

More than ‘information provider’ and ‘counselor’: Constructing and negotiating roles and identities of nurses in genetic counseling sessions¹

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This paper contributes to research on genetic counseling by exploring the complexity of this activity from the angle of identity construction. We argue that an analysis of the processes through which healthcare providers construct and negotiate their roles and identities in these encounters may contribute to a better understanding of the complexities of genetic counseling. Drawing on more than 150 video-recorded genetic counseling encounters between nurses and clients in Hong Kong, we illustrate that the discursive processes involved in the construction of the nurses' identities are complex, overlapping and at times contradictory as the nurses respond to the (sometimes) competing norms and expectations of their institution, their clients and their own. They manage to solve these tensions by drawing on the roles traditionally assigned to nurses in these encounters such as information provider and counselor, as well as creating the new roles of co-decision maker and cultural broker/mediator.

本文從身份建構觀點出發,探討醫療言語行為中的遺傳輔導/諮詢服務複雜性。深入探索醫護人員與病人溝通時如何建構自己的角色和身份,並從中總結其複雜性。透過分析超過150個香港的護士與病人會診對話的錄影,我們發現在會診過程中,護士的身份具有多重意義,甚至互相矛盾。這現象源於護士受到他們的機構、病人和自己的期望和規範所限制。為了處理這些矛盾,他們會擔任傳統的角色,如提供諮詢和輔導服務,以及創造新的角色,如與病人共同決策和協調與病人間不同的文化差異。[Chinese]

KEYWORDS: Role, identity, identity theory, nurse, genetic counseling, Hong Kong

INTRODUCTION

A lot of attention has been paid recently to the activity of genetic counseling. We aim to contribute to this research by exploring genetic counseling from the

angle of identity construction. Our focus in this paper is on the genetic counseling context in Hong Kong where healthcare professionals interact with clients who are either at risk of having a baby with a genetic disorder or whose newborn baby has been diagnosed with a disorder. The aim of these sessions is to inform the clients about a genetic disorder, as well as about available tests and options for post-test management of a condition. This information is intended to facilitate the clients' (informed) decision-making about future actions relating to a genetic disorder. Although genetic counseling services in Hong Kong may be provided by doctors and nurses, in actual practice, they are typically delivered by nurses.

Previous research has noted that genetic counseling is a complex and hybrid activity (Sarangi, 2000), partly because of unclear and fuzzy boundaries between genetic counseling and other related activities (such as mainstream medical consultations, or psychosocial counseling), and partly because of often remarkably different demands and expectations in terms of the purpose, aims, and practices involved in genetic counseling by those participating in this activity. We argue that these complexities are also reflected on the level of identity construction, and consequently, that an analysis of the processes through which healthcare providers and clients construct and negotiate their roles and identities throughout these encounters will contribute to a better understanding of the complexities of genetic counseling.

More specifically, in the analyzed genetic counseling sessions healthcare providers and clients are faced with (at least) three different and sometimes contradictory agendas, which they have to negotiate and reconcile throughout the interaction. First, there are institutional guidelines about the practices and procedures involved in genetic counseling sessions. These guidelines refer to, for example, the roles and responsibilities of the healthcare providers and describe them as mainly information providers. Secondly, there are the clients' expectations and demands about the services that they hope to receive. For example, the clients often view the healthcare providers as advice givers and sometimes even co-decision makers. And thirdly, the healthcare providers have their own agenda which is informed, to some extent, by the institutional guidelines and their professional ethos but which also reflects their own understanding of their role in these encounters and their personal preference for what tests (if any) the clients should take.

The meeting of these different agendas results in a particularly complex and demanding situation for the healthcare providers, who have to carve out and construct their professional identities through negotiating these different (and sometimes contradictory) roles that are being projected onto them by the various stakeholders. It is the aim of this paper to explore some of the processes of identity construction in this complex interactional context, and to analyze the ways in which the healthcare providers negotiate their professional identities and take on particular roles in response to the three different agendas outlined above.

Constructing and negotiating roles and identities

We follow recent constructivist conceptualizations of identity construction as a dynamic and inherently collaborative process that is enacted throughout an interaction as participants orient to each other and negotiate their expectations, roles and responsibilities (e.g. Bucholtz and Hall 2005). In this dynamic and performative view, identities are conceived, as Hall (2000: 7) maintains, as being 'never unified and [...] increasingly fragmented and fractured; never singular but multiply constructed across different, often intersecting and antagonistic, discourses, practices, and positions.' In other words, identities are always created, and literally talked into being, intersubjectively by drawing on and trying to reconcile different and often contradictory aspects. Moreover, identities are 'not simply a reflection of institutional roles and responsibilities but are the results of ongoing interactional negotiations' (Schnurr and Zayts 2011: 42; see also Hall, Sarangi and Slembrouck 1999). As a consequence, identities are not assigned a priori but are the product of ongoing negotiations among interlocutors (Bucholtz and Hall 2005).

According to this view, roles, like identities, are discursive accomplishments (e.g. Holmes, Stubbe and Vine 1999; Roberts and Sarangi 1999) which are always to some extent co-constructed (Bucholtz and Hall 2005; Schnurr and Zayts 2011; Sunderland and Litosseliti 2002), subject to change (Burke 2006), and dependent on the context in which they occur (e.g. Ellemers et al. 2003; Hall 2000). Thus, rather than viewing roles as static constructs comprising of 'fixed sets of expectations and responsibilities associated with particular social positions, for example, occupation, class, gender or family', we follow more recent approaches which acknowledge the dynamic nature of roles (Hall, Sarangi and Slembrouck 1999: 293).

Further insights into the complexities of roles and identities can be gained from identity theory which is 'principally a micro-sociological theory that sets out to explain individuals' role-related behaviors' (Hogg, Terry and White 1995: 255), and which conceptualizes roles as 'a set of expectations prescribing behavior that is considered appropriate by others' (Simon 1992, as cited in Hogg, Terry and White 1995: 257; see also Echabe 2010: 30). Identities, on the other hand, are understood as the 'meanings one attributes to oneself in a role (and others attribute to one)' (Burke and Reitzes 1984: 84). According to this view, then, roles form the basis for identities (Stets and Burke 2000: 225), and by performing particular roles, identities are created. As a consequence, the concepts of role and identity are closely intertwined: the identities that individuals construct (for themselves and others) are closely related to the expectations associated with their respective roles in a specific context. At the same time individuals also adapt and reinforce or challenge and reject these roles, thereby constructing specific identities (for themselves and others) (see also Holmes and Schnurr 2006).

This idea that identities (and roles) are not constructed in isolation but are intersubjective achievements is also captured in the relationality principle that Bucholtz and Hall (2005) describe as part of their framework for studying identity construction. This principle emphasizes the relational nature of identities and states that they 'are never autonomous or independent but always acquire social meaning in relation to other available identity positions and other social actors' (Bucholtz and Hall 2005: 598). Moreover, this dynamic and relational understanding of identity is also acknowledged in positioning theory, which is not only interested in how speakers position themselves (usually during narratives) but also puts particular emphasis on how they are being positioned by others (e.g. De Fina and Georgakopoulou 2012). Following these theorizations, then, we aim to explore how the nurses position themselves and are being positioned by others throughout an interaction, and what kinds of roles and identities they thereby construct, negotiate and enact.

Roles and identities of nurses

In spite of the crucial importance of nurses for many healthcare services, including genetic counseling, there is very little research that focuses specifically on their roles and identities (for example, see e.g. Candlin 2011; Candlin and Candlin 2007; Laffrey, Dickenson and Diem 1997).

While there is some variation in nurses' roles (which may depend, in part, on the nurses' area of specialization), Burkitt et al. (2001: 4, as cited in Candlin 2011: 555) describe a generic, shared nurse's identity which entails 'care, compassion and empathy' (see also Laffrey, Dickenson and Diem 1997). This point is reiterated by Candlin (2011: 555) who maintains that this generic nursing identity is enacted through various roles that nurses regularly perform and within which they construct their professional identities, namely as healer, carer, educator, advisor, counselor, manager, referrer, advocate, assessor, etc. (see also Gulino and LaMonica 1986).

As our analyses below illustrate, previous theorizations of nurses' roles and identities do not always adequately capture the complexities of nursing in the specific context of genetic counseling. In this setting the roles and identities are always, to some extent, co-constructed between the nurses, their institutions, and their clients, taking into consideration the three different sets of role expectations by these three stakeholders. As part of this process, the nurses reinvent their professional roles and identities to a certain extent in response to the demand to 'be and act in new ways' (Roberts 2006: 178).

DATA

The data that we draw on in this paper were collected as part of two large-scale research projects on pre- and postnatal genetic counseling in Hong Kong. The

first project concerned prenatal screening for Down's syndrome. The second project looked at counseling for a mild hereditary disorder, G6PD deficiency (commonly known as favism).² The prenatal screening encounters were recorded in a public hospital offering ambulatory care for antenatal and postnatal clients in Hong Kong. The participants included nurses, doctors and expectant mothers (and sometime their partners or other family members). The mothers were 35 years old or older at the time of delivery, and were considered at a higher risk of having a child with Down's syndrome due to their age. The nurses informed the mothers about various screening and diagnostic tests³ to enable the mothers' decisions whether to pursue any of these tests. The counseling for G6PD deficiency took place shortly after the delivery while the mother and her newborn (who had tested positively for G6PD deficiency) were still on the maternity ward. Due to the increasing number of clients (from Hong Kong and also the Mainland China) these consultations were normally conducted via telephone by nurses of a specialist genetic clinic in Hong Kong. The aim of those interactions was to ensure that the mother had sufficient information about her baby's condition and the preventative measures to be taken to avoid adverse scenarios.

Although the two data sets that we draw on include face-to-face counseling and landline telephone counseling encounters, the differences in modes of communication and their possible impact on identity construction are not the primary focus of this paper. However, we do acknowledge that the mode of communication may impact on interlocutors' performance, and more specifically, on the ways in which they construct and negotiate the nurses' roles and identities. But in spite of differences between the modes of telephone and face-to-face counseling, both types of encounters pursue the same aims (i.e. information delivery and clients' informed decision making) and are also affected by the different sets of role expectations, as discussed above. Combining examples of both modes of genetic counseling thus provides interesting insights into the nurses' identity construction in these complex interactional contexts.

Each project used a similar methodology for collecting data: after the participants (clients and nurses) had given their consent to participate in the projects, their counseling sessions were audio- and video-recorded. Table 1 summarizes the data for the two projects. As follows from Table 1, six nurses were recruited in the two projects, all of whom were Hong Kong Chinese and Cantonese-English bilingual speakers. In this paper, we focus on 151 consultations with an overall recording time of more than 37 hours. During these consultations English or Cantonese were used either as the first language of at least one of the participants, or as a lingua franca. Where participants' non-native language proficiency interfered with the information delivery and decision making and resulted in miscommunication, we draw attention to these instances in the data analysis. Following data collection, the data were transcribed using simplified transcription conventions traditionally used in

Table 1: Data summary

Feature	Data set	
	Prenatal screening	G6PD deficiency
No. of recruited healthcare providers	4	7
No. of recruited nurse(s)	1	5
Socio-cultural and linguistic background of nurse(s)	Hong Kong Chinese/ Cantonese-English bilingual	Hong Kong Chinese/ Cantonese-English bilingual
No. of recruited clients	112	70
Overall no. of consultations conducted by nurses	99	52
Number of consultations with clients from socio-cultural backgrounds other than the nurses (e.g. non-Chinese clients)	79	4
Socio-cultural and linguistic background of clients	50 Filipino, 1 German, 2 Nepalese, 1 Italian, 11 British, 1 Japanese, 4 Canadian, 1 Sri Lankan, 3 Australian, 3 Spanish, 2 American	3 Filipino, 1 Mainland Chinese

conversation analytic studies (see ten Have 2007 for details). We followed standard procedures for anonymization that included using pseudonyms for all study participants and anonymizing any identifying information in the transcripts. The consultations conducted in Cantonese were first transcribed and then translated into English. We have paid particular attention to validating the translations of the transcripts: initial transcriptions and translations were carried out by two bilingual research assistants, and were then verified by a bilingual member of the research team. We have also followed the procedures for validation as suggested by Peräkylä (2004: 216) in that we have paid particular attention to the ‘next speaker’s interpretation of the preceding action’ in our analysis.

In our analysis, below, this primary data is supplemented by secondary data in the form of semi-structured interviews with the clients prior to and after the Down’s syndrome consultations and questionnaires that were mailed to women after the G6PD deficiency consultations (the return rate was around 30%). In the interviews and questionnaires we gathered ethnographic

information about the participants and asked for their feedback on consultations. We also looked at institutional documents that concerned job specifications for the nurses. Such an integrated approach to data involving multiple sources enabled us to get insights into the analyzed institutional context and the complex intertwined processes of identity construction.

From this data set we have chosen five representative examples to illustrate in more detail some of the processes through which the nurses' roles and identities are constructed and negotiated. Four out of the five examples that we have selected are taken from consultations with Filipino women. These examples were chosen because of their representativeness of the overall corpus (see also Table 1) and their suitable length. The fact that the majority of the participants in our study are Filipino can be explained by the relatively high number of Filipino women who are employed as domestic workers in Hong Kong households. In analyzing these examples we are particularly interested in exploring how the nurses construct their professional identities through negotiating the different roles and associated expectations that are being projected onto them by the various stakeholders including the wider institution, their clients, and themselves.

ANALYSIS

According to the job description for registered nurses by the Hospital Authority of Hong Kong, the *professional duties* of nurses include the following:

1. To plan and organize nursing activities according to nursing philosophy, nursing professional delivery model, nursing standards and procedures, as well as nursing process approach.
2. To provide education and counseling to patients and their families.
3. To provide information, education and advice to patients.

These duties correspond to and reflect some of the roles for nurses that have been described in the literature, including the roles of educator, counselor, information provider and advice giver (Candlin 2011). However, as our analyses below illustrate, in the genetic counseling sessions that we have recorded, the nurses draw on a multitude of roles when constructing their professional identities that go beyond this prescribed professional role-set.

The roles of information provider and advice giver

Extract 1 (This example is also analyzed in Zayts and Schnurr 2011: 204–205)

Context: The extract comes from the beginning of the decision-making stage of a prenatal screening consultation between a woman (W) and a nurse (N). The woman is a 37-year-old first-time mother from the Philippines who attends the consultation on her own. This is the woman's first pregnancy, and she does not have prior

experience of screening for Down's syndrome. The nurse has just finished delivering information about different screening options.

1. N: Huh huh. so um: what do you prefer?
2. W: Uh uh as a nurse, [huh huh]=
3. N: [°um, yes°] ((smiles and nods))
4. W: =because of course you may know better than I do
5. when it comes to medical thing. So what do you suggest?
6. whether I have a blood test or the- do I have the: amni:=
7. N: = an invasive [test].
8. W: [h In]vasive test?
9. N: °Um:° .h Yeh. Where's your husband?
10. W: My husband is in Phi[lippines].
11. N: [in Phi]lippines. Um huh. .h
12. nah depends on your- on your preference.
13. .h um each test has its um advantage and disadvantage.
14. W: Yeh.
15. N: For the screening test, it is safe.
16. W: Ok.
17. N: But less accurate. Eighty percent accurate.
18. With the invasive test, it is accurate.
19. But with the- the little bit risk of miscarriage one in
20. two hundred. .h so .h em: whether you want to have an
21. accurate test, or you want to have a safe test.

In this extract two different roles for the nurse are evoked and negotiated by the interlocutors. First, the role of information provider is assigned to the nurse and is taken up and oriented to by both interlocutors. This is particularly obvious in the woman's overt reference to the nurse's institutional role (*'as a nurse'* line 2) and the implicature about the nurse's medical knowledge derived from *'of course you may know better than I do when it comes to medical thing'* (lines 4 and 5). Second, the woman also invokes the role of the nurse as advice giver by explicitly asking for advice, *'So what do you suggest?'* (lines 4 and 5). The nurse responds to the first role of information provider (as she goes on to inform the woman about different tests, from line 11 onwards), thereby adhering to professionally and institutionally defined norms and regulations. The nurse thus constructs herself as a professional working within the boundaries of her institution and upholding the tenets of her profession. In responding to the client's request for advice (lines 2 and 4), however, the nurse refrains from giving direct advice, which is aligned with the professional ethos of nondirectiveness. Instead she inquires about the woman's husband (line 9) and thereby steers the woman's focus onto another subject.

The nurse thus manages to construct her professional identity by negotiating the different demands and expectations of the client and institutional and professional guidelines and practices. Although the client seeks to enlist the nurse as both an advice giver (and possibly a co-decision maker), the nurse

maintains and reinforces her alignment with the professional ethos of nondirectiveness, and thereby acts out the institutionally defined role of nurse as information provider. This is further illustrated in lines 11 and 12 when the nurse explicitly states that the decision lies with the woman. Again, rather than giving advice, the nurse elaborates on the information about the available testing options which she has previously presented (lines 11–12, 15, and 17–21). She thereby reinforces her professional identity as a nurse who adheres to the tenets of her profession and the institution.

However, information delivery is not always as straightforward as in Extract 1, and sometimes clients challenge nurses in performing the role of an information provider, as the next example illustrates. Extract 2 is taken from a telephone consultation between a nurse and a mother whose baby has been diagnosed with G6PD deficiency.

Extract 2

Context: The mother (M) has been asked to call the nurse (N) in a specialist clinic to discuss her child's condition. Prior to the telephone call the mother has also received a leaflet about the condition from the staff at the maternal unit. The mother is from Mainland China and has the condition herself. The consultation is conducted in Cantonese, the mother's second language.

1. N: 所以, 要預防嘅話, 噉呀:, (.) 媽咪, 頭先你講過啦有
So, to prevent, so:, (.) Mommy, you have just said
2. 大部份嘅中藥係唔可以食.
he can't take a large number of Chinese medicine ingredients.
3. 噉呀, (.) 其實呢主要就係五種.
So, (.) actually there are five main types.
4. M: 係.
Yes.
5. N: 係啦. 噉呀, 你記唔記得係邊五種呀?
Yes. So, do you remember which five?
6. M: 唔記得.
I don't remember.
7. N: 唔記得? 噉, 噉, 我, (.)
You don't? Mm, so, I, (.)
8. M: 單張嗰到有無架?
Does the leaflet have the information or not?
9. N: 單張呢有嘅, 不過, 不過如果問媽咪, 你, 你自己點樣做呀?
The leaflet has it, but, but if I ask Mommy, you, what will you do?
10. M: 誒:.
Eh:.
11. N: 即係你, 自己本人呀, 因為你知你有呢個病, 架嘛?
That is you, yourself, because you know you have this deficiency, right?

12. M: 我, 我, 我知道邊啲唔食得或者唔好接觸. (.)
I, I, I know what I can't eat or touch. (.)
13. N: 噉呀, 誒: 譬如, 噉, 因為你頭先話你又唔記得咗
So, ah: like, ok, because you just said you don't remember
14. 邊啲中藥唔食得啦, 噉樣如果你=
what kinds of Chinese medicine ingredients you can't take.
Then if you=
15. M: =所以我咩中藥都唔食囉.
=So I don't take any Chinese medicine.

This extract starts with the nurse eliciting whether the mother remembers the types of Chinese medicine that the child cannot take (lines 1–3 and 5). This question may be taken as very directive and almost condescending considering that the mother has informed the nurse in the previous part of the consultation (not included in the extract) that she knows about the Chinese medicine as she has the condition herself. The nurse's questions and formulations (e.g. '*do you remember which five?*' [line 5]) resemble classroom discourse and seem rather unusual for an interaction in a clinical context – especially with a client who may be reasonably assumed to have prior knowledge about the condition.

In responding to this question the mother says she does not remember the information (line 6) and inquires whether it is included in the leaflet that was given to her prior to the telephone consultation (line 8). This could be interpreted in two ways: as an attempt to divert the nurse's attention away from the fact that the mother does not remember the Chinese medicine to be avoided; or as resistance to discussing this information in detail as it can also be obtained from the leaflet. In both scenarios, the mother delegitimizes the nurse's role as information provider by undermining the nurse's attempt to repeat this information. She thereby also challenges the nurse's attempts to construct her professional identity of an expert or 'teacher' – i.e., as someone who knows better and whose responsibility it is to ensure that the mother has sufficient knowledge about the condition and can manage her child after hospital release.

This challenge becomes even more explicit in line 12 when the mother continues to refuse to co-operate with the nurse by categorically stating '*I, I, I know what I can't eat or touch*' rather than demonstrating her knowledge of the Chinese medicinal products that she (and, more importantly, her newborn baby) should avoid. This rather harsh reaction of the mother may at least partly be a response to the nurse's diminutive reference '*mommy*' (lines 1 and 9) and her way of talking which may be perceived as patronizing.

The nurse continues attempting to act out her institutionally prescribed role of information provider in spite of the mother's obvious resistance to this agenda. She justifies her next attempt at information delivery ('*because you just said you don't remember...*' [lines 13 and 14]). Before

she has the chance to start providing the information, however, the mother interrupts her with another categorical statement ('*So I don't take any Chinese medicine*' [line 15]). The mother thus again delegitimizes the nurse's attempt to maintain the institutionally assigned role as an information provider, and she also challenges the nurse's attempts to construct her professional identity in line with these institutional and job specific demands.

Role of counselor

The role of a counselor involves addressing the client's psychological and social concerns (e.g. about taking an invasive test, the risk of miscarriage, disclosure of test results to family members, or a client's ability to take care of a child with a genetic disorder). As we have elaborated elsewhere, the genetic counseling in Hong Kong typically involves both a medical and a psycho-social agenda (e.g. Zayts and Schnurr 2013; Zayts, Wake and Schnurr 2012). While the medical agenda emerges through explanations about the genetic condition and the tests, the psycho-social agenda tends to address the clients' concerns and anxieties. In the context of Hong Kong, the medical agenda typically takes precedence over the often marginalized psycho-social agenda. As a consequence, the role of a counselor is not as prominent in this context as the role of information provider discussed above. We discuss one example here to illustrate how the nurses in our data enact this traditional role but with a new twist.

Extract 3 (an extended version of this example is analyzed in Yau and Zayts 2014)

Context: Participants of this interaction include a pregnant woman (W), her husband (H) (from the Philippines) and a nurse (N). After an initial screening, the woman's risk factor has been estimated at 1:60 (with anything below 1:250 considered 'high risk'). The participants are discussing whether or not the woman should do an invasive test (amniocentesis) to confirm the Down's syndrome diagnosis. Prior to this extract the clients have said that they would not have an abortion for religious reasons.

1. H: In that case, let's not do it.
2. N: Um (.) This is also an option.
3. Um .h but will you, say, are you going to be very worried
4. throughout the pregnancy (.) eh: worried till the baby is born.
5. Because I've seen some people who are quite worried, ok?
6. If you are going to be worried until the baby is born,
7. you will be quite disturbed, ok?
8. (2.0)
9. H: For example, if I now say I am not going to do it,

10. but later I decide to have amniocente[sis,
 11. N: [Eh: ok,
 12. you don't have to tell me so- so firmly today whether or not
 13. you will do it. I am just asking you about your opinions. .h if,
 14. I give you a date (.) to come back at around nineteen weeks,
 15. we will have a detailed ultrasound on that day.
 16. It's routine, everyone has it. Ok, a detailed ultrasound,
 17. if, on that day, you are, right, you change your mind that you
 18. want to do it, then on that day, you let us know and we can
 19. arrange it for you. As you have just mentioned, you can go
 20. for amniocentesis until twenty-one weeks at the latest.
 21. It does not make sense if you do it after twenty-one week.
 22. I know you have several factors to consider,
 23. you had difficulty in getting pregnant, right?
 24. You are also religious. .h
 25. Another option is to decide after you have had the ultrasound.
 26. Of course, we cannot confirm it if the baby has Down's
 27. syndrome by ultrasound. But, if there is no sign of an
 28. abnormality during the ultrasound, it's also a good sign.
 29. (.) Right? .h That means that the chance of of having Down's
 30. syndrome is lower. Ultrasound cannot confirm Down's
 31. syndrome, because (.)more than half of Down's syndrome
 32. have no symptoms. There are some with symptoms.
 33. If there is a symptom, you can consider further investigation.
 34. If there is no symptom, it can lower the risk.

Although much can be said about this example, here we concentrate on the roles and identities that the nurse constructs for herself and how the other interlocutors orient to them. This example is particularly interesting as the nurse carefully negotiates the client's expectations and agenda while at the same time upholding her own preferences regarding testing options.

The husband's confirmation '*in that case, let's not do it*' (line 1) clearly states the couple's decision not to undergo amniocentesis. At this point, the decision has been made and the nurse could have moved on to the next stage of the counseling session. However, rather than leaving this topic, she draws the couple's attention to the possible anxiety they may experience as a consequence of their 'not knowing' status. She starts her turn with a 'reflective question' (Sarangi et al. 2004) and makes this hypothetical scenario more real by referring to some people who she personally knows and who were '*quite worried*' (line 5).

This contextualization of the risk of 'not knowing' at a personal rather than a general level appears to have an impact on the husband who re-evaluates his position and now inquires whether the decision could be changed at a later stage (lines 9–10). Before the husband manages to finish his question, the nurse overlaps with him and assures him that the decision does not have to be final but that the couple may take time to think it over until 19 weeks of

gestation when a routine ultrasound will be arranged at the clinic. The nurse then reiterates some of the aspects that the couple may want to consider in their decision making, namely their difficulty in conceiving and their religious beliefs which would prevent them from terminating the pregnancy (lines 22–24).

By raising possible psychological concerns and framing them within the context of the couple's background, the nurse moves beyond the traditional role of information provider. Although there appear to be some overlaps with the role of counselor and the role of advice giver (as discussed above) and although the nurse seems to be drawing on elements of both roles here, in this extract psycho-social concerns over her client's well-being are clearly foregrounded. Through negotiating and combining these various roles, the nurse portrays herself as someone who cares and has an interest in her clients' psychological well-being. Though she no longer provides information in a neutral way, her goal still appears to help facilitate the couple's decision making. She contributes to this process by questioning the couple's initial decision and sharing with them her own experience (of other people in a similar situation). In doing so, she sets herself up as a co-decision maker.

However, this role and the kind of leading and involved behavior that characterizes it, is in stark contrast to the nondirective professional ethos described above. The nurse thus creates a space in which she constructs her professional identity in between the practices and guidelines of the wider institution (as here reflected in the professional ethos of nondirectiveness) on the one hand, and her client's expectations and needs together with her own preferences, on the other hand. She negotiates and solves these tensions by challenging the traditional role of information provider and creating the new role of co-decision maker.

Ultimately, the nurse's involvement has an effect on the couple: at the end of the interaction (not shown here), they agree with the nurse's preference to defer their final decision about diagnostic testing until after the woman has had an ultrasound scan. The next extract provides another example of how the nurse enacts the role of co-decision maker.

Role of co-decision maker

While in many healthcare encounters nurses perform the role of co-decision makers, in genetic counseling contexts they typically follow a nondirective approach. As our previous work has highlighted, however, healthcare professionals in Hong Kong, including nurses, tend to take a more directive approach in counseling (Zayts, Wake and Schnurr 2012). This occurs both explicitly through active engagement in the decision-making processes and implicitly, for example, by highlighting the tests of their own preference or by deferring the clients' decision about the tests that they personally do not favor.

In these cases the nurses expand traditional roles and act as co-decision makers. Extract 4 is a good illustration of this.

Extract 4

Context: The woman (W) in this extract is a 41-year-old first-time mother from the Philippines. Both the woman and her husband work in Hong Kong as migrant workers, but the husband could not come to the consultation. The woman is in her second trimester of pregnancy so there are only a limited number of tests available to her.

1. N: So, you can have either amniocentesis, or the second trimester
2. blood test, or the third choice is no test, because some people
3. doesn't want <any test, all right?>
4. W: What do you say the other people can ((inaudible)) the test?
5. N: Ok, different people have different opinion. Some people want
6. to have an accurate test so they choose amniocentesis although
7. there is a risk of miscarriage. Some people are very difficult to
8. get pregnant and they want to have a safe test. So, some choose
9. the blood test. So it depends on you and your husband.
10. W: ((laughs))
11. N: ((laughs)) Maybe it's a bit mhm too rush, to ask you to make a
12. decision. So you can go home and discuss with your husband
13. and then tell us your decision next time. I can give you a copy
14. of this one and then you can discuss with your husband. Your
15. age risk is about one in eighty so your choice is mhm number
16. four, amniocentesis, or number six b, second trimester blood test.
17. Or another choice is no test. Ok? Seven is no test. Three choices,
18. either one, if you want to have an accurate test, then amniocentesis.
19. If you want to have a safe test, then ((clears throat)) (.) second
20. trimester blood test. If you think that anyway I'll continue with the
21. pregnancy, no matter whether the baby is Down's syndrome or not
22. I carry on with the pregnancy, then you may consider no test.
23. It's up to you.
24. (11.0) ((W looks at the paper in front of the nurse that lists tests))
25. W: <((laughs)) better no. ((laughs))>
26. N: Better no.
27. W: <((laughs)) better no ((laughs))>
28. N: Or you can discuss with your husband.
29. W: Ok.
30. N: Ok? Mhm, ((clears throat)) maybe we preliminarily we, we
31. say that you, you don't want to have any test.
32. [In that case, we'll arrange ultrasound for you only
33. W: [Uh huh. Uh, it depends on me.
34. N: Scan only. Ok? But, you discuss with your husband and then
35. next time when you come [back,

36. W: [Yeah
 37. N: you tell us whether you want to have=
 38. W: [Yeah]
 39. N: [scree]ening test. But this, this must be (.) the blood test must
 40. be done before twenty weeks, so you if you have to change
 41. your mind you have to inform me as early as possible, ok?
 42. W: Yeah, because I'm scared.
 43. N: Because mhm?
 44. W: I'm, it's very embarrassed to get the blood here.
 45. N: ((laughs)). Oh, I see. Because you are now eighteen
 46. and three already.
 47. W: ((laughs))
 48. N: So time is limited, ok? Not, not too much.
 49. <L2 Today is L2> nineteenth. So preliminarily
 50. you choose to have ultrasound only.
 51. W: Uh uh.
 52. N: So we will have an ultrasound, uh, I think it, it is better for
 53. you to bring your husband next time so that we can have
 54. a detailed look.
 55. W: Yeah.
 ((N goes on to make arrangement for the ultrasound appointment))

At the beginning of this interaction the nurse appears very nondirective as she lists different testing options available to the woman in her second trimester of pregnancy (i.e. amniocentesis, second trimester blood test, and no test). Moreover, her reference to the various choices that other people make and her repeated use of general reference terms, such as '*some people*', and '*different people*' (lines 2, 5–9) further reflect her attempt to be nondirective. This impression is further supported when she explicitly constructs the woman and her husband as the main decision makers ('*it depends on you and your husband*' [line 9]). The nurse thus delineates her role in this encounter as that of an information provider and constructs a professional identity that is in line with institutional and professional expectations and norms.

After reiterating the information about available testing options and encouraging the woman to discuss these options with her husband before making a decision (lines 11–23), there is a long pause (11 seconds) during which the woman looks at the document in front of the nurse that contains the description of all these tests. The woman then announces her decision, namely not to undergo any tests ('*better no*' [line 25]), which is repeated both by the nurse (line 26) and the woman (line 27). On both occasions the woman laughs before and after she announces her decision, which is not reciprocated by the nurse. The woman's laughter here serves to mitigate her decision not to undergo testing (for a more detailed discussion of the role and functions of laughter in these encounters see Zayts and Schnurr 2011). Arguably, in a clinical context such as prenatal screening, even when women are given a

choice of not taking the tests, they may still perceive the agenda of these consultations as ultimately leading to testing. As Clarke and Parsons (1997) note, the very fact that these pregnant women are invited for prenatal screening consultations makes these consultations directive.

However, rather than ratifying the woman's decision, the nurse suggests postponing the decision in favor of discussing the various options with the woman's husband (line 28). Through this suggestion and her subsequent behavior, the nurse's preference for testing rather than no testing becomes evident. For example, she refers to the woman's decision not to take a screening test and just do a routine ultrasound as '*preliminary*' (line 30) thereby implying that this decision may be changed later. This implied meaning becomes more obvious later in the consultation when the nurse states '*if you have to change your mind*' (lines 40–41). Moreover, the nurse's use of the conjunction '*but*' in line 34, and foregrounding of the screening test in '*you tell us whether you want to have screening test*' (lines 37 and 39) further highlight the nurse's preference of the screening test. This observation is also supported by the interview data with the nurse conducted after the consultation, where she acknowledged that she personally considered a screening test to be '*in the best interest of pregnant women*'. The woman then provides an account as to why she does not want to have a test. The sequential positioning of this account, 16 turns after the woman has announced her decision, suggests that the woman is *justifying* her decision here (Scott and Lyman 1968: 47).

Although on the surface level the nurse performs the role of information provider through her nondirective choice of words and presentation of the information, a more detailed interactional analysis reveals that she is actually attempting to *co-participate in the decision making process* in subtle ways, i.e. by postponing the woman's decision until she has discussed it with her husband. Thus, the nurse clearly oversteps the boundaries of the traditional role of information provider, in which she would generally take on a more neutral stance in the decision-making process. Through this behavior the nurse ultimately delegitimizes the role of the mother as a sole (autonomous) decision-maker by refusing to ratify the mother's decision about not having the test.

The next extract shows yet another role that nurses often create and perform in these encounters, namely the role of cultural broker and mediator (Meyer et al. 2003).

Role of cultural broker and mediator

As a cultural broker the nurses explicate and negotiate culturally-influenced ideas and practices that may become relevant during a genetic counseling session. The process of mediating that forms a crucial part of this role involves more than interpreting complex medical information to clients. It is an act of

meaning-making and rendering the information understandable to each individual client, which involves a close engagement of nurses and clients. It could thus be argued that this role is an extension of the traditional role of information provider and is arising out of the nurse's local knowledge while still being driven by her clinical agenda of ensuring that the mother has sufficient information about her baby's condition. Mediating and explicating culture-specific meanings and practices constitutes an important activity in the genetic counseling context as it may impact on the decisions that the clients make. In enacting this particular role the nurse goes beyond the traditional role of information provider, as Extract 5 shows.

Extract 5

Context: The extract comes from a telephone consultation with a Filipina mother whose newborn son has been diagnosed with G6PD deficiency. Although this is the woman's second pregnancy she has not heard about the condition before.

1. N: Okay? So, firstly, you don't give any medicine to your baby
2. by your own.
3. M: Okay.
4. N: .h actually are you Indian or Pakistan?
5. M: No, eh is eh Filipino.
6. N: Oh! Filipino. So do you have any (.) I mean traditional herb,
7. (.) or medicine in Philippine for the baby?
8. M: No.
9. N: No, so that's fine. So you just .h ah stick to the rules, okay?
10. No matter it is your family ah traditional medicine or
11. whatever. Just don't give the baby any kind of medicine or
12. drug without seeing doctor.
- [10 turns omitted]
13. Don't feed your baby with the broad bean, (.) or the fava bean.
14. Do you see the number three?
15. ((refers to patient information leaflet))
16. M: (2.0) Um: where?
17. N: Number three. [Do you see?]
18. M: [Number three?]
19. N: Yea, the broad bean. So (.) ah only the broad bean (.)
20. the baby cannot eat. Okay?
21. M: Okay.
22. N: Okay? All other kind of food, (.) he can eat.
23. M: What does it mean of broad bean?
24. N: Broad bean, it is a kind of bean.
25. M: Bean?
26. N: Yeah, look like the kidney shape. And it is quite big. .h
27. And some people use it as a snack. .h So if you go to
28. those shops selling the snack, you ask them for the broad

29. bean, they would show you. Usually they are very (.)
 30. quite big, I mean compare with other kind of bean. Okay?
 31. M: Okay.
 32. N: They are quite big and slightly brownish color.
 33. M: Okay.
 34. N: And some are (.) have the brown hard coat, okay? And look
 35. like a kidney. You- you- you know how the kidney look like?
 36. M: (.) Sorry?
 37. N: Kidney.
 38. M: Kidney bean?
 39. N: Yeah, it look like the kidney, the shape.
 40. M: Oh, yeah.
 41. N: Okay. So if- if you are not sure how it look like, you can
 42. (.) go to those shop selling the snack and then ask them
 43. for broad bean. Then they will show you.
 44. Okay.
 45. N: Okay? Just don't feed your baby with the broad bean,
 46. then will be okay=
 47. M: =Um:: is the broad bean looks like a kidney bean?
 48. N: Mhm?
 49. M: Kidney bean.
 50. N: Not- not red kidney bean. No, this is a broad bean. Okay?
 51. M: Okay.
 52. N: And (.) they call it eh favi, F-A-V-I, favi bean.
 53. M: Okay.
 54. N: Alright? So, other kind of bean, fine. But except
 55. the broad bean, alright?
 56. M: Oh, yeah.
 57. N: Yea, actually the kidney bean you are talking about is
 58. red colour, is it?
 59. M: Yeah.
 60. N: Yea, so it is- so that is not this one. Okay?
 61. M: Mhm.
 62. N: This one is (.) brown (.) slightly brown colour (.) and very hard.
 63. M: Hard?
 64. N: Okay?
 65. M: Okay.

The role of a cultural broker or mediator begins to emerge in lines 6 and 7 when the nurse asks her Filipina client about any '*traditional herbs or medicine*' that may be given to babies in the mother's home country. This question is particularly important in this context as there are certain Chinese medicinal products and other substances which individuals with the condition should not be exposed to. This also concerns breastfeeding mothers of infants diagnosed with the deficiency. The nurse's question about the mother's cultural practices is thus also an important aspect of information delivery, i.e. of ensuring the mother has all the necessary information about her child's

condition and is aware of the potential dangers of feeding the baby specific substances.

After ensuring the mother has understood this point, the nurse moves on to the next item that the baby must not consume, namely broad beans (line 13 onwards). Since this consultation takes place over the telephone and the mother and the nurse are not in the same location, the nurse points the client to the picture of a broad bean ('*the number three*' [line 14]) in the information leaflet that the mother has been given prior to the consultation. After some initial confusion by the mother and further clarification by the nurse (lines 16–18) the mother seems to have understood the nurse (as her agreement token '*Okay*' indicates [line 21]). However, in spite of her initial signaling of understanding and the fact that nurse explicitly pointed her to the picture of the broad bean in the brochure in front of her, as the next turns reveal, the mother is still uncertain about the information relating to the bean: '*What does it mean of broad bean?*' and '*Bean?*' (lines 23 and 25). This misunderstanding may not only be due to different cultural practices and knowledge (relating to the different types of beans and their usage in traditional herbal medicine) but it also seems, at least partly, to be related to the mother's non-native English proficiency, and it may be further complicated by the fact that the interaction takes place over the phone rather than face-to-face. All these factors may lead to the extra interactional efforts of the nurse to ensure the mother's understanding.

In addressing the mother's questions and uncertainty, the nurse thus provides further explanations of what a broad bean is. She not only describes its shape ('*kidney shape. And it is quite big*' [line 26]) and color ('*slightly brownish color*' [line 32]) but she also explains what people in Hong Kong use it for ('*some people use it as a snack*' [line 27]). When the mother continues to be confused (lines 36 and 38), the nurse, rather than repeating her standard description of the bean one more time, tells her where she can find broad beans ('*those shop selling the snack*' [line 42] and '*ask them for broad bean. Then they will show you.*' [lines 42–43]). The nurse thus moves beyond a description of the bean's appearance and sets up two different, and in this case opposing, subject positions for the mother ('*you*') on the one hand, and local Hong Kong people ('*they*') on the other hand. Interestingly, the nurse positions herself in between these two poles: she is not claiming an in-group status with either the mother or the Hong Kong locals. Thus, the mother is constructed as a foreigner who is provided with crucial information by the nurse who is at the same time portrayed as a mediator and facilitator between the (foreign) client and the locals.

By going beyond her standard description of the bean (relating to its shape and color) and by talking the mother through the details of how it is typically used and where to buy it in Hong Kong, the nurse expands the traditional role of information provider and creates the new role of cultural mediator or broker who spells out specific cultural practices. She thereby also explicitly constructs a professional identity that responds to the specific demands of her clients in

the culturally diverse context of Hong Kong. And while it could be argued that this identity arises, at least partly, as a consequence of the mode of the encounter, namely a telephone interaction during which interlocutors are not physically co-present (although they do have the same information leaflet, which also includes a picture of the broad bean, in front of them), the nurse's behavior performs an important function in this consultation context as it facilitates the mother's understanding of vital information and thus crucially contributes to the success of this counseling encounter.

However, after summarizing the main point one more time by the nurse (*'Just don't feed your baby with the broad bean, then will be okay'* [lines 45–46]) it becomes clear that the mother is still experiencing some difficulties with comprehending the concept of the broad bean (see e.g. her clarifying question about the bean's resemblance with the kidney bean in line 47). The nurse thus resorts to another strategy of providing the mother with the popular name that Hong Kong locals typically use when referring to this bean: *'they call it eh favi, F-A-V-I, favi bean'* (line 52). Note again her use of the pronoun *'they'* which once more creates a 'you' and 'them' dichotomy and constructs the mother as a non-local and positions the nurse in-between these two groups.

For the remainder of this extract the nurse repeats the information about the bean bit by bit to which the mother signals agreement. In what resembles a summary of the previous discussion, the nurse starts by repeating the name of the bean (line 55), its shape and color (lines 57–58), which is followed by a question to check the mother's general understanding (line 60) which is then answered by the nurse herself by once more repeating the color and consistency of that specific bean (line 62). Although based on the interactional evidence provided here, it is difficult to say whether the mother has actually understood the information about the bean; the nurse seems to assume so and the interlocutors move on to discussing something else.

CONCLUSION

In this paper we have approached the activity of genetic counseling from the angle of identity construction, and have shown how the nurses' professional identities are being negotiated and constructed in these interactions. Our examples have illustrated some of the processes through which the nurses (together, but not necessarily in agreement, with their clients) draw on, as well as sometimes reject and expand, a range of roles traditionally assigned to them in order to orient and respond to the sometimes competing expectations and agendas of their institutions and profession, their clients, and themselves.

The specific roles that we have looked at in this paper include the 'traditional' roles of information provider and counselor, noted in previous research on nurses' roles and identities (see e.g. Candlin 2011), as well as the

roles of co-decision maker, cultural broker, and mediator, which in our corpus emerge as a direct response to the different demands and agendas that the nurses have to address and reconcile in these genetic counseling sessions. More specifically, as our examples have shown, enacting traditional roles which position nurses in genetic counseling primarily as information providers, does not always meet the expectations of the clients who in addition to receiving information also expect advice in relation to decisions about testing (Extract 2). At times, 'traditional' roles also appear to conflict with the nurses' own agenda (Extracts 3–5) and preference of choosing specific tests. In these instances, the nurses skilfully negotiate these different expectations and agendas by enacting and upholding 'traditional' (and institutionally reinforced) roles, and by modifying and expanding them to new roles.

In doing this, the nurses and their clients engage in several linguistic processes that include:

- making overt reference to specific roles (e.g. '*as a nurse*' in Extract 1);
- making relevant implicatures about interlocutors' activity-specific roles and activity-associated knowledge (e.g. '*you may know better than I do when it comes to medical thing*' in Extract 1);
- performing institutional practices (e.g. of not giving advice, thereby adhering to the professional ethos of nondirectiveness in Extract 3); and
- going beyond institutional practices (e.g. by getting involved in the decision-making processes in Extract 4), as well as setting up specific (and sometimes opposing) subject positions for the client and Hong Kong locals (e.g. by creating a 'you' and 'them' dichotomy) thereby positioning themselves in between these two groups (Extract 5).

In line with Bucholtz and Hall's (2005) relationality principle, these roles for the nurses are constructed in relation to the roles of the clients, or as Sarangi (2006: 4) puts it 'the role-relationship between the professional provider and the patient/client is meant to be reciprocal'. For example, while positioning one interlocutor as the 'mother', 'less knowledgeable', or even 'non-local' or 'foreign', the other interlocutor is at the same time constructed as 'more knowledgeable', 'expert', 'nurse' and 'cultural mediator' (Extract 5).

Our analyses have also demonstrated that role and identity are useful analytical concepts that facilitate understanding of some of the interactional complexities involved in genetic counseling. Drawing on these concepts can help us account for some of the substantial differences that have been observed between studies of genetic counseling in different socio-cultural contexts (e.g. Arribas-Ayllon, Sarangi and Clarke 2011; Lehtinen 2013; Sarangi 2010a, 2010b, 2010c; Thomassen and Sarangi 2012). Based on our findings we would argue that some of the distinctive ways in which genetic counseling is enacted in specific contexts are also reflected in and can be accounted for by the different roles that the nurses enact in these different contexts. For example, whether they view themselves (and are positioned by their clients)

primarily as information providers or as co-decision makers has a huge impact on the nurses' active involvement and on the ways in which the counseling service is actually being provided.

To conclude, genetic counseling is an inherently complex activity and one, we would argue, that is quite likely to remain the interest of academic scrutiny among health communication and discourse researchers for some time to come. We hope that our analyses have illustrated some of the benefits of approaching the complexities of genetic counseling from the angle of role and identity construction, and we believe that future research, particularly research focusing on various areas of health communication, would benefit from the analytical power of these concepts – not only for an understanding of genetic counseling but also for other activities.

NOTES

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 2. G6PD deficiency is a life-long condition that in the worst-case scenario can be fatal. The condition can, however, be managed by avoiding certain substances (e.g. fava beans and some medications).
 3. Women are offered indirect/non-invasive tests which are safe for the baby (blood tests and/or a nuchal translucency test, i.e. sonographic measurement of the fetus's neck); these tests however, do not have a 100 percent detection rate. If the tests indicate a high risk of having a baby with Down's syndrome (more than 1:250), further testing is recommended which includes direct/ invasive tests (such as amniocentesis or CVS) that have an almost 100 percent detection rate but carry a small risk of miscarriage. Women also have the choice not to pursue any testing.
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