

To appear in C. N. Candlin (ed.) *Research and Practice in Professional Discourse*.
Hong Kong: City University of Hong Kong Press (2001).

DISCOURSE PRACTITIONERS AS A COMMUNITY OF INTERPROFESSIONAL PRACTICE:
SOME INSIGHTS FROM HEALTH COMMUNICATION RESEARCH

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1 Introduction

In this chapter my main concern is to show how discourse and communication based studies in the context of health and social care do provide a basis for reflecting on our practices as discourse researchers. For current purposes, I take all discourse analysts as belonging to a shared professional community of practice – despite their differences in the use of analytic tools, and their engagement with different types and sites of data. Indeed, such differences within a professional community are rather commonplace and do not warrant concern. In the health care setting – which will be the focal site of my discussion here – patients and professionals are used to the idea of contested treatment regimes and differential patterns of healthcare delivery, which sometimes culminate in seeking ‘second expert opinions’. It is quite likely that another health professional will either interpret the same symptoms and evidence differently, or might divert his/her gaze elsewhere, seeking new evidence and/or tests as a sound basis for offering a more informed assessment. Apparently, in discourse research we are all too familiar with scenarios of different interpretations of the same data leading to different claims. Such differences come to no harm most of the time, as our variable and situated interpretations may not have any consequence for the people whose text/talk-data we may be analysing.

There is another dimension to our professional practice. The participants who we make our subject of study (doctors, nurses, therapists) are themselves discourse workers. They are using language to elicit and narrate symptoms, offer diagnosis, arrive at treatment decisions etc. This then begs the question of what it is that is distinctive about our way of looking at the practices of other professionals? To what

extent will our observational account help them to understand their discourse work and perhaps trigger any change in practice? It is worth mentioning that both the reporting of discourse-based findings and their actual uptake by professional communities remain largely unexplored (Sarangi and Roberts 1999, 2000). This is not to say that discourse research cannot be made consequential, but such an injunction will depend on a whole set of other things: how we go about negotiating our researcher identity and expertise; how we seek endorsement of the research topic and design; where we look for data and how we interpret such data; how we package our research findings and manage the situations beyond the reporting stage. Here I will limit my discussion to the extent to which working on the interface of professional communities (e.g., medical, legal, educational) makes it possible to reflect on what we do as discourse researchers and what constitutes our practice. In the spirit of constructionism, we may end up researching the research process – how we construct other professions, and our own, through our own discourses. To extend this position, from a discourse/communication perspective, any professional discourse site is interprofessional by definition. There remains the difficulty of having acquaintance with another professional genre, and the willingness to socialise into these communities of practice (Lave and Wenger 1991). I will use the healthcare site to illustrate my argument, but my discussion would extend to other sites – especially language education – where there is a long tradition of collaborative action research, but not without the tensions I allude to later (see section 6).

I will use the term ‘discourse practitioner’ as a convenient identity label, keeping in mind the out-group with which we need to interact for carrying out collaborative work. Unwittingly, I started using this label to describe myself in the company of healthcare professionals before I realised its usefulness. Whenever I used the unmarked term ‘discourse analyst’, I was called upon to elaborate further what this entailed in terms of tasks and knowledge. The accounts that I gave were more like glosses of language-as-discourse – a kind of explanation of our object of study rather than what it meant to be have a professional identity as a discourse researcher. Also, I realised that the term ‘analyst’ pointed to the fact that discourse researchers were outsiders to the event that they were studying. Inevitably, it had the connotations of an investigative – and at times, moral – stance, as if we were breathing down our subjects’ necks in insisting on our co-presence while recording their interactions. This is partly reflected in the ethnographic field study involving General Practitioners (GPs

– equivalent to family doctors, see section 5.1) when GP-examiners, at the end of the oral interviews, turn around and ask the observer-researcher: ‘do you think I asked the right questions?’, ‘could I have done this better?’. It is through such direct questioning that they nearly challenge your ‘neutral’ participant-observer status and push you towards your consultancy role. For some reason, by labelling myself as a discourse practitioner I was not only able to draw a parallel to my subject cohort – the general practitioners – it also somehow helped to minimise the outsidersness, and to project the professional status of discourse researchers. Our identity is cast as one of professional practitioners who do discourse research.¹

2 The overlay of professional knowledge and professional practice

Freidson (1970) offers a blue-print of what constitutes a profession: following Cogan’s (1953) classic study, he identifies, among other things, the legal basis, licensing and freedom of action as relevant benchmarks (see Hughes 1958, also Candlin 1997). As far as the medical profession is concerned, Freidson suggests that it is the clinical mentality as opposed to the scientific mentality which defines the practitioner’s professional status. Doctors are mainly action-oriented, as they apply scientific knowledge rather than contribute to the growth of knowledge. The application of scientific knowledge, however, has to be mediated through one’s clinical experience. In casting the professional as a practitioner, Freidson legitimises the role of personal experience in professional practice.² As he (1970:169) summarises it: ‘In his commitment to action, his faith, his pragmatism, his subjectivism, and his emphasis on indeterminacy, then, the practitioner is quite different from the scientist’. Ravetz (1971) draws a similar distinction between scientific problems and practical problems. Historically, this distinction can be traced to Ryle’s (1949:32) proposed separation between *knowing that* and *knowing how*.

¹ . In a recent multi-disciplinary meeting of the National Assembly for Wales, I found myself in the midst of experts from health policy, health economics, biochemists, sociologists, environment studies – who had difficulty in understanding what discourse analysis is all about. The meeting was about Health Impact Assessment (HIA), so apart from labelling myself a discourse practitioner, I also started using the acronym CDP (to stand for Communication and Discourse Perspective) on health care issues.

² . For Freidson, ‘practitioner’ is a relatively neutral term, unlike ‘professional’ which connotes status, specialised work knowledge etc.

What distinguishes sensible from silly operations is not their parentage but their procedure, and this holds no less for intellectual than for practical performances. "Intelligent" cannot be defined in terms of "intellectual" or "knowing how" in terms of "knowing that"...

The 'procedure' that practitioners follow, in Schon's (1983:50) terms, constitutes 'knowing-in-action' and it goes beyond the simple application of technical/rational knowledge to practice. Professional practice becomes a form of 'knowing how' in an accumulative sense.

The gap alluded to above between scientific knowledge and professional practice applies to the profession being studied as much as to the discourse practitioners who are doing the looking. As discourse researchers, we may be preoccupied with what Schon (1983:viii) characterises as 'inquiry into the epistemology of practice':

What is the kind of knowing in which competent practitioners engage? How is professional knowing like and unlike the kinds of knowledge presented in academic textbooks, scientific papers and learned journals?

In situations where we study other professions, do we see ourselves as knowledge workers (in the sense of 'know that') or practitioners (in the sense of 'know how')? More realistically, where in the continuum between scientism and practice do we position ourselves?

This already poses a tension. As discourse researchers, one of our interests must be to contribute knowledge to discourse theory. But with regard to our commitment to a professional group, a discourse practitioner identity will need to foreground concrete action – 'a rather thoroughgoing particularism, a kind of ontological and epistemological individualism' (Freidson 1970:170), in the sense that our observations and findings can lead to some kind of a resolution of professional dilemma. It is not enough simply to ask questions and delve into problematisation per se. What is needed is 'meaningful problematisation' (Luhmann 1990), so that discourse research fulfils the criterion of accountability.

3 Accessing, problematising and interpreting professional discourse

There is a long tradition of sociolinguistic and discourse analytic studies in different areas of professional practice, e.g., legal, medical, therapeutic, educational settings. Studies of professional-client encounters focus on themes such as power asymmetry, expert-lay knowledge systems, role-relationships, face management, co-operation. Many discourse researchers are primarily interested in how language mediates professional activities, and not all of them may engage explicitly in what constitutes professional knowledge and practice beyond language performance. Exceptions here are the ethnomethodological and ethnographic studies into professional work (see, for example, Atkinson 1995, Goodwin 1994) which go deeper than the linguistic and interactional surface in their attempt to understand professional practice and knowledge representations from the insiders' perspective.

My aim here is not to summarise the wide range of topics and findings from discourse-based studies of different professions, but to raise the following three issues as a way of anticipating the tensions I will address in section 6. The three issues are : (i) accessibility; (ii) salience/problem identification; (iii) coding/interpretability/articulation. Let me in turn elaborate each of these very briefly.

Firstly, access to professional data sites has remained a longstanding problem for discourse researchers. With special reference to the legal domain, O'Barr (1983) problematises the issue of gaining access. Generally speaking, in addition to blunt denials and failed attempts, negotiations for routine access to different professional sites can be time-consuming and frustrating. At the far extreme, there is an element of suspicion, and perhaps mistrust, especially when the practitioners under study do not have any (or, limited) access to the discourse research process and outcome.³ In many cases, discourse researchers are seen as outsiders, only driven by their own motives to access real-life data, and armed with their own expertise to analyse talk and text and use such analyses to verify linguistic/pragmatic theories of interaction,

³ . Even when participants give informed consent for being recorded, they have very little idea about how the data would be analysed in the future. It is often not clear what rights and obligations they have over the interpretation of 'their data', nor do we know much about the liabilities that a discourse researcher may have to live with.

meaning construction etc. Such an agenda is the counterpoint to being a discourse practitioner in the sense I am using the term here.

The issue of access is linked to a sense of mutual usefulness. With regard to negotiating access, Humphreys (cited in Agar 1980), in his study of 'Tearoom trade', talks about the researcher taking on the identity of a 'watch queen' – how the researcher is allowed to observe homosexual acts, but in return is required to watch out for the police or straight males. In professional discourse studies, one also needs to be mindful of the competitive research ethos. In the health care setting, for instance, discourse researchers have to vie for space and credibility. There is keen interest from other stakeholders representing different disciplinary backgrounds: medical sociology, medical anthropology, medical law/ethics, medical education; health psychology, health economics, health technology. The competition, however, becomes diffused when we learn that other researchers may have different agenda (topics of study) and methodologies. Sociolinguistics- and discourse-based researchers have to show how they can make a distinctive contribution to a given field of professional practice, while underscoring the fact that language is one of the major social variables that can account for differences at the level of performance. We find here a client-practitioner relationship, where subject-clients will seek out different professions and practitioners for solving their practical problems.

This leads me to my second point, i.e., the extent to which the issue of problem identification is central to carrying out professional discourse studies. Assuming that we are successful in obtaining access, we are then faced with the problem of identifying what we choose to make the focus of our study. In many instances, however, our prior formulation of research problems does mediate the negotiation of access. Does our motivation for a given topic or problem align with what the professional group see as worth investigating? What kinds of data do we need to collect in order to be able to address our research questions? In approaching our research questions and data in this way, we are already introducing an analytic bias. Moreover, we start to emphasise that linguistic and interactional data are necessary and sufficient conditions for our study of professional practice. As Schon (1983:viii) rightly points out,

Competent practitioners usually know more than they can say. They exhibit a kind of knowing-in-practice, most of which is tacit. Nevertheless, starting with protocols of actual performance, it is possible to construct and test models of knowing. Indeed, practitioners themselves often reveal a capacity for reflection on their intuitive knowing in the midst of action and sometimes use this capacity to cope with the unique, uncertain, and conflicted situations of practice.

If we follow this line of argument, talk and text does not always constitute the whole of professional practice. Hak (1999), among others, draws our attention to the talk-bias in most conversation-analytic and discourse-analytic studies with their preoccupation on analyses of talk-in-interaction. Not only does this scientific/analytic mentality reveal a misconception that 'talk is work' but it also suggests a reductionist approach in the sense of the researcher-analyst not engaging fully with professional practice. As I have already suggested, it is hard enough to access talk and text data in a professional setting. When we succeed, all we get access to is what constitutes the frontstage activities. The backstage activities which constitute the core of professional practice are very well guarded and may not be made accessible to researchers perceived as outsiders.⁴ This is very much the case in professions such as medicine, where other-initiated gaze and criticism may be a dispreferred activity.

Thirdly, coding and interpreting talk/text data of another profession requires on our part adequate insider knowledge of the professional practice we are investigating. It is very likely that we will identify a problem based on the access we are given to in professional sites, and based on our analytic tool boxes. As Ravetz (1971:354) puts it, 'The solution of a practical problem ... is determined by the categories in which it is conceived'. Coding therefore assumes priority. The identification and naming of a problem is often constituted in the act of seeing. Cicourel (1968), among others, argues in favour of adopting an insider perspective in order to understand professional practice. As he points out, talk and text which is produced in a professional context, such as police case notes, are other-directed. The 'other' here refers to one who already belongs to this community of practice, i.e., medical case

⁴ . See Goffman (1959) on the notions of 'frontstage' and 'backstage', and Sarangi and Roberts (1999) on their relevance in professional discourse studies.

notes, police case records as being targeted at other co-professionals and specialist readers (Goffman 1961, Garfinkel 1967). Even typical professional-client encounters serve other-directed institutional purposes, so there will be gaps in our understanding of how a specific interaction develops. The discourse researcher in this setting occupies an 'other other' position – one who does not belong to this community of practitioners, and so may lack the necessary perspective to interpret what is going on. It is one thing to say, along the ideological lines of conversation analysis (CA), that we do not need to bring any contextual baggage to the data we are looking at. But it is not far from admitting that we might end up with misinterpretations, although such misinterpretations do not have any consequences for either professionals or clients. This brings me back to my earlier point that if our work were to be practically relevant, we need to align our interpretation with professional practitioners' 'knowing in action', which is not always linguistically manifest. Hence, what we may regard as real-life linguistic or interactional data can in itself pose a limitation as to what we can say about professional practice, especially when we take on board Schon's (1983:viii) observation that 'competent practitioners usually know more than they say'.

In light of our inadequate knowledge of 'other' professional practice, Cicourel (1992) advocates the idea of collaborative interpretation as a necessary condition, and so emphasises the need for seeking support in the form of feedback data and triangulation as a way of ensuring ecological validity. Collaborative interpretation is at par with Garfinkel's (1967) notion of 'documentary method of interpretation'. If types and tokens are intricately linked, then when we observe a token of professional practice, we need to have an understanding of the type against which the token is to be made sense of. Many CA researchers orient themselves to a participant perspective, but they hesitate in embedding 'the participant' whole-heartedly into their analysis. The talk data in its transcribed form becomes a constraint and the ensuing interpretation becomes a scientific rather than practice-driven enterprise.

Conducting collaborative research is fraught with difficulties if we do not engage our professional practitioners in the act of interpretation of data. An early example of (lack of) collaborative interdisciplinarity is the study of therapeutic interaction by Labov and Fanshel (1977). As we know, the final outcome of this study is a corpus of generic rules of discourse coherence. In this sense, it is an example of 'knowledge

that' in Ryles' sense above, as it stands out as a theoretical contribution to discourse comprehension, rather than providing us any insights into the 'know how' of therapeutic practice. Indeed this looking for general principles in a scientific vein is counter-productive in terms of a practitioner identity (see our discussion of Freidson above). Collaborative modes of inquiry, which include collaborative interpretive practices, are still very rare in professional discourse studies. This is particularly striking when we note the overall interpretive turn in the study of professions.

4 The interpretive turn in professional discourse studies

Within sociology, there has been a shift from normative to interpretive work as a continuation of the hermeneutic tradition (Wilson 1971). The focus, to varying degrees, has been on aligning participants' and analysts' perspectives rather than imposing categories external to the object of study. This trend is most prominent in the studies labelled 'sociology of deviance' or 'social problem construction' (e.g., Becker 1963, Stoddart 1974, Wieder 1974, Whyte 1955, Best 1989) – both in terms of topic and method. Rather than address bigger social issues such as suicide, kinship, marriage in the Durkheimian tradition, researchers in this interpretive paradigm identify almost any everyday activity as their topic of inquiry – the street corner society, drug addict communities, the half-way house etc. Ethnography and ethnomethodology have offered the methodological tools necessary to study such everyday sites. Even this hasn't been very easy – in terms of access to sites and interpretation of data. A few researchers have gone for disguise – i.e., they pass as one of the group/community being studied in order to access data and to become socialised into another interpretive community of practice – but this is perhaps more difficult in professional and institutional settings.

Stoddart (1974), for instance, sought to pass as a group member in order to study the lives of heroin users. He talks about the power of argot, i.e., specialised register, and how it can impede the interpretive process. Not just learned professions, but every community of practice is constitutive of their specialised genre. How do we as outsiders understand others' language use, especially when words are used to signal some non-conventional meaning and when it is counterproductive to ask explicitly what something meant? Stoddart gives the example of 'pinched' as it was used in this community of heroin users to denote the unconventional meaning of 'someone

has been arrested for junk'. In my work with the genetic counsellors, I had difficulty in making sense of what they meant by DNA. They were using the term in a non-technical way to refer to patients who 'Did Not Attend'.⁵ I waited for a considerable amount of time before I could ask for clarification about this unconventional use. I had to pretend to have understood it until then (see Cicourel [1992] and Becker [1993] for similar accounts).

MacKay (1974) talks about children's 'interpretive competence' in the context of child socialisation studies. In a similar vein here we are concerned with the researcher's interpretive competence in discourse socialisation studies. We need to seek membership into the professional community under study, while acknowledging the limits of our interpretive practice (see section 6.3 on analyst paradox). If meaning is embedded in context (Duranti and Goodwin 1992), then discourse researchers need the help of professionals to understand what is going on in a given situation in order for their interpretation to be ecologically valid. One needs to go beyond what Heritage (1984) refers to as 'double contextualisation' – every action shapes and is shaped by context. In the professional discourse studies, we need to make an attempt to integrate the broader context (in the sense of institutionalised framing of activities, hence the need for ethnographic fieldwork) with the narrow context (in the sense of locally organised and negotiated interaction). The assumption here is that participants (professionals and clients) draw upon both levels of context, and so this leaves the discourse researchers with no choice but to engage with the context at all levels in order to be able to put into practice Garfinkel's 'documentary method of interpretation' (see section 7 on contextual constructionism). In this sense, Giddens' (1976) idea of 'brought about' and 'brought along' contexts apply to both participants and researchers. We have evidence of this ecological interpretive practices in the medical domain in studies such as Becker et al (1961), Cicourel (1992) which attempt to combine ethnographic and micro-analytic methods of observation and interpretation.

In what follows I first briefly introduce the three health care sites where my current work can be located and then identify some key areas of tension in conducting inter-

⁵ . According to my consultant colleague, they now use FTA (failed to attend) instead of DNA to refer to absent patients. This new acronym will need explaining to other non-medical researchers.

professional research in terms of knowledge, identity and genre, as well as the linkage between discourse research and its potential uptake.

5 An overview of discourse/communication-based studies in three health care sites

From the discussion above, it is apparent that decisions about where to look for data are bound up with what insights we are likely to get about professional knowledge and practice. Also, it is important to bear in mind the extent to which we may feel competent and comfortable in analysing such data given our own level of knowledge about professional practice. Here I draw on three data sites from my ongoing health communication research – all of which pose challenges of ‘expert’ interpretation and intervention.

5.1 Professional socialisation: the RCGP study

The mainstream studies in healthcare are doctor-patient encounters (especially in general practice settings), with the analytic focus on what doctors do.⁶ The clinic is still the site of study when one orients to the patients’ perspective (with the exception of narrative studies of patients’ accounts of illness). Earlier I have drawn attention to frontstage and backstage activities of a professional community and the problems associated with gaining access to backstage activities. In some cases, the backstage activities may be regarded as constituting ‘the core’ of a profession’s knowledge and identity. For instance, talk between doctors in gatekeeping settings such as the oral examination brings to the fore how professional knowledge and practice are constructed, maintained and contested at any given time.

Here let me briefly outline one such research project which Celia Roberts and I carried out as part of consultancy research. During 1995-1996, we were approached by the Royal College of General Practitioners (RCGP) to record and analyse the oral exam interviews (for details see Roberts and Sarangi 1999, Roberts et al 2000,

⁶ . Mainstream discourse analytic studies seem to have identified prototypical sites of investigation. As with the focus on the clinic in medical discourse, there is more focus on courtroom interaction than between lawyer-client interaction outside the courtroom (or lawyer-lawyer talk for that matter); more focus on teacher-pupil interaction inside the

Sarangji and Roberts, in press). Our brief was to see if the oral examination was in any way discriminatory as far as GP candidates from different linguistic and cultural backgrounds were concerned. The consultancy paradigm however allowed us to redefine our/their research interest. Rather than jumping into conclusions about racial discrimination, we chose to concentrate on the oral examination in its entirety as a discourse event. This led us to look closely at what the examiners were looking for in terms of successful candidates, and not just focus on how candidates from ethnic and linguistic minorities fared. Were the examiners, for instance, looking for good doctors (competent in professional practice in Ryles' sense of 'know how') or good interview performers (competent in displaying abstract scientific knowledge in Ryle's sense of 'know that')? To what extent did the examiners' questions and interactional moves index one or the other outcome? This connects with my earlier point about keeping knowledge and practice analytically separate.

In this study we identified three modes of talk – institutional, professional, personal experience – which seemed to be present in different degrees in all of the oral interviews. Here we are not talking about different and oppositional voices – voice of medicine vs. voice of the lifeworld in Mishler's (1984) sense – but about different layers of hybrid modes within the voice of medicine. Further analysis revealed that the examiners were not particularly privileging one or the other mode of talk, although overall it seemed that the institutional mode (in Ryle's sense of 'know that') took priority over the professional and personal experience modes (in Ryle's sense of 'know how'). Indeed smooth transitions between these modes seemed to be the right kind of recipe for success. The maintenance of hybridity became a key issue for both examiners and candidates.

One thing that soon became apparent was the difficulty in identifying and labelling, in a rigorous way, these different modes of talk in the discourse data. A related difficulty was to note all the transition points and then to locate which ones were particularly awkward and might have been consequential in terms of interactional outcomes. The consultancy format provided an excellent opportunity to access further insider knowledge from the examining doctors. So, we produced a checklist of possible awkward moments for a group of selected examiners to respond to as

classroom rather than what happens outside the classroom (or teacher-teacher talk, for that matter).

part of their video training sessions. (See appendix 1 for a sample filled-in form, with the numbers in italic referring to the time frame of a specific video.) This then became a kind of collaborative coding – like collaborative interpretation – which led us to look specifically for those interactional moments which had been identified by the examiners as being awkward.

For me, this amounts to integrating participant and analyst perspectives at the time of identifying and coding data – a kind of discursal construction of problems. Also, in identifying awkward moments, the examiners can be said to be reflecting on their practice – or ‘knowing in action’ (Schon 1983).⁷ In this instance, it then made sense to map the three modes of talk on to the awkward moments as a way of finding out what contributed to success and failure of individual candidates. Through such systematic analysis of data, aided by professional insights at the stage of coding and also later, we were able to develop a comparative perspective which was crucial to making our work practically relevant. As one of the by-products of this collaboration, we were in fact able to formalise better what we meant by the different modes of talk. Interestingly, these same modes of talk became salient in our negotiation of expertise with our medical colleagues (Sarangi and Roberts 2000). In other words, the institutional and professional modes of talk that we had identified in the oral interview data also defined the research process: how we went about demarcating our (in)expertise, how we mixed institutional, professional and personal experience modes and, more importantly, how we mapped discursal evidence onto aspects of cultural difference and potential discrimination.

5.2 Communication skills in medical education

My second site concerns oral exam interviews involving final year medical students in the UK. This study was also designed as consultative, with Celia Roberts and myself working closely with medical educators and practitioners. This is a fertile area for discourse research to have an impact – especially when medical curricula are taking the issue of communication skills training seriously (see Cameron 2000, more generally). Our work, unlike a psychological package of skills training, had an applied angle as we tried to show how a micro-analysis of interaction can reveal what kind of

⁷ . Following from this activity, the examiners (as part of their annual convention meeting) sent us more instances of awkward moments – almost voluntarily.

socialisation is expected of student doctors before they get rites of passage to the community of medical practice. It broadly falls within the strand of studies in medical socialisation (Merton et al 1957, Becker et al 1961).

The site here – like the RCGP one – is also a gate-keeping occasion, except that we are looking at how novices move from the periphery to the centre of what constitutes medical knowledge, practice and identity. One of our primary concerns was to see if ethnicity of candidates was linked to rate of failure. Like in RCGP, however, we chose to look at the entire event and across the candidates from all backgrounds in order to be able to determine whether or not culture and ethnicity are the proper predictors of success/failure (the same can be said about gender). A general point here is that consultancy research in intercultural settings should not fall into the trap of pure academic research on cross-cultural differences. A lot can be gained (and prevented) if we looked at cases of intercultural encounters alongside others, not just the ones involving ethnic participants as that might restrict our sphere of interpretation and our assessment of the exact effect of ethnicity on interactional process and outcome.

These oral interviews consisted of professional role players acting as patients. The student-doctors moved from one patient case to another taking histories, giving or not giving treatments, but above all, performing their physician identities through various interactional routines. This oral talk, like the RCGP one, consisted of a mixture of institutional, professional and personal experience modes. Unlike our analysis of RCGP data which focused on awkward moments, here we decided to have full mappings of the orals in order to capture the interactional flow and the thematic staging (Roberts and Sarangi 2001). This was easily accomplished because these were fairly standard encounters, with fixed topics, involving the same actor-patient and each session lasting about six minutes. Through the full mappings we identified two major involvement styles – which we termed empathetic and retractive – each one with a further set of sub-categories. It seems candidates can be assessed overall as being empathetic or retractive, with their preferred styles underpinning different ideologies. Hybridity of the kind we found in the case of RCGP data is also a characteristic feature of this data. It is perhaps too early to predict what relevance our findings will have for purposes of training examiners, student-doctors and/or actor-patients.

5.3 Communicative frames in genetic counselling

The third and final site of this overview is my ongoing work in genetic counselling. Genetics as a new area of expertise poses specific challenges to discourse researchers. Unlike mainstream doctor-patient encounters, here the boundaries between lay and expert knowledge systems are hard to demarcate. The complexity is also manifest in a dispersed notion of patienthood, the range of topics that can be discussed in any one counselling session, including aspects of non-treatability and non-diagnosable nature of certain genetic conditions. As an activity, it wavers between being consultation, counselling and therapy with regard to information, explanation and advice giving sequences (Sarangi 2000).

As I began to sit in the clinics to collect data, I became increasingly aware of the nuances associated with different genetic conditions. Compared to the two other healthcare sites mentioned above, I was no longer dealing with a structured activity. I soon realised how genetic counsellors had to constantly grapple with issues of uncertainty and non-directiveness – two key aspects of genetic counselling – in condition-specific ways. For instance, it may be possible to become directive when one has the relevant scientific evidence and clinical knowledge about the genetic condition in question. Or, based on results from a predictive test concerning, say, Huntington's Disease, one can be very certain about inheritance, but not about the exact onset.

A discourse researcher coming from outside the profession needs to have a certain amount of knowledge about genetics and genetic counselling in order to be able to assess the status of any information as advice or as explanation. This is not even taking into account the fact that any information offered by a counsellor could be taken up as potential advice by clients – putting them on course to make specific decisions as if that was what the counsellor intended. Equally, dealing with matters of uncertainty, a discourse researcher will be unable to keep at pace with the ever-expanding genetic knowledge base. New genes and new gene functions are being discovered on a regular basis, as are new technologies and tests. Such developments are bound to have an impact on how uncertainty is managed in the clinical setting.

As I started to look for interactional patterns in the data, I was constantly asking myself questions of a different nature: Why didn't the counsellor elicit more details about the family history? Why was the counsellor reluctant to give a diagnostic label when the clients desperately wanted one? Why was the counsellor repeating himself/herself when the clients seemed to know what was being talked about? To some extent, I felt that I needed to know more about the genetic conditions themselves and about specific family histories before my analysis of the clinical interaction could have any credibility. Let us consider here an example of a post-clinic discussion between the researcher (R) and the consultant geneticist (G), related to a condition called Rett Syndrome.⁸

Genetic Counselling: post-clinic discussion

- 01 R: I was saying looking at it from the last clinics I went to [(.)] where a lot was
=
- 02 G: [mm]
- 03 R: = going back to (.) you know much more .hh (.) family tree and [(.)] all the
=
- 04 G: [yes]
- 05 R: = question about the risk and so on and so forth (.) and that was very much
tied up with (.) future planning and [(.)] so on (.) er the the two cases we =
- 06 G: [yeah]
- 07 R: = looked at today were nothing to do with (.) family trees I mean
[that didn't come up at all] and therefore it was much more (.) naming =
- 08 G: [no that's one of the things (.) yeah]
- 09 R: = and labelling and (.) the other things rather than [(.)] you know the risk =
- 10 G: [yes]
- 11 R: = and so on even th- the whole issue of another child wasn't even raised
here
- 12 G: *mm (.) yeah* (.) no it's a very different context (.) from (.) from that
(name of town) clinic
- 13 R: mm
- 14 G: *yeah and* (.)
- 15 R: and how do these things get framed so differently [(.)] is it because of the =
- 16 G: [mm]
- 17 R: = nature of (.) I mean w- what I was thinking of is um (.) these are the test
cases you don't have a label (.) you can't trace it back to the (.) the the
mainstream family tree kind of [(.)] er er logic and therefore (.) the case =
- 18 G: [mm]
- 19 R: = comes with the (.) with the child [(.)] so you can't name it until (.) it is =
- 20 G: [mm]
- 21 R: = there if you like (.) and for it to be there (.) you need to wait and see (.)

⁸. I will use the following transcription conventions: dots or numerical between round brackets denote pause; texts within double round brackets are glosses; square brackets signal overlaps; equal sign (=) means latching; extended colons stand for lengthened sound and untranscribable segments are signalled by [^^^]. Asterisks on both sides of an utterance denote words spoken in relatively lower voice.

- with tests and developments and so on [(.)] so so the whole question of
naming =
- 22 G: [mm]
- 23 R: = something now [(.)] is is not an option because you have to wait for it to =
- 24 G: [mm]
- 25 R: = happen or occur
- 26 G: yes (.) s- sometimes (.) I mean people will (.) differ in their skill I mean some
 people will be able to (.) be quite sure (.) about (.) er (.) a diagnosis (.) and
 a child's (.) growing into a diagnosis sooner than others so I mean
- 27 R: people meaning (.) medics yes
- 28 G: geneticists
- 29 R: right
- 30 G: so some will (.) will spot something quicker and (.) er (.) than than others
 will and you know I'm not dysmorphology (.) is is something that I do in
 terms of (.) trying to recognise syndromes [(.)] but I'm not a natural at it I'm
 not =
- 31 R: [mm]
- 32 G: = brilliant at it (.) so that's why I rely on taking pictures and discussing with
 colleagues an' (.) sometimes asking er ((name of G)) in ((town)) or someone
 else elsewhere even (.) to look at one of my children's (files) and (.) send a
 family to see (.) someone else [(.)] if I think there is a label there to be =
- 33 R: [mm]
- 34 G: = named but I can't make it (.) um but but this last child (.) I really don't
 think there is a label to be made um
- 35 R: but you would take it back to (.) your colleagues [and] does it (.) I mean is it
 =
- 36 G: [well I]
- 37 R: = one of those ones
- 38 G: well there's not much point I mean because she's not dysmorphic I mean
 physically just looking at her
 ((discusses medical symptoms))
 [...]
- 39 G: and so one's really left with (.) very little (.) to go on and the one (.) if her if
 ((CF's)) (.) hand use had been different had been affected much more than it
 is then I'd have (.) been saying yes she's got Rett Syndrome (.) 'cause
 everything else would fit with it [(.)] so I mean I want I'm likely to end up =
- 40 R: [mm]
- 41 G: = saying when I see them next time (.) I'll see what the EG shows but
 probably what I'll say is (.) that she's got a (.) sort of (^ ^ ^ ^) or variant of
 Rett Syndrome and that's going to be an unsatisfactory label but the best
 one there is and if they're not well I mean they can always=
- 42 R: =that's something you probably already hinted at (.) [even] without the test
 =
- 43 G: [yes]
- 44 R: = that it has a bit of both [(.)] or these features do match up with something
 =
- 45 G: [yes]
- 46 R: = that goes with that but not entirely so
- 47 G: but she hasn't got it in a classical form=
- 48 R: =right right
- 49 G: and (.) they'll probably probably end up asking another paediatric neurologist
 to see her (.) because they probably won't be happy with just me seeing her
 I think they'll want somebody else to confirm it (.) I think (.) I'll probably
 send her to (.) well there's no one else in ((name of city)) they'll probably
 send her to ((name of hospital)) or somewhere (.) er (.) you know to see if
 there's somebody else who sort of (.) go along the same story that I'm (.)
 telling them

Such post-clinic discussions, for me, constitute collaborative interpretation. This episode is triggered by the researcher who notices a striking difference between counselling sessions: how on one occasion the clinician may choose to dwell upon the family tree in order to attempt diagnosis, whereas on another occasion s/he may decide not to follow a similar route. The latter scenario captures the clinic being talked about here. R obviously needs the insights of G so as to make sense of the linkage between genetic explanation based on family trees on the one hand, and how such information is to be utilised for purposes of diagnosis and labelling on the other hand. This tension characterises what happens in the clinic, although there are reasons behind what gets explicitly said or not said. The follow-up discussion therefore provides a means for explicating some of the 'unseen but noticed' – giving a twist to Garfinkel's (1967) idea of 'seen but unnoticed' – aspects of the counselling session. In turns 26-32, G draws R's attention to the existence of differential practice as far as degree of certainty about diagnosis is concerned – 'some people will be able to be quite sure about a diagnosis'. G also points to his zone of expertise, including his inclination to seek a second opinion (see also turn 49). We also have evidence here (see in particular turns 26, 30 and 32) of how clinical expertise is acquired through exposure to individual cases in practice. The idea of 'taking pictures and discussing with colleagues' constitutes an important route to enhancing one's professional 'knowing-in-action'. Backstage considerations such as these are bound to affect the quality of the interaction in the frontstage clinical setting. It seems to me that insider perspectives on tacit knowledge are a necessary condition for analysing what surfaces at the level of talk and interaction. Each interaction that a discourse researcher is looking at, especially in the clinical genetic context, will always come with a biographical history of its own. So, the discourse researcher will remain an outsider unless some attempt at collaborative interpretation is made.

6 Tensions in negotiating inter-professional boundaries

On the basis of my discussion so far (see in particular section 2), let me single out four types of overlapping tensions which characterise the study of professional discourse.

6.1 Deconstructing the researcher identity

For a long time communication scholars have urged us to deconstruct the research process (see, for example, Cameron et al 1992). However, the role of the researcher has largely remained a monolithic concept. This is particularly striking in view of the fact that many of us adopt the Goffmanian participation structure framework to talk about different producer and receiver roles in social interaction, but we are somewhat less forthcoming when it involves the characterisation of the multi-faceted researcher role-identities in inter-professional discourse settings. As discourse researchers, when we decide to gain access to professional research sites, it is very likely that we will need to negotiate our own identities on a contingent basis. It will bear on the notion of presentation of self as 'professional strangers' and how our subjects 'will draw on their own repertoire of social categories to find one that fits you' (Agar 1980:54). In other words, how the researcher is perceived by the subjects is as crucial as how the researcher manages his/her presentation of self. We can think here of multiple possibilities, e.g., researcher as insider, as outsider, as agent of change, as animator, as overhearer etc (Sarangi and Hall 1997). These different identities index different levels of participation and involvement (including trust and accountability) with research subjects. A good example here is Gubrium (1975) who constantly shifted between doing menial work (toileting) and being a gerontologist at staff meetings, as part of his ethnographic study of a nursing home.

The issue of socialisation of the discourse researcher into another professional practice needs to be taken seriously. It is bound to be an incremental process, similar to how novices get socialised into their professions – moving from the periphery to the centre (in the sense of Lave and Wenger 1991, see section 4 above on socialisation and ecological validity in terms of interpretive practices). In the ethnographic tradition, when researchers carry out their fieldwork in 'other' surroundings, they make an attempt to socialise into their subjects' ways of doing things. Becker's (1963) highly influential paper 'Becoming a marijuana user' can serve here as a metaphor. According to Becker, the technique of marijuana use needs to be first separated from smoking tobacco: unlike tobacco smokers, marijuana users take in a lot of air, get it deep down their system and keep it there for as long as they can. This results in getting sufficient dosage for intoxication. Becker breaks this inhaling process down into three components: (i) learning the

technique; (ii) learning to perceive the effects and (iii) learning to enjoy the effects. In terms of interprofessional research sites, this means that discourse researchers need the practice to get enough of professional air into their system in order to understand what they are observing and enjoy the collaborative research experience.

If discourse is a form of marijuana, then professionals also need to inhale discourse slowly and steadily in order to become competent practitioners of discourse. In other words, what we have here is a relation of complementarity: not only do discourse researchers become socialised into professional practice, but professionals also learn to become socialised as discourse practitioners. This will then amount to redefining the role-relationship between the researcher and the professional practitioner as we are no longer positioning ourselves as experts, making explicit recommendations for change of professional practice. In any case, as Freidson (1970) alerts us, practitioners do not always seem to be keen on changing their practice based on scientific findings (see also Bloor 1997). Professional practitioners work with different kinds of knowledge, including their own cumulative practical knowledge, so any new findings – such as the ones arising from discourse-based studies – need to be seen against other competing knowledge resources available to practitioners. Self-appraisal is more likely to result in change of practice than other-initiated-advice. This is not very different from the preference of self-initiated repairs in the conversation analytic sense. In very modest terms, discourse practitioners can make it their goal to turn their subjects into discourse practitioners which would lead to self-appraisal. It is then a matter of developing a way of seeing (gaze) and use of (meta)language or specialised register. Does this then pose a threat to our livelihood as discourse researchers? Not any more than discourse researchers in large part being ignored by professional communities of practice.

6.2 Aligning differential knowledge bases

The role of discourse analysts when dealing with professional sites needs further scrutiny. Goodwin (1994) exemplifies how each profession is constituted in different ways of seeing, leading to differential practices of coding, highlighting and articulating material representations. In his discussion of the Rodney King trial, he shows how the police have a distinct way of coding evidence from that of the lawyers. He also draws our attention to how even within the legal profession, the

defendant's lawyer and the prosecution lawyer will adopt different ways of presenting evidence. These differences are likely to be heightened further when we cross inter-professional boundaries.

Goodwin's characterisation above concerns the act of interpretation. When extended to our interprofessional sites, it may not be so easy to attain a reciprocity of participants' and analysts' perspectives. As Cicourel (1968:15) remarks:

I assume the critical task of the researcher is to show the reader how the research materials are always understood by reference to unstated and seen (but unnoticed) background expectancies both members and observers employ to recognise and to understand their activities.

There seem to be two extreme choices: alignment with participants' perspectives or transformation of what is observed (Sarangi and Candlin 2001). Alignment may be seen as a form of contextualisation in search for 'ecological validity' – which is different from the process of transformation since it impinges on analysts' imposition of external categories and labels. Transformation is thus a form of recontextualisation (for an overview, see Linell and Sarangi 1998). Alignment is also a matter of feasibility as well as desirability (see section 7 on strict and contextual constructionism). It is quite possible that different participants, say, lawyers and defendants, will pursue different goals in a given encounter. When we find ourselves torn between different participant perspectives, on whose side do we lean (Becker 1967)?

Let us return to the genetic counselling context and ask: what happens when there are differences between researcher and participant perspectives; or what happens when we have a counsellor's perspective which may differ from that of the patient/client. As I have suggested already, the method of getting participant feedback is one of gaining access to what participants think is going on and to align their views with the analyst's perspective. But from a social constructionist position, we need to be aware that seeking feedback constitutes another speech event and does not provide reliable data to assess *what actually happened*. But a participant perspective must recognise that the participant is a discourse practitioner who is entitled to reflect on his/her practice, as the geneticist does in the post-clinic session

discussed earlier. Also, when interacting, participants no doubt analyse each other's conversational exchanges on a contingent basis. Once we bestow upon our participant the analyst status, then their post-hoc accounts are as authentic and credible as any outsider discourse analyst's commentary. But what may make a discourse analyst's task different is his/her motivated lookings for patterns and rules.⁹ It is worth noting that not all practitioner-participants will bring with them a similar degree of discourse analytic insights (in the same way that not all discourse analysts will approach a professional data site in the same way). It will depend partly on how much discourse they were prepared to inhale during the collaborative research process. There also remains the issue of knowledge differences within a given a profession (practitioners vs. practitioner researcher vs. policy makers). In the case of our RCGP consultancy study, medics who were only practitioners, as opposed to those who were researchers, responded to our discourse analytic work rather differently.

6.3 The interplay of Observer's Paradox, Participant's Paradox and Analyst's Paradox

In sociolinguistic research, the notion of observer's paradox (coined by Labov 1972) has been discussed at length, and has probably been overstated at the expense of other paradoxes – participant's and analyst's – which characterise discourse studies in the professional settings (see Appendix 2). Labov (1972) claims that we can only get authentic data when we are not observing the interaction – that is, our observation (which also includes the use of audio and video recording equipment) contaminates the data. Whatever we observe becomes a product from an observer's viewpoint. In Labov's formulation, the researcher as observer is conceptualised as having a unified identity. But as we have discussed in section 6.1, researchers may be accessing professional sites in various capacities. We can therefore extend the notion of observer's paradox to think about the activity of participants observing the observer – which is what I would call the 'participant's paradox'. For instance, some participants may be completely oblivious of the presence of the researcher-observer and/or the recording equipment during various stages of the interaction. Indeed, many participants admit this to be the case after a recording session. Other

⁹ . Here we can refer to the problem inherent in practitioners becoming full-fledged researchers, i.e., the difficulty of negotiating researcher identity with people with whom they previously have had professionally sanctioned role-relationships.

participants may remain conscious of the researcher's presence and even wish that the researcher were a legitimate participant, albeit with restricted interactional rights and obligations. It is the latter group who may find the 'uninvolved' stance of the researcher-observer as unnatural and distracting (Clarke 2000). Following Goffman's participation categories, we can think of a cline of involvement – at one end the researcher remains a 'participant as observer' and at the other end, s/he becomes a 'participant as interactant'. This distinction between the sphere of observation and the sphere of interaction is likely to be a matter of practical concern for many researchers in the field. Participant observation without becoming involved in the ongoing activity may not be so problematic if one is observing, say, classroom lessons or hospital ward rounds. But it is different in the clinical setting. Doctors and patients are very much used to the presence of various participants in a clinic and are aware of the fact that different participants may have activity-specific rights and obligations. So, in such a setting, if the researcher-observer remains fully uninvolved, then it may not go unnoticed. As far as participants are concerned, observer neutrality cannot be taken for granted, so it may be useful for the researcher-observer to participate, however minimally, in the interaction without influencing the course of events.¹⁰

Let us now consider yet another paradox: the analyst's paradox. This connects with our earlier discussion about collaborative interpretation and ecological validity. I have already made the point that we need not only data of professional practice, but also professional practitioners' insights to inform our data analysis. The notion of collaborative interpretation, in my view, accommodates the participant perspective as it is upheld in CA studies, but it is not reduced to it. Collaborative interpretation does not privilege participant perspectives unduly: instead it tries to align participant's perspective with analyst's perspective. This, of course, includes participants taking on the role of analysts in their own right (see section 6.2). Research interviews as an activity is in fact based on the assumption that participants know best what they do and why – i.e., they have the knowledge which discourse researchers are seeking to uncover. This does not mean that research interviews should not be interpreted as situated events, which make specific demands on participants to maintain a given

¹⁰ . It is perhaps worth mentioning here that in our RCGP research site, it has been difficult to keep separate the roles of 'researcher as observer' and 'researcher as participant/consultant'.

role-relationship. The accounts of professional practice that we access in an interview are not necessarily the same as what constitutes professional practice in action. As discourse researchers, we remain, for most part, peripheral but legitimate participants, eager to rely on our subjects' insights so that we align (rather than transform) analyst and participant perspectives.

6.4 Discourse ecology and discourse ethics

The ecology of context argument, as we have discussed earlier, bears upon the significance of aligning analyst and participant perspectives. This form of interpretive alignment is not only different from conversation analytic preference for 'members' method', it is also distinctly different from how critical discourse analysts draw upon the external, socio-political context in a ritualised manner to account for talk and text data. Indeed this latter kind of context-embeddedness – or, 'brought along' context by the researcher (in Giddens' sense) – runs the risk of overriding the participant perspective, i.e., the 'brought along' and 'brought about' contexts from the participants' perspective. So, we have to see ecology not just in the sense of context-embeddedness but also in the sense of interpretive alignment.

In a recent interview, Candlin (2000) teases out the various meanings associated with the ecology metaphor to include (i) an interactional view of language which coincides with how everyday people perceive language use; (ii) a notion of dynamic (and systematic) change as in the case of language acquisition/socialisation or colonisation/globalisation; and (iii) uptake in interprofessional settings. The latter has to do with how discourse researchers relate to practitioners such as lawyers, doctors, social workers who use language professionally and for whom language is the essence of what they do.

The above ecological considerations will have to be supplemented with ethical issues. In the field of discourse and communication research, the issue of ethics has been mainly confined to matters of data collection and data presentation (see Cameron et al 1992). I feel that when we work in professional discourse sites such as healthcare, ethical issues go beyond data collection and researcher-researched field relations. This is where my earlier discussion of collaborative interpretation again comes to the

forefront. In addition, we need to be open about what might happen to the data in the future in terms of re-interpretations.¹¹ This is particularly relevant when professional practitioners – individually or collectively – and professional organisations are showing a keen interest in the value of communication and discourse analytic studies.¹²

Let me formulate the ethical issues in the form of some key questions.

Where do we look?

My answer to this is 'almost everywhere'. In addition to the difficulties in accessing various frontstage and backstage activities of a professional community, we are also constrained by our own expertise. For instance, our interest may be only in talk and text rather than professional practice as such. We may then tend to select those moments of professional practice that are constituted in talk and text. In fact discourse scholars working with text do not even consider examples of professional talk. The reverse is also true. For instance, researchers interested in medical discourse seem to take for granted that medical work is constituted in talk in the clinic, and so ignore the practising of medicine as it happens elsewhere, including in the text format. What Hak (1999) refers to as the talk bias can also be extended to discuss text-bias. Basically our naming of a topic of inquiry can be reductionist. Both

¹¹ . This point came home to me when a genetic counsellor whose clinics we have been taping for quite some time showed signs of concern about what kinds of analyses we were doing. Although we have had consent for the clinics to be taped, it is legitimate to be apprehensive about what happens to the data and who gets to read the analyses (despite assurances of anonymity). There is a parallel here to the current debates about genetic tissue banking and how such tissues are utilised for research or other commercial purposes.

¹² . Recently I met an oncologist to discuss possible collaborative research on cancer communication. Routinely, he taped all his clinics and handed the tapes to the patients so that they could listen to the clinic discussions again. Following the usual consent procedure, the oncologist invited me to listen to a few tapes as a way of identifying topics of mutual interest. When I was asked, what I might say in relation to problems of communication, I saw it as similar to a kind of referral practice which blended research design and consultancy. As discourse practitioners, then, we need to come up with a concrete set of points and make clear our intentions and speciality (or lack of it) in dealing with such sensitive data. In approaching us, professionals are both worried about our sense of ethics and confidentiality, but at the same time they are indicating that we can do something that would help improve their day-to-day practice.

strictly motivated lookings (like Labov and Fanshel 1977) and open-ended lookings can be unhelpful for professionals.

Do we identify a set of problems that might be of interest to our participants?

My preferred response here would be 'Yes, as far as practicable'. If the problem identification is jointly negotiated, the research findings are more likely to be interpreted favourably. But this needs to be seen against Perakyla's (1995) warning that the primary motivation of interaction research is not to solve problems faced by professionals. This is a cautious and honest assessment and it partly coincides with my point that we may be lacking adequate knowledge to solve another profession's dilemmas. However, this kind of an opposition between discourse research and professional practice can be bridged through collaborative interpretive work. Also, solving problems, raising awareness and reporting of findings are different activities, although in a consultancy model these two may become inseparable. More generally, discourse-based studies must try to orient their work for professional uptake – whether or not this leads to change of practice and solution of specific problems. On the contrary, adopting an indifferent stance or approaching professional discourse sites with an 'open mind' can be viewed with suspicion by professional colleagues.

To what extent do we involve participants in the interpretive process?

The notion of collaborative interpretation, as I have discussed so far, needs to be reassessed on a case-by-case basis. As we have seen in the RCGP study, it can be at the stage of identifying key moments for analysis, or it can be, as in the genetic counselling site, to back up or clarify preliminary analysis of data. Much will depend on the level of involvement and understanding that the discourse researcher brings to the research site. In a sense, it is similar to anthropologists' use of the native informant on the top of participant observation in order to make sense of 'other' cultural practices. Levi-Strauss (1978:26) calls this the 'anthropological doubt' which he glosses as 'knowing that one knows nothing, but of resolutely exposing what one thought one knew – and one's very ignorance'. In a similar vein, here we are talking about 'discoursal doubt' which is bound to be a feature of interprofessional research.

Do we tell our participants everything we find?

The answer to this question has to be a cautious 'No'. This is partly because we have only done a motivated looking, but also because our interpretations may not be sophisticated at all levels. The final decision as to what to offer as feedback will depend on what problems have been jointly defined for scrutiny. As Becker et al (1961) point out in their study of medical education:

But our purpose is not criticism, but observation and analysis. When we report what we have learned, it is important that we do so faithfully. We have a double duty - to our own profession of social observation and analysis and to those who have allowed us to observe their conduct. We do not report everything we observe, for to do so would violate confidences and otherwise do harm. On the other hand, we must take care not to bias our analyses and conclusions. Finding a proper balance between our obligations to our informants and the organisation, on the one hand, and our scientific duty, on the other, is not easy.

Cameron et al (1992:14) make a similar point when they say that 'the interests of the researched are a negative force limiting what researchers can do'. This perhaps relates to the general issue about studying social problems. Our involvement as discourse researchers needs to be assessed in light of contributions from neighbouring fields – especially from sociologists, anthropologists and psychologists. It is not just a matter of problem construction but also how we construct our findings for the uptake of the professionals involved, as Becker et al so clearly attest. Discourse researchers need to verify their interpretations not so much against theories of language use but against the participants' theories of practice. That will have a double benefit of participants becoming reflexive about their practice, as well as discourse researchers challenging their own theories that are not always data-driven and in doing so, reflect upon their own discourse and interpretive practices.

When it comes to determining the audience of discourse research, we need not fall into the ethnographic trap where research accounts have to be produced to conform

to established genre and in the process amount to decontextualising the native's practices and the very act of participant observation/involvement (Marcus and Fischer 1986). An additional tension concerns what Bloor (1997) refers to as the provision of feedback based on contrastive performance. In presenting our audience with instances of good and bad practice (say, examples of empathetic and retractive encounters, see section 5.2) can be regarded as part of good pedagogy for raising awareness among practitioners. But this may raise ethical dilemmas. Apart from threatening the individual face of some practitioner, it can amount to non-cooperation for future research.

It seems that our usefulness as discourse practitioners can be enhanced in a model of 'professional consultancy' research. But can we imagine ourselves as discourse clinicians listening to other professionals' troubles-telling and being able to offer concrete advice, not theorise? It need not be therapeutic, but a kind of on-line gloss on what's going on, as is the case with medical education and training. Collaborative interdisciplinarity, which is part and parcel of the professional consultancy model as I see it, has the promise of successful uptake. This is partly because practitioners invariably analyse their practice, so they may naturally see the value of discourse-based insights. The professional collaborator may change his/her practice based on findings and this then may have the ripple effect – change happening over time in ever increasing circles. This is very different from a model of mass preaching or backstage engineering.

7 Conclusion: Professional discourse research as a co-constructionist enterprise

In this chapter I started with the promise discourse research has for the study of professional sites – especially in the healthcare domain – in light of the interpretive turn in social sciences generally. Discourse research can offer a range of linguistic and rhetorical categories to capture the 'know how' of a professional group, while also being able to distance oneself from passing judgement about individual practice. This raises the question as to whether discourse analysis is a science or an art or a form of practice. Clearly, as we have seen, one needs more than linguistic skills and knowledge in order to engage with professional practice. The strength of discourse research lies in our ability to identify suitable data for analysis, while underscoring

the fact that no single interpretation is valid in itself and that alternative interpretations are always inevitable. Our discourses have to be flexible to accommodate different ways of seeing and doing across professional boundaries. For this to be the case, we need to have an understanding of the professional practice before we can analyse any discourse data (S. Candlin 2000).

It is therefore important to recognise the limits of discourse research. The irony is that much of our work may lack the kind of rigorous scientificity for the claims we make to be credible. And for professional practice to change, our discourse-based claims need to be robust. Starting from collecting data to interpreting data to reporting findings, we are bound to be selective. Our analytic findings, in Durkheimian sense, may simply be aimed at illustration rather than demonstration. But illustration in this context can be a useful exercise, especially when what we are illustrating coincides with what professionals might intuitively think to be the case (Sarangi and Roberts 2000). The outcome of discourse research may simply be that our subjects will know more about their own discourses – with a new metalanguage offering a window on their discourse practices – as we also come to realise our own individual disciplinary preferences.

Throughout the chapter I have highlighted the need for collaborative interdisciplinarity where the collaborators are also professional practitioners. This is different from discourse scholars joining with sociologists or psychologists in order to achieve a fuller understanding of a given professional practice. Working with professional practitioners, I have argued, will guarantee interpretive ecology, while also facilitating the potential uptake of findings. Wherever possible, such collaborative work needs to be carried out over a longer period of time, rather than being designed as one-off relationships which begin and end with access to data sites. There is the need for discourse practitioners and professional experts to align their ways of seeing and accounting as they attempt to understand the phenomenon under study and try to bring about changes in everyday practice through reflexivity. This is not a reductionist position, since the discourse researchers have at their disposal other kinds of contextual information which they can draw upon to evaluate various participants' contributions. Joel Best (1989) makes a useful distinction between strict and contextual constructionist positions. The first one – characteristic of the purist form of conversation analytic research – constrains the analyst by not

allowing him/her to *evaluate* what members say. The analyst is seen as just one other member and as not having a privileged status. In the case of the latter, the analyst is obliged to contextualise what members say with other kinds of available data. In their preface to the Best volume, Kitsuse and Schneider (1989:xx) summarise this as follows:

Best's distinction between a contextual and strict constructionist analysis, then, is one that differentiates research on social problems where the researcher participates, with members, in the practical projects of documenting and explaining a state of affairs that they find objectionable or important and that they may want to change, and research where an analyst pursues a distinct, theoretical project organised around the description and understanding of the form, substance, and development of the members' practical project.

Indeed collaborative interpretation – which will constantly seek insights from professional practitioners – must become a guiding principle for discourse research, much in line with multidisciplinary, team-based work in professions such as medicine, social work, law, education etc. The onus is on discourse practitioners to present themselves as a 'community of interprofessional practice' in order to make their research both credible and socially relevant across professional boundaries.

THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

ORAL EXAMINATION

AWKWARD MOMENTS

Thank you for agreeing to help us with our study of the RCGP Oral Examination.

There is a considerable amount of research which suggests that ethnic/cultural/linguistic differences lead to communicative difficulties, and these show up as awkward moments in talk. However, such awkward moments can occur in the oral examination situation, irrespective of the candidate's ethnic/linguistic background. Please use the following checklist and any other criteria to pick up any examples where things are not going so well in the oral. You might wish to look out for the following:

Checklist

1. Long pauses, often filled by further questions from the examiner.
9.25 / 9.26 / 9.43 / 12.36
2. Interruptions.
3. Too many questions in succession, without allowing adequate time for candidates to respond.
10.59 / 11.58
4. Asking simple, factual questions, while the exam requires higher level questioning.
12.20
5. Problems of understanding, which require examiners to rephrase or give more context.
9.26 / 11.18-11.20
6. Any other difficult moments, such as culturally different styles of communicating, as perceived by you.

Please note that this is only a guide; there may be other aspects of awkwardness and discomfort in the video data you're looking at.

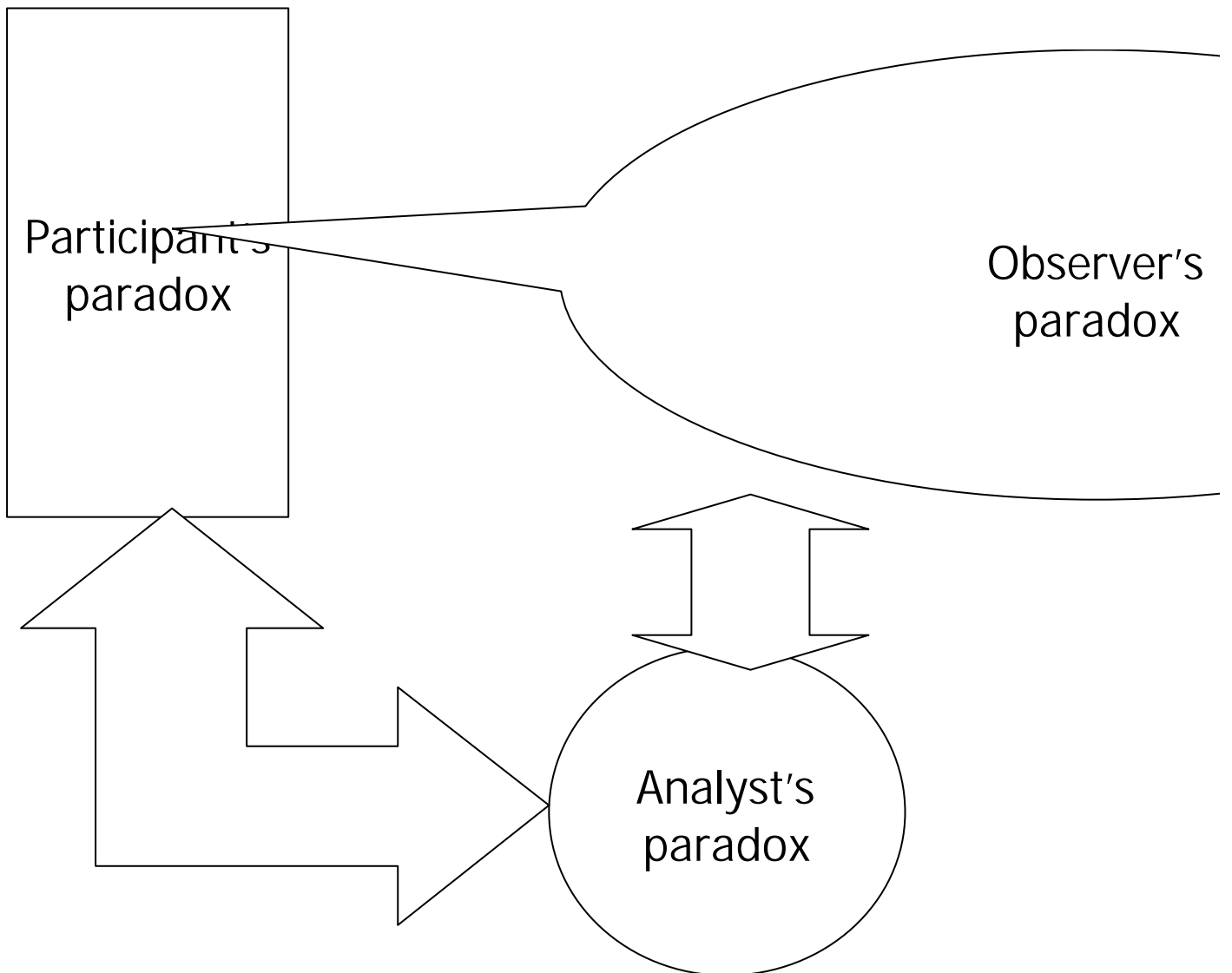
Thank you once again for your cooperation.

Celia Roberts/Srikant Sarangi
Consultant Researchers, RCGP

25 July 1996

Appendix 2

Interplay of observer's, participant's and analyst's paradoxes



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