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A Comparative Study on Identity Construction in Doctor-Patient Communication: From Reality to Virtuality

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ABSTRACT

Medical practices in contemporary times demonstrate an asymmetrical relationship between patients and doctors, which lies at the heart of the medical enterprise and is consistent in the process of doctor-patient interaction, especially the face-to-face communication. In this asymmetrical relationship, both doctors and patients tend to construct different identities, which is pervasive in the face-to-face medical communication. However, with the popularity of online medical consultation, identities constructed in the traditional communication are undergoing changes. In view of this, the present research investigates the identities constructed in online medical consultation websites and attempts to find out the identity changes in comparison with traditional face-to-face communication. The analysis shows that there is a tendency for doctors and patients to construct different identities according to specific circumstances, either in reality or in virtuality. In the meantime, the asymmetry is still a central issue in medical practices, but it exists in a more dynamic way. The tentative conclusion in this study provides several suggestions and implications for effective doctor-patient communication.

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1. INTRODUCTION

Growing tension between doctors and patients is a serious social problem causing adverse effects on both parties involved. It is urgent to seek ways to improve the current deteriorating relationship and to achieve harmony between them. There are many factors that result in doctor-patient disputes, such as the medical system, medical insurance, and the drug distribution mechanism, among which insufficient communication between doctors and patients is one of the important reasons. As a matter of fact, doctor-patient communication performs “a central clinical function in building a therapeutic doctor-patient relationship, which is the heart and art of medicine” [1].

With the continuous advancement of science and technology, especially the increasing use of internet, ways of doctor-patient communication are in transition from reality to virtuality. In other words, they are not just confined to traditional face-to-face talk, but also expand to online medical consultation websites. Different from face-to-face communication, online medical consultation is text-based and possesses two important elements, i.e. institutional aspect of medicine and technology-mediated communication, allowing both doctors and patients to communicate anonymously or virtually. On the online platforms, patients describe their health conditions (pains, symptoms, etc.) followed by doctors’ professional diagnosis and expert suggestions or advice. After the consultation, patients can decide whether to see the doctor in person for further examination, which could improve the quality of health care services as well as the patient’s safety while lowering the medical costs.

Medical practices in contemporary times demonstrate an asymmetrical relationship between patients and doctors. In fact, the asymmetry “lies at the heart of the medical enterprise” [2] and is consistent in the process of doctor-patient interaction, especially the face-to-face communication. In this asymmetrical relationship, both doctors and patients tend to

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construct different identities, which is pervasive in the face-to-face medical communication. However, with the popularity of online medical consultation, the identities constructed in traditional communication are undergoing changes.

In view of previous studies, this research investigates the identities constructed in online medical consultation websites and attempts to find out the identity changes in comparison with traditional face-to-face communication, with an aim to provide some suggestions and implications for effective doctor-patient communication.

2. LITERATURE REVIEW

Conversation plays an essential role in human communication and it "is all-pervasive and is by far the commonest use of language" [3]. Institutional communication may occur in various physical settings, such as a hospital, courtroom, company, or school. In this sense, the communication between doctors and patients is a kind of institutional talk. The following sections will review the related studies on the doctor-patient communication and identity construction in the context of both face-to-face and online medical consultations.

2.1. Previous Studies on Doctor-Patient Communication

Research on doctor-patient communication began from Parsons' seminal study in the 1950s. Drawing on a functionalist perspective, Parsons [4] developed a normative framework to identify a series of mechanisms existing in the doctor-patient relationship, focusing on different aspects, such as the functional setting of medical practice, the social structure, the situation of both the patients and doctors, and the functional significance of the institutional pattern in medical practice. In his view, doctors play a leading role in the doctor-patient relationship because they have medical knowledge or expertise while patients have to be obedient to doctors because of their "sick role" [4]. Therefore, there is a communication gap between the participants in the institutional communication.

In the 1970s, there are two major studies establishing the research domain of doctor-patient interaction. The first one was conducted by Korsch and Negrete in 1972. Drawing upon the adapted version of Bales' Interaction Process Analysis, Korsch and Negrete [5] observed 800 pediatric acute care visits and produced the striking results: nearly one fifth of the mothers were not told what was wrong with their child, and almost half of them were still wondering the causes of their child's illness when they left. The study finds that there was a strong connection between these communication failures and non-adherence with medical recommendations and also shows that many parents (56%) were not satisfied with the doctors' disregard of their concerns.

Another research was conducted by Byrne and Long in 1976. On the basis of about 2500 audio recordings of medical consultations, Byrne and Long [6] divided the medical visit into a series of stages and further elaborated the characterization of doctors' verbal behaviors in each of them. Inspired by Balint's research on therapeutic value in primary care visits, Byrne and Long [6] focused on how the prevalence of doctor-centered behaviors weakened the therapeutic possibilities. However, it seems that they place too much emphasis on the study of doctors' behaviors but neglect the patients' contributions to the medical encounters as well as the socio-cultural context of social interaction in the primary medical care.

As a viable research domain established in 1970s, doctor-patient communication aroused widespread concern in the academic community. For example, Waitzkin [7] regarded medicine as a discourse and argued that medical discourse consisting of the underlying and largely unrecognized structure has an effect on the expression of personal difficulties. By comparing doctor-patient communication with ordinary interaction, Maynard [8] investigated the ways of how asymmetry was interactively achieved in clinical discourse. Heath [9] examined the delivery and reception of diagnostic information in the general-practice consultation and further explored why relatively little diagnostic information is distributed in the consultation. Maynard [10] discussed the effects of some practices such as telling good or bad news on how doctors and patients deal with particular interactional tasks.

Although there are abundant studies on doctor-patient communication, most of them are in the face-to-face settings. By contrast, studies concerning online medical consultation are relatively scarce. Lu et al. [11] examine the use of the internet-based "Ask an Expert" service among low-income breast cancer patients and conclude that online medical consultation is an effective complement to other resources, which can enhance those patients' confidence to be more actively involved in their health care, making decisions about their treatments and thus improving their relationship with doctors. By using online medical consultation records from four ambulatory practices and employing multilevel regression model, Jung and Padman [12] conduct a descriptive analysis of virtualized health care delivery

and find out the characteristics of online health-care users and their usage patterns. With archival data from a leading online health-consultation platform in China, Zhang et al. [13] propose a model to probe into how unfairness in online interaction (both interpersonal and informational unfairness) influences the quality of online patient-doctor relationship and the roles of a doctor's professional seniority and a patient's disease severity. This study advances the development of ICT-based health care research and makes great contributions to maintaining the effective patient-doctor interaction in the health care context. Through the analysis of doctor-patient conversations retrieved from a Chinese medical consultation website, Mao and Zhao [14] investigate what identities Chinese doctors tend to construct and how these identities are constructed.

What is mentioned above shows that most previous studies focus on online medical consultation from the perspectives of medical informatics [11,12], but few studies focus on the online conversation between doctors and patients [14].

2.2. Identity Construction in Medical Consultation

Identity is "the product rather than the source of linguistic and other semiotic practices and therefore is a social and cultural rather than primarily internal psychological phenomenon" [15]. In other words, identity can be viewed as "the social positioning of the self and others" [15]. In recent studies, identity construction has been a research focus in different fields, such as conversational analysis, sociolinguistics, pragmatics, anthropological linguistics, and systemic functional grammar.

In the healthcare context, there has been an increasing number of studies concerned with the identity construction, such as professional identity formation in medical education [16,17,18], doctor's professional identity in face-to-face communication [19], and doctors' identity constructed in the online medical consultation websites [14]. In what follows, two related studies are presented in detail on identity construction in doctor-patient communication.

With an analysis of excerpts from a corpus of 69 medical communication, Barone and Lazzaro-Salazar [19] focus on the doctor's transactional and relational role as a narrative facilitator. They have identified four types of the doctor's professional identity in the medical interview, namely, the doctor of this patient, the institutional authority in the conversation, a member of the institution and an ordinary person. This study also reveals that the doctor employs various discursive strategies, such as alignment, repair moves, and mitigation, to construct his multiple identities, which is expected to assist in building solidarity and trust with the patient. Different from Barone and Lazzaro-Salazar's research, Mao and Zhao [14] aim to investigate Chinese doctors' identities constructed in the online doctor-patient conversations. Their analysis reveals that Chinese doctors have constructed the following three identities in the online medical consultation: professional identity through use of medical jargon, independent vocatives, and diagnostic questioning; authoritative identity by employing collective vocatives and high modality; and ordinary personal identity through the use of self-reference I, intimate vocatives and markers of politeness. Considering that doctors have different potential identities, their study could provide suggestions for them to choose more proper identities in specific contexts on the online medical consultation platforms.

3. ANALYSIS AND DISCUSSION

3.1. Identity Construction in Face-to-Face Medical Communication

In traditional face-to-face communication, many researchers have regarded doctor-patient interaction as "a site where doctors exercise power over patients" [2]. Previous analyses of the recorded doctor-patient conversations have shown a systematic pattern of asymmetry in that doctors ask more questions than patients, control the topics of the consultation, interrupt the patients and employ different ways to start or end the consultation. Actually, this asymmetrical relationship is also reflected in the process of identity construction. In what follows, examples that are selected from previous studies will be employed to illustrate the identity construction in the traditional face-to-face medical consultation.

Example 1:

(Chest examination)
1 Dr: → 'hhhh You've got erm: (0.8) bronchitis::.
2 P: ˚ er:.
3 (4.5) ((Dr begins to write prescription))
4 Dr: 'hhh (0.3) I'll give you antibiotics: to take
5 for a week. hhh
6 (.8)
7 Dr: How long are you here for?
8 P: We go back on Satur˚ day::

As can be seen from the above example, the doctor and the patient are both in the institutional context of the chest examination. In this conversation, the doctor initiated the turn by making the diagnosis (line 1),

followed by the patient's downward-intoned *er* (line 2). Since the patient didn't give any helpful response, the doctor continued and moved from the diagnosis to the management (lines 4-5). Still the patient didn't give any response, and then the doctor asked the last question (line 7), which elicited the patient's answer (line 8). The analysis shows that the relationship between two parties is asymmetrical and also indicates that the doctor exercises power and authority over the patient.

In terms of identity construction, the doctor tends to construct his identity as professional by using medical terms, including disease names and medicine names, such as *bronchitis* and *antibiotics* in above example. The usage of medical jargon can show that doctors are well trained in the field, which makes the patients believe that they can receive professional diagnosis or treatment. The doctor's identity as an ordinary person can be revealed through his pause on line 3 and line 6, which suggests that the doctor is waiting for the patient's response and leaves space for the patient to avoid embarrassment. The doctor's question on line 7 is about the patient's personal life, which also reflects his identity. By contrast, the patient in the above example is constructed as a person in need of help and the passivity of the patient is clearly interpreted from lack of response to the doctor's words.

Example 2:

1 Dr: ya see that blood pressure
2 P: it's always high //( )-\
3 Dr: /I can't
4 that's right \\ that's right
5 we uh what is it we do uh
6 P: . this is my this week's blood 1//pressure\1
7 there are a whole bunch of other months blood 2//pressure\2
8 and it seems to be around in the one thirty to seventy.
9 Dr: we uh we actually uh
10 P: you monitored me
11 Dr: we monitored yeah
12 P: with an electronic monitor when was it last summer spring
13 Dr: yeah I remember now I'm sorry

In this example, the doctor and patient talked about blood pressure which is a common symptom in health communication. The doctor started the conversation with a question (line 1), requesting information from the patient to find out why the blood pressure is so high. However, the patient did not provide any useful information as illustrated in line 2. As a medical expert, the doctor constructed his professional identity in the form of initiating the consultation and his follow-up efforts (lines 3-5) to elicit the patient's response to make an accurate diagnosis. Besides, the doctor tends to construct his identity as an ordinary person to shorten the distance to the patient, which is reflected through use of the informal addressing word *ya* (line 1), inclusive pronoun *we* (lines 5, 9, 11), and apology (line 13). In the above medical consultation, the patient is still in the position of seeking help from the doctor and constructs his identity as an ordinary person seeking professional advice and treatment from the doctor. Compared to the patient in example 1, this one is more cooperative, but he still failed to provide any useful information for the doctor.

Drawing from the analysis of the above two examples in the context of traditional face-to-face medical consultation, we can summarize that doctors tend to construct their identities as professional, authoritative, and personal while patients tend to construct themselves as an ordinary person seeking professional advice or help. In other words, it can be shown that both doctors and patients have multiple identities. However, in the context of face-to-face medical consultation, professional identity is essential for doctors in contrast with other identities because providing professional medical advice is the basic requirements for being doctors whereas the patients are mostly seeking help and are passive in the doctor-patient relationship.

3.2. Identity Construction in Online Medical Consultation

As mentioned earlier, online medical consultation is different from face-to-face medical consultation in that it is based on texts, allowing patients and doctors to communicate anonymously or virtually. Another difference is that online medical consultation involves technology-mediated communication, but it has the same elements as face-to-face communication, i.e. institutional aspect of medicine. Thus, both online and face-to-face medical consultations can be regarded as institutional communication. To an extent, development of online medical consultation platforms has challenged the traditional sense of identity construction in doctor-patient communication. In what follows, two examples will be analyzed to show what identities are constructed and how they are constructed in online medical consultation.

Example 3:

1 P: Hello, my daughter was diagnosed with diabetes and she was just 1-year-old. I've seen it's possible to raise insulin cells and implant those into the body from the website. Is it true?

2 Dr: *Analysis*: Diabetes is still a worldwide problem and there is not any successful medicine

which can cure this kind of disease so far. You must keep away from all the advertisements that claim a good curative effect. *Suggestion*: It is extremely difficult to cure diabetes, as it is a metabolic system disease. I recommend to you a good combination of western medicine and Chinese herbal medicine.

The above example occurs in an online medical consultation website, where a mother consults the doctor about her daughter's health condition. In this consultation, the mother initiated the conversation by presenting her daughter's diagnosis and general information, followed by revealing her knowledge about the medical information from the internet. Her consultation ends with a question (*Is it true?*) with an aim to confirm whether her knowledge is true. After the mother's description, the doctor first reassured the mother by stating a general fact about the disease, and then expressed his opinions about the internet advertisements. Finally, he provided his suggestions about how to deal with that kind of disease.

In providing the analysis and suggestions, the doctor explained what diabetes is and introduced the general situation of this disease, which shows the doctors' professional medical knowledge and hence his professional identity is constructed. The use of modal verbs and adverbs (such as *must* and *extremely*) suggests that the doctor is confident about his judgement and establish his identity as authoritative. In addition, it can be inferred that the doctor tries to build a close relationship with the patient when he started his conversation with the statement on the general situation of the disease instead of giving suggestions directly. As for the identity construction of the patients, it is a little bit different from the traditional medical consultation. On the online consultation, the patient initiated the conversation and asked relevant questions. Interestingly, the patient in the above example employs some medical terms to explain her health condition, which seems to indicate that patients can get more access to professional medical knowledge on the internet, but they are still not sure about the accuracy of the information. Therefore, in this institutional context, the patient tends to construct her dual identity of being both professional and personal.

Example 4:

1 P: Aspartate aminotransferase (AST) is lower than the normal standard. What's wrong and what should I pay attention to?

2 Dr: *Analysis*: Hello, if the AST is higher than the normal standard, it means that there is something wrong with your liver. If the AST is lower than the normal standard, it certainly does not have a problem. *Suggestion*: Don't worry about that. Please pay attention to develop a healthy habit. Wish you all the best.

The above is also an example of the doctor-patient interaction in the medical consultation website. The communication opens with the patient's confusion about the level of AST, followed by his request for explanation and suggestions. As for the patient's concern, the doctor provides his professional analysis and suggestions. In this round of medical communication, the patient is in the position of seeking for professional advice from the doctor and hence constructs his identity as an ordinary sick person. In comparison, the doctor constructs his identity as professional through the explanation of the results and various levels of AST. In addition to projecting his professional side of various identities, the doctor also shows his personal side in order to maintain a closer relationship with the patient. The doctor in the above example initiates his turn with an intimate greeting form *Hello* and employs a number of polite words (such as *Don't worry, Please, Wish you all the best*), which reveals that the doctor would like to show his care and wish to the patients and hope to build rapport and trust between each other.

Based on the analysis of above examples from the online medical consultation websites, we can make a summary of the identity construction in this institutional context. For doctors, different identities have been identified, including professional, authoritative and ordinary personal, but it seems that doctors tend to make their ordinary personal identity more prominent. For patients, they continue to act as the sick role seeking for help from the doctor, but at the same time they tend to construct their identity as professional and is equipped with professional medical knowledge due to easier access to the information from the internet.

3.3. Discussion of Identity Changes in Doctor-Patient Communication

In previous two sections, the identity construction in the doctor-patient interaction has been discussed, including face-to-face and online medical consultations. Both doctors and patients are inclined to construct various identities through use of different discursive strategies, which reveals that identity is dynamic rather than static. With the transition of the medical consultation from in-person to virtual forms, there must be some changes in the doctor-patient relationship as well as their identity construction. In what follows, these changes and the underlying reasons will be illustrated.

Firstly, asymmetry in doctor-patient relationship has improved but is still interactively achieved. In traditional face-to-face medical consultation, the asymmetrical relationship is quite typical between doctors and patients. Doctors with professional medical background are more likely to control the communication in different ways such as opening the conversation while patients are always obedient and passive in the whole process due to their lay knowledge, as discussed in examples 1 and 2. However, the picture in online medical consultation is different, as analyzed in examples 3 and 4. The online communication is always initiated by the patients, followed by doctors' diagnosis and suggestions, which indicates that patients tend to be more active rather than passive. Besides, the rapid development of internet helps improve the asymmetrical doctor-patient relationship because patients have much easier access to the online medical information. In spite of this, patients can't judge the accuracy of those information online as shown in example 3, which in turn reinforces the asymmetrical doctor-patient relationship. Therefore, asymmetry is still there but in a more interactive way.

Secondly, the overall identity construction of doctors is similar in both face-to-face and online medical consultations but there is a different focus in different contexts. As summarized earlier, doctors tend to construct professional, authoritative and ordinary personal identities. No doubt that the professional identity is the primary and most significant one in both contexts, but it seems that they are more likely to show the personal side of their identity in the online medical consultation, which can be inferred from examples 3 and 4. In online medical consultation websites, the doctors are all real-name registered, providing detailed information, such as names, ages, photos, and other working information, which is open to the public online. In view of this, the doctors are inclined to show their concern with patients in a more polite and intimate way to build their online image. At the same time, it is an effective way of branding doctors themselves because patients may go to have a face-to-face communication for follow-up diagnosis if doctors produce a positive personal identity.

Thirdly, patients seem to occasionally construct their identity of being professional on the online medical consultation. In most cases, either in face-to-face communication or online medical consultation, patients display the essential identity as sick people seeking professional help, which is clearly supported by their discursive strategies, such as no response, passive answer to doctors' questions in previous examples. From the perspective of patients, it appears that their response or doubt may challenge the doctors' authority, hence resulting in the adverse effect on the medical consultation. By contrast, due to the anonymous and virtual nature of online medical consultation, patients are free to express their inquiries in a more direct way and don't need to worry about the doctors' response. Another interesting change of patients' identities is that they are experiencing a transition from novice to "expert" in that the internet allows them to be accessible to much medical information before consulting the doctors. However, their lay understanding of the relevant knowledge may not be accurate enough, and hence needs the confirmation from the doctor, as mentioned in example 3.

In summary, both doctors and patients construct multiple identities as mentioned above through different language choices or discursive strategies to achieve different communication purposes in the doctor-patient interaction, either traditionally or virtually. Compared with identity construction in the face-to-face communication, identity changes can be identified in the online medical consultation, which reemphasizes the dynamic nature of identity. Meanwhile, asymmetry, as a significant issue in understanding the doctor-patient relationship, is also accomplished and maintained through the communication between doctors and patients.

4. CONCLUDING REMARKS

The analysis shows there is a tendency for doctors and patients to construct their identities according to specific circumstances, either in reality or in virtuality. In the meantime, the asymmetry is still a central issue in medical practices, but it exists in a more dynamic way. The tentative conclusion in this research provides some suggestions and implications for effective doctor-patient communication.

First, both doctors and patients should be aware of the significance of identity construction. As mentioned earlier, identity is dynamic and multiple, which requires the participants to employ various language or discursive strategies to build a mutual and collaborative doctor-patient relationship. Second, doctors should make good use of their dynamic identities. Although professional and authoritative identities are essential in providing medical diagnosis and advice, the personal side is equally helpful, especially in building the solidarity and rapport with the patients. Finally, patients should trust the doctors and actively cooperate with their diagnosis and treatment. Traditionally, patients are always playing a sick role in the medical consultation, which suggests that they should present a different self to maintain a more harmonious relationship.

All in all, this research focuses on the study of identity changes in the doctor-patient interaction by comparing identity construction in traditional face-to-face medical communication and online medical consultation, as elaborated in previous sections. It must be pointed out that this study is essentially a preliminary and tentative research with secondary data collected from previous studies, so it is difficult to present a complete picture of identity construction in medical consultation. Future studies can be conducted on the basis of a larger body of data and a more systematic analysis.

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