a discipline to charter these emergent changes, and eventually, to contribute towards the pedagogy of their professional application.

Whilst I have advocated that the dynamism of healthcare discourse must be emphasised in medical pedagogy, as this closing chapter suggests, dynamism should also be a concern of the applied linguist in the approach to research and collaborations in

professional arenas. During just the period of writing this thesis, the political and cultural changes in the UK alongside the COVID-19 pandemic have had a significant effect on work practices, healthcare delivery as well as the nature and availability of research funding for universities. The findings of this thesis have gone some way to argue for the sustained value of studies of professional discourse – illustrating that the continuous evolution of professional identities and discourse is of relevance both inside and outside of the academy. Indeed, whilst this research domain remains pertinent, the means by which the collaborative ‘on and for’ (Cameron et al. 1992) is achieved may remain an ever-moving target.

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