WOMEN IN WHITE COATS: FEMALE PHYSICIAN ROLE ENACTMENT

IN MEDICAL CLINIC INTERACTIONS

by

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We have read and discussed the thesis submitted by student Katie Lynn Bohannon, and we have also evaluated her presentation and response to questions during the final oral examination. We find that the student has passed the final oral examination, and that the thesis is satisfactory for a master's degree and ready for any final modifications that we may explicitly require.

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DEDICATION

I wish to dedicate my thesis to all of the amazing women physicians who participated in my study. Your hard work and compassion for others is truly inspiring. Each day you selflessly dedicate yourself to others, in ways few individuals can understand. The sacrifices each of you make, along with your capacity to help and heal, is astounding. Thank you for allowing me to be in the presence of such greatness.

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INTRODUCTION

Roles are a fundamental part of our lives. We constantly play a variety of roles within different relationships. In turn, these roles are embedded into social networks, such as organizations. It is through our interactions within such networks that we enact particular roles.

Scholars have provided numerous definitions for the concept of role. Early research by Coutu (1951) defines a role as "representing what a person is supposed to do in a given situation, due to the social position one holds" (p. 180). Katz and Kahn (1978) define roles as "specific forms of behavior associated with given positions" (p. 43). A common thread between all definitions of role is the importance and centrality of communication. It is through interaction with others that individuals enact particular roles. More importantly, the roles that one enacts can change depending on the context and relationship of the interaction. Some scholars argue that individuals depend upon communicative interactions with organizational members in order to guide future role behaviors (Weick, 1979). Thus, we interpret others' behaviors and adapt and enact roles based on the interaction.

The way individuals behave within particular interactions enables others to identify what role they are enacting. There are many recognizable roles that scholars have identified: social roles, character roles, and gender roles. Most individuals are aware of

what social or status roles they hold. Individuals are also aware of what behaviors are appropriate for their roles. This knowledge of role behavior comes from formal expectations and individual experiences (Apker, 2001). It is through this knowledge that roles are enacted and understood within interactions.

When examining roles, it is important to recognize the influence of gender. Historically, there has been a division between the roles that men and women play. Women have often been expected to follow their traditional roles of wife, mother, daughter and homemaker (as cited in Kelly, 1991). Outside of the home, specifically in the medical field, women's roles have been stereotypically limited to the role of the nurse (Horman, Campbell, & DeGregory, 1987). Throughout the decades, scholars have identified various differences regarding gender roles and communication. These roles were often associated with more expressive and nurturing behaviors (Aube, Norcliffe, Craig, & Koestner, 1995).

Traditionally in the medical field, the image of the physician is strongly influenced by gender-linked stereotypes (Horman, Campbell, & DeGregory, 1987). According to Clavan and Robak (1980), historically the medical profession has been overwhelmingly male, and performance of the physician's role has been stereotypically gender typed as male.

In the past few decades with an influx of women entering the workforce, especially the medical field, women's roles have expanded to occupy positions of status and power within medical organizations. With the increased number of women entering medical school, scholars have now begun to examine the female physician.

The emergence and advancement of females within the highly specialized medical profession has generated insightful research on the issue of physician roles. Due to stereotypical gender roles, scholars have been particularly interested in women balancing the role of physician, with the more traditional role of wife and mother. This study adds to recent research on role enactment by going within the institutionalized walls of the medical clinic and exploring how female physicians enact different roles while participating in various contexts and relationships.

This is a qualitative study that attempts to understand *how* female physicians enact roles through communication and *how* those roles change throughout interaction. The study is pointed towards the identification, definition, and contextual understanding of how female physicians construct their roles as they participate in various interactions. This study will not attempt to generalize its findings across all female physicians.

This study creates a general awareness among physicians about the roles that they enact, and provides a deeper understanding of *how* roles are enacted and *what* roles physicians enact when interacting with patients, staff, and colleagues. If physicians are aware of the particular roles that they enact, they can communicate more effectively and efficiently with other organizational members. Thus, physicians may be able to better their services within their profession.

On an academic level, this study explores how female physicians organize and make sense of their roles in a changing, uncertain environment such as the medical clinic. This study is important because it examines how female physicians engage in communicative interactions with others in order to make sense of ambiguous roles and

unpredictable contexts. In addition, this study may also contribute to a contemporary understanding of role theory and gender in the workplace. This study examines how female physicians balance and negotiate gender roles in a position stereotypically gendered male. The current study is also significant because it highlights the multiple role expectations of the female physician and how female physicians might enact different roles in order to respond to role pressures.

REVIEW OF LITERATURE

Conceptualization of Role

To gain a better understanding of the literature concerning role enactment, one should first define the concept of role. Past scholarship has provided numerous conceptualizations of roles. Roles have been defined as "sets of behaviors that persons expect of occupants of a position" (Graen, 1976, p. 1201). These role behaviors can stem from formal, etic knowledge or an individual's organizational experiences. Katz and Kahn (1978) define roles as "specific forms of behavior associated with given positions" (p. 43).

Individuals enact behaviors that are appropriate for their role within a social system. Roles are behavioral processes that are a product of social interaction. Zurcher (1983) argues that individuals constantly enact roles according to their self-concepts and through interaction with others. Scholars have found that social interaction is the vehicle for role enactment. Through interpersonal communication we can enact certain roles.

Interpersonal communication functions as a sustaining force, linking us to others through shared values, goals, institutions and ways of life (McDermott, 1980). Theorists also explain that interpersonal communication is central in constructing a system of roles in which human beings function (Apker, 2001). According to Graen, "individuals develop and change their roles through communication with other organizational

members" (as cited in Apker, 2001, p. 118). We are constantly enacting different roles based on our communication with others. We utilize certain communicative behaviors in order to fulfill others' ideas and expectations about how a particular role should be enacted. For example, during a physician's explanation of a possible diagnosis for symptoms his or her patient is experiencing, perhaps the patient begins to cry. The physician might adopt a compassionate role such as: caregiver or comforter. Specific communicative behaviors would be associated with this new role. Perhaps touching the patient or hugging the patient are behaviors that the physician uses in order to communicate that he or she is enacting a compassionate role. Individuals learn which behaviors are associated with which roles through the process of socialization.

The conceptualization of roles has often been characterized by one of two traditions: structuralism or symbolic interactionism. These two traditions are usually viewed as being in critical opposition to each other (Callero, 1986). Therefore, it is important to examine each perspective in regard to their conflicting conceptualizations of role.

Structuralism

Under structuralism, role is conceptualized as a set of normative expectations, rights, or duties attached to positions or statuses in the social structure (Callero, 1986). Roles are perceived as fixed features in a social system. Therefore, role-related behavior is seen as a direct response to role expectations (Callero, 1986).

The structuralist perspective also focuses on "social structures," conceived as stable organizations of sets of persons who share the same, patterned behaviors (roles) that are directed towards others within the structure (Biddle, 1986). The social environment, rather than the individual is the focus of structuralism (Biddle, 1986).

Symbolic Interactionism

Mead was one of the major scholars interested in the concept of role among symbolic interactionists (Biddle, 1986). Mead stressed the importance of the individual actor, the evolution of roles through social interaction, as well as social actors understanding and interpreting their own and others' conduct.

According to Biddle (1986), from the perspective of symbolic interactionists, roles are thought to reflect norms, attitudes, contextual demands, negotiation, and the evolving definition of the situation as understood by the actors. Other underlying assumptions of symbolic interactionism is the emphasis that humans live in groups, and it is their interaction within that group that molds the individual (Longmore, 1998). Moreover, an assumption of symbolic interactionism is that the self can be seen as an object, and the meaning of all objects arise out of interaction (Longmore, 1998). If the self can be seen as an object, roles can also be seen as objects. Because roles do not have innate meaning, meaning must be defined and interpreted through interaction. Therefore, to symbolic interactionists, social interaction is fundamental in the concept of role.

Historically, these two traditions have been in opposition to each other. Recognizing the fundamental differences between structuralism and symbolic

interactionism reveals how Mead conceptualizes role, while addressing features of both perspectives.

Mead's Conceptualization of Role

In Mead's conceptualization of role, there are two defining characteristics (Callero, 1986). First, roles are constructions dependent upon social interaction for existence. Second, once established through social interaction, roles are assumed stable and objectively real features of a social structure.

Based on Mead's first characteristic of role, roles are seen as social objects that emerge through interaction. Thus, roles become objectified through a normalization or stabilization of subjective interaction. As social objects, roles are patterns of social action that are identified and shared by members of a particular community. According to Callero (1986), "Mead argues that roles are defined by the act and that it is the actual or implied behavioral response toward the role that establishes its functional identity and gives it its' meaning" (p. 346). Thus, roles can only emerge through interaction. It is through interaction that roles are ratified, given meaning and become identifiable as a social object. An example of this would be a female physician-as-surgeon, (to modify Mead's classic example). A female physician-as-surgeon cannot exist without a patient needing an operation. Just as a female physician-as-surgeon is identifiable as a social object through social processes, so is role premised on the action of others towards it in a network of already established meanings.

According to Mead's second characteristic, social objects/roles are objectively real features of the social environment and are experienced as universal and real when individuals share a common perspective (as cited in Callero, 1986). Mead resolved that objectivity is found in action. Therefore, objectivity is produced when a self-conscious, problem-solving individual uses common solutions within a common perspective (Callero, 1986). For example, if while explaining a diagnosis to a patient, it becomes clear that the physician's patient does not understand the explanation. In order to facilitate patient understanding, the physician might enact the role of a teacher, using diagrams and lengthy explanations. Given that the role of the teacher is a nonphysical social object, objectivity rests within the interaction. In order to complete a social interaction, where role is the perceived social object, there must exist a shared perspective. It is the sharing of perspectives that confers objectivity to all social objects. Another more commonly known term for this process is intersubjectivity. According to Callero (1986), Mead found that *subjective* roles or *subjective* meanings are impossibilities since they are by definition unsharable. When subjective roles and meanings are shared by groups of individuals, roles and meanings become objectified, making them objective features of a network that comes to operationalize a particular social system.

A seeming contradiction with Mead's development of his characteristics is that he reconceptualizes what objectivity means from a subjective position. Therefore it could be argued that roles are common social constructions that emerge through interaction as seemingly objective agreements among individuals. Although Mead's conceptualization

of role might appear to be objective and transcendent in the view of some scholars, it does not represent structure in the fundamental sense advocated by most structuralists (Callero, 1986). In this sense, Mead's conceptualization of role does not fully transcend both structuralism and symbolic interactionism, but rather combines and addresses criticisms of both perspectives.

To understand how Mead presents a unique conceptualization of role that addresses aspects of both structuralist and interactionist definitions, one can examine how individual perspectives operate within the social act. From a structuralist perspective roles exist as part of a social environment as social objects. Therefore, during social interactions, roles can become the object of the social act. On the interactionist side, roles also represent a dimension of the self, making roles unique and individual. Roles represent perspectives from which individual perception and action originate (Callero, 1986).

While some believe these two theoretical perspectives might be in conflict with each other, they are actually quite complimentary (Callero, 1986). Mead points out that while roles as social objects are contingent on perspective for their definition, they are also the *source* of perspective (Callero, 1986). Thus, social objects are 'context dependent and context shaping.' Because roles are dimensions of the self, roles also represent perspectives from which individual perception and action originate (Callero, 1986). One of the keys to understanding how roles can be both universal social objects and sources of individuality is Mead's explanation of how perspectives operate within a social interaction.

Mead's belief that we are born into a preestablished community perspective provides us with a common way of structuring the world. It is from this community viewpoint that individual perspectives emerge allowing for individual action and responses (Callero, 1986). In order for the self to develop, the individual must be aware of the other and learn to take the perspective of the other. The other can be understood as a general norm in a social group or setting. Through this form of cognitive empathy the self develops and one understands what behavior is appropriate in any given context. Because roles define the self, they also function as a perspective. It is through this that roles serve as a basis for organizing and classifying the world, and as a basis for action (Callero, 1986). By defining the role as a perspective, it is possible to see how roles also allow for individual differences.

Mead offers a unique conceptualization of role that addresses criticisms of both structuralism and interactionism (Callero, 1986). Mead's conceptualization of role shows that role can be both a part of the self and part of a social structure, allowing for individual agency at the same time. It is evident how Mead's concept of role accommodates aspects of both structuralist and interactionist traditions.

Mead's conceptualization of role takes on a much broader view of role-using and works towards bridging structuralist and symbolic interactionist perspectives. Besides examining Mead's conceptualization of role, scholars have distinguished between Mead's role-taking and role-playing while highlighting the centrality of communication within these various conceptualizations of role.

Role-Taking vs. Role Playing

Mead was a pioneer among social scientists in describing the processes through which role-taking affects human communication and in turn, human social structures. When distinguishing role-taking from role playing, his work is essential for comparison. Role-taking and role playing are ways that we interact and communicate with others in particular social situations, and communication is a central component of this process.

According to Kelley, Osbourne, and Hendrick (1974) Mead claims that "the ability to take the role of the other is a process which underlies all human interaction" (p.62). Taking the role of the other is a cognitive empathetic process. Putting one's self in the other's shoes appears to effect an understanding of the other's behavior. Through this interaction, we are able to adopt what we interpret to be the attitudes of others toward our selves. In this process, we respond to our own gestures in terms of the communicative attitudes of others. Taking the role of the other allows an individual to be self-objective and is essential to self-realization on account that the self is produced face to face with others through constant communicative interaction.

Through communication, we are constantly adapting how we act in various situations and we change roles based on our interactions. For example, during a boxing match, the play back and forth is evident. The individual not only adjusts himself to the attitude of others, but also changes the attitude of others. Throughout each interaction the process of role-taking will change based on who we are interacting with.

We are constantly changing roles because we constantly have to take the role of 'the other' in order to be self objective and in fact to be an appropriate participant in the interaction as it unfolds.

According to Kelley, Osbourne, and Hendrick (1974), role taking is essential to communication because it enables communicators to identify differences in role attributes and adapt to others. "Role taking is a cognitive behavior wherein one infers relevant interactional cognitions held by others, then compares those inferred cognitions with his own cognitions, and formulates a variety of adaptations for his behavior with respect to others" (Kelley, Osbourne, & Hendrick, 1974, p. 64-65). This process could be characterized as an interpersonal and intrapersonal dialectic. When we identify with the 'other' by role-taking, we are able to control our own behaviors. For example, if a patient exhibits signs of nervousness and concern while a physician is explaining a medical procedure, the physician might engage in role-taking. In other words, the physician puts one's self in "the patient's place" or tries to understand the patient's "point of view." With a new knowledge about what the patient might be thinking, the physician can now act accordingly. The physician's behaviors might change in order to become more sympathetic.

Role playing, similar to role-taking, can be difficult to conceptualize. Role playing is different from role-taking in that role playing is associated with overt behaviors or an enactment of one's roles as appropriate to a given situation (Coutu, 1951; Kelley, Osbourne, & Hendrick, 1974). Coutu (1951) also defines role playing as an individual performing the functions that are associated with a certain societal position.

For example, a woman could play the role of a mother by performing certain functions, such as feeding a child, changing a child, and so forth. We adapt our behaviors in an attempt to play a certain role. It is fairly easy to observe behaviors culturally associated with particular roles; however, role-taking is basically a cognitive activity. Consequently, it is difficult to empirically identify when role-taking is occurring. Scholars accept role-taking is happening based on the empirical evidence provided by role playing behaviors.

Although scholars have tried to distinguish between role-taking and role playing, there is still ambiguity when it comes to a conceptualization of the two terms. While confusion between the terms may still exist, it is clear that communication is a central feature in both conceptualizations.

Scholars have presented some major conceptualizations of role. Role-taking in particular, is an important aspect of Mead's concept of role. Because role-taking is a covert cognitive activity, we are unable to empirically identify when role-taking is actually occurring. Thus, for the purpose of this study, I will be focusing on overt, role playing behaviors in order to identify how female physicians enact roles as they participate in various interactions.

Social Construction of Roles

Scholars have presented numerous conceptualizations of role, role-taking and role playing, but how do roles come to be known? Roles do not simply exist and function in social networks. Roles emerge or come to be known through the process of socialization. Most theorists argue that roles appear because persons are taught appropriate ways to

behave by others (Biddle, 1979). These roles are taught through the medium of expectations. According to Biddle (1979), individuals are exposed to experiences that will lead them to form similar expectations for their own roles, which in turn lead them to exhibit or encourage appropriate role behavior. These learning experiences and expectations are part of socialization.

Scholars who take the social constructionist stance claim that anything that has meaning in our lives originates with the relationships we are engaged or participate in (Allen, 2005; May & Mumby, 2005). Social constructionists emphasize that meaning develops from social systems rather than individuals (Allen, 2005; May & Mumby, 2005). Therefore, social systems manifest meanings accepted in our world. Socialization refers to the processes individuals are engaged in that shape and create their unique self. Socialization is the process of social interaction by which individuals acquire skills such as, attitudes, values, motives, norms, beliefs, language, and knowledge (Longmore, 1998).

Humans derive knowledge of the world from larger social discourses (Allen, 2005; May & Mumby, 2005). An important element of knowledge creation is language. Individuals use language to produce and reproduce knowledge as various roles are enacted within various contexts (Allen, 2005; Leeds-Hurwitz, 1995; May & Mumby, 2005). "Social constructionists stress the significance of language to construction processes, including its ramifications for identify development" (Allen, 2005, p. 35). Therefore, individuals can identify and enact roles because of knowledge created through socialization.

Language and the social process help us to sustain knowledge about roles. Thus, we can objectify subjective roles through the process of communication.

In their book titled *The Social Construction of Reality*, Berger and Luckmann (1966) highlight the process of knowledge development, while stressing the significance of human interaction. Roles are human creations that come to be defined in certain ways through social interaction (Herek, 1986). Berger and Luckmann (1966) claim that what most people call reality is a consensus worldview that develops through interaction as well.

The fundamental concept in *The Social Construction of Reality* is that interaction in a social system will form knowledge, which guides individuals conduct in everyday life (Berger & Luckmann, 1966). This knowledge will become habitual as roles are played out by individuals throughout interaction. Institutionalization occurs whenever there is a reciprocal typification of habitualized actions by individuals. Knowledge of what reality "is" becomes embedded within institutions. Consequently, the institutionalized world is experienced as an objective reality (Berger & Luckmann, 1966). Accordingly, it can be said that roles become understood and seemingly objective through the way they are seen to occur so reliably in interaction between competent members of any given social system.

Berger and Luckmann (1966) also point out that the objectivity of the institution is a humanly-produced, constructed objectivity. Thus, Berger and Luckmann reconceptualize objectivity from a subjective point of view, much like Mead does. Berger and Luckmann (1966) also emphasize the importance of the relationship between man,

the producer, and the social world, his product. Experiencing the institution as external and objectivation is a continual dialectic process. Objectivated and objectivation refer to converting the social world into an object. The individual and the social world constantly interact with one another. Through this process and interaction, a society can be seen as an objectified reality.

Knowledge is at the heart of this dialectic. Knowledge objectifies the world through interaction and language, and it is internalized as objective truth through socialization (Berger & Luckmann, 1966). Thus, knowledge about the social world comprehends the objectivated social reality and produces and reproduces reality (Berger & Luckmann, 1966). Knowledge about society is passed down through the generations. Through the process of socialization, this knowledge is learned as objective truth and internalized as subjective reality, which then shapes the individual. According to Berger and Luckmann (1966), objective reality can be translated into subjective reality and vice versa. In other words, we cannot understand roles or how to perform them without the particular knowledge that has been socially produced. Roles become objective when we actively perform them, based on socially-constructed knowledge.

We can identify roles and the enactment of roles because of socially objectivated typifications. According to Berger and Luckmann (1966) "there is not only the recognition of an actor performing an action of type X, but of type X action as being performed by *any* actor to whom the relevance structure in question can be plausibly imputed" (p. 72). We can then begin to see roles as types of actors in such contexts.

Roles are an important part of institutions. "Institutions are embodied in individual experience by means of roles. The roles, objectified linguistically, are an essential ingredient of the objectively available world of any society" (Berger & Luckmann, 1966, p. 74). The individual can participate in the social world by the enactment of roles. As individuals internalize roles, the same world becomes subjectively real (Berger & Luckmann, 1966).

Roles become known through social construction. Physicians know what roles to enact in particular contexts because of experiences and expectations of appropriate behaviors. Roles also become recognizable to others because they become common social constructions through the process of socialization and interaction. Through interaction, roles become objectified features of the social world as well as subjectively real to individuals.

Enactment and Sensemaking

Weick's development of sensemaking illustrates how individuals take their social, yet cognitive knowledge of role-taking and enact it in role playing, all as part of the sensemaking process. Sensemaking is a significant process of organizing. According to Weick, Sutcliffe, and Obstfeld (2005), "sensemaking unfolds as a sequence in which people concerned with identity in the social context of other actors engage ongoing circumstances from which they extract cues and make plausible sense retrospectively, while enacting more or less order into those ongoing circumstances" (p. 409). Thus, the central component of sensemaking and organizing is communication.

Situations are talked into existence through social processes and tacit knowledge is made more explicit or usable (Weick, Sutcliffe, & Obstfeld, 2005). Viewed conceptually, it is proposed that sensemaking can be treated as reciprocal exchanges between actors (Enactment) and their environments that are made meaningful (Selection), and preserved (Retention) (Weick, Sutcliffe, & Obstfeld, 2005). The process of sensemaking illustrates that people organize in order to make sense of ambiguous information and enact this sense back into the world to make it more orderly. Weick (1995) argues that organizational members depend on interactions to make sense of ambiguity and guide future role behaviors. Thus, we become aware of others perceptions through interactions. Interactions can be seen as reciprocal communication between individuals. Further, we internalize and make sense of others perceptions through negotiation and interaction, thus, reacting to those perceptions through role enactment. Reacting can be seen as an individuals response to others within an interaction and an individual process in which we interpret others perceptions and adapt appropriate behaviors. Weick, Sutcliffe and Obstfeld's development of the sensemaking process illustrates how cognitive role-taking knowledge can be enacted by means of role playing.

Schema Scripts

Scripts are an important part of understanding the organizational behavior of physicians. Scripts serve as a way of knowing, analyzing, and describing many facets of behavior within the hospital and clinic. Much like role enactment, scripts provide a guide for appropriate behavior (Giola & Poole, 1984).

An examination of past literature regarding scripts will provide an explanatory dimension to the concept of roles.

According to Giola and Poole (1984), a schema is a cognitive framework. An individual uses a schema in order to impose structure on and impart meaning to social information or social situations, in order to facilitate understanding. A script is a schema that an individual holds in his or her memory that describes behaviors appropriate for a particular context. This is much like the idea of role that was presented earlier. Scripts enable understanding of situations and provide a guide to behavior appropriate to those situations (Giola & Poole, 1984).

Individuals within an organization know how to act, due to the working knowledge that they have about their organizational world. According to Giola and Poole (1984), organizational members will enact the "right" behaviors most of the time because they retain a cognitive repertoire of scripts fitting a host of organizational settings. Individuals will perform a script based on the processing of conscious or unconscious organizational cues given off by another during an interaction. Therefore, the script that individuals draw on and utilize may change throughout an interaction.

Mismatched Schemas

Tannen and Wallat (1987) conducted a study examining the use of schemas in a physician-patient interaction. In the study, they analyzed a videotaped interaction of a pediatrician examining a patient while the patient's mother was in the room. The analysis of the interaction helped them identify conflicts in framing, resulting from mismatched

schemas. In this particular study, "frame" is defined as a speech activity. Frame also refers to a definition of what is going on within an interaction. In order to comprehend any utterance within an interaction, the listener must know within what frame it is intended (Tannen & Wallat, 1987). To use Bateson's classic example, a monkey needs to know whether a push from another monkey is intended within the frame of *play* or in the frame of *fight* (Tannen & Wallat, 1987).

Tannen and Wallat (1987) used the term schema to refer to patterns of knowledge, specifically patterns of expectations and assumptions about the world. When different expectations exist within the frame, conflict arises causing mismatched schemas. In their analysis, Tannen and Wallat (1987) found that mismatched schemas led to changes within the interaction.

According to Tannen and Wallat (1987), an understanding of mismatched schemas accounted for many of the doctor's lengthy explanations during the examination**,** as well as the mother's discomfort when her schema contradicted that of the doctor in the study. An example of mismatched or conflicted schemas occurred during the physician's examination of the patient. The patient was having problems breathing at night, causing great concern for the mother. The mother believed that her child was not getting enough oxygen. When the physician examined the patient's throat and moved on to her ears, the patient's mother interrupted the physician in order to state her concern about her child. The physician had to stop the examination and explain that muscle weakness was causing the symptoms, rather than not enough oxygen. Due to the mother's mismatched schema, the physician switched from an examination frame to a consultation frame.

The interaction between the physician and the mother changed based on each individual's schema. The significance of this study is that Tannen and Wallat (1987) found that there is every reason to believe that schemas operate in similar ways in all face-to-face interactions, although particular schemas will differ in different settings.

Therefore, based on Tannen and Wallat's study, individuals enter into an interaction with a knowledge base that serves as a guide for interpretation of actions, information and expectations (Giola & Poole, 1984). Based on the context of our interactions, individuals will use a different schema script. The schema script that we have for a particular interaction can change based on cues given off from others, prompting us to use a different schema script within the interaction. This may account for the physician switching from examination to consultation frames, based on the mother's differing schema.

Past scholarship has shown that the notion of scripts complements the idea of role. Both are cognitive and behavioral structures, providing a framework for the appropriate behavior within a given situation. Schema scripts help to provide an understanding for actions, events and behaviors in the organization. Additionally, schema scripts provide a framework for understanding how individuals perform their own behaviors within an organization.

Gender Roles and Communication

It is nearly impossible to overlook the impact of gender roles on communication when examining the different roles female physicians enact throughout their interactions.

Theorists claim that it is important to examine the differences between gendered communication patterns due to the way that individuals are socialized. According to Payne (2001) the way that society defines roles for women and men provides expected behaviors and values associated with these roles. These gender role expectations also affect the way that individuals communicate with one another.

Gender roles occur through socialization, the processes in which individuals are engaged in, that shape and create their unique self (Allen, 2005; May & Mumby, 2005). Given that gender roles can be seen as social constructions, they can be enacted and performed in interaction. Individuals come to understand what behaviors are appropriate for their gender based on societal or cultural expectations communicated through others or through institutionalized structures. Thus, communication of some form is essential in this examination of gender roles. Women and men reflect gender roles through communication and they are also impacted by communication about gender (Payne, 2001). Researchers have found that it is through communication that we can understand gender differences in verbal communication, gender roles and power and nonverbal gender communication.

Instrumentality vs. Expressivity

Researchers have been dedicated to understanding the differences between masculine and feminine communication. Masculine and feminine are social gender roles, whereas male and female are biological sex states. In the past, expressivity has been associated with a more feminine style of communication. Feminine communication is

said to be more expressive and nurturing (Aube et al, 1995). Women's speech has also been stereotyped as nonassertive, tentative, and supportive (Haas, 1979). Studies have also found that women use more emotional language, contributing to the idea that feminine communication is more expressive (Haas, 1979). Psychologists found that often times women use words such as "lovely," "nice," and "pretty" (Kelly, 1991). Women have also been found to have four levels of pitch that they use in speech. According to Kelly (1991), women's pitch levels expand women's ability to express themselves.

Conversely, masculine forms of communication are classified as being more instrumental. Men are typically said to be conveyors of information and facts (Haas, 1979). The male instrumental style includes debating and lecturing, and being assertive, and argumentative (Haas, 1979). Men also tend to have more instrumental or 'agentic' friendships, whereas women's friendships tend to be expressive or 'communal' (McAdams, 1985). Women's friendships are considered expressive because they tend to share and discuss their feelings; conversely men tend to organize friendships around the *doing* of activities (Burleson, Kunkel, Samter & Werking, 1996). For example, men often call their friends in order to set up a time to do an activity. In contrast, women tend to call their friends in order to self-disclose.

From the time individuals are young, they learn gendered communication styles and patterns from particular others, friends, and social institutions. In a study done by Garcia-Zamor (as cited in Haas, 1979), nursery children were asked to ascribe various uttered sentences to a boy or girl doll. The study found that the nursery children believed that aggressive and competitive language was appropriate for the males only (as cited in

Haas, 1979). This study exposes the stereotype that women are more communal in their communication than men.

<u>Styles of Conversation</u>

Early research in the area of gendered communication found notable differences in the way males and females communicate during conversation. Today, however, much has changed regarding gender roles and communication. Jesperson (1922/1949), an early observer of style in language, found that women's speech was more conservative than men's in various ways: men used more profanity, obscenities, new terms, and slang.

Jesperson also found a difference between men and women in sentence structure. Women left sentences unfinished or dangling more often then men (Jesperson, 1922/1949). Lakoff (1975) also found differences in sentence structure between men and women. Women have been observed to have longer sentence forms, contributing to the idea that they speak more then men.

Researchers have also found that women state more requests while men issue commands (Lakoff, 1975). This contributes to the idea that, in general, women's communication style is more polite and stereotypically tentative and supportive. Research in the 1970's found that women use more euphemisms, politeness forms, apology, laughter, and crying (Haas, 1979). In contrast, men's communication tends to be coarser and more direct (Haas, 1979). These differences in male and female conversation styles also contribute to our understanding of gender roles and power.

Gender Roles and Power

Sources of power are constantly operating within the organizations. Historically, feminists viewed power as control, authority, or influence over others (Payne, 2001). It is through our interactions with others that these sources of power can be identified. Traditionally, females have used self-disclosure to equalize status and control with both men and women. Women's communication and self-disclosure tend to be the center of relationships (Payne, 2001). They use talk in order to match experiences. It is through women's communication that they are able to support others as they focus on the relationship (Tannen, 1994).

Personal power is another important source of power within organizations. Charisma, an important form of personal power, is often associated with men rather than women. In men, charisma is associated with personal attractiveness, likeability, style, intellect, and leadership (Kelly, 1991). "Charisma in men is often associated with highly controlling, assertive behavior, as well as strength, humor, energy, warmth and articulateness" (Sargent, 1977, p. 469). For a woman to be viewed as charismatic she must combine personal attractiveness, strength, energy, sensitivity, warmth, and humor being 'together,' and self-aware in a way in which she is perceived as feminine (Sargent, 1977). It is through personal power and charisma that individuals are able to establish characteristics such as trust, mutual respect, credibility for good judgment, and reliability (Kelly, 1991). This is why power is an important aspect of gender roles within organizations.

<u>Nonverbal Gender Communication</u>

Researchers have identified various differences between males' and females' use of nonverbal communication. One form of nonverbal communication is proxemics; the way in which individuals use space. Past literature has determined that the way males and females use space reifies socialized gender roles. According to Evans and Howard (1973), women tend to use less space than men, keep their elbows closer to their bodies, hold their knees closer together, and use smaller gestures when speaking. Women also adopt postures that are symmetrical and less open than their male counterparts (Cashdan, 1998). Research has shown that women also tend to sit closer to each other than men, as well as allow others to communicate in closer proximity to them (Hartnett, Bailey, & Gibson, 1970).

Body language is another form of nonverbal communication that differs between females and males. Researchers suggest that males use more dominating forms of body language whereas females tend to use more submissive forms of body language. When communicating with men, especially, females tend to tilt their heads while talking or listening, use less body space, put their hands in their laps more often, cross their legs, and sit forward in their chairs (Payne, 2001). Women often act as if they were of lower status when interacting with men of similar status through their nonverbal behaviors. Henley (1977) argues that women are less forceful and decisive than men with their nonverbal behaviors; therefore, women are viewed as less powerful.

Eye contact is another important form of body language. Researchers have found that women tend to look at another person during a conversation more than men do. This

type of eye contact helps to establish and maintain interpersonal relationships, something society expects women to do (Payne, 2001). Women also tend to use more eye contact because the appearance of eye contact is often associated with the 'listener' role. Thus, the whole arrangement constructs our identification of a particular social behavior, listening.

Another non-verbal behavior that is often associated with women is touch. Researchers have found that there is more reciprocation of touch among women (Jones, 1984). Women tend to initiate hugs and touches which express support, affection, and comfort (Payne, 2001). Gender role theories have traditionally suggested that women will communicate in order to achieve connectedness, among other things. Touch is an important nonverbal communication behavior that helps in achieving connectedness within a variety of relationships.

Gender role theories help us to examine the influences on gender, such as social, cultural, and organizational forces. It is through these perspectives that we can begin to understand how these influences impact gendered communication.

Purpose of Research

Past literature has provided substantial scholarship concerning the idea of role, schema scripts, and gender role communication. These theoretical constructs help researchers examine how organizational members understand and enact their roles throughout various interactions. This line of scholarship shows that individuals actively enact roles based on context and interaction. Research also emphasizes the importance of

communication in the process of role enactment and highlights how socialized gender roles play a part in the way females communicate with others.

Given the literature that has been presented, it is particularly interesting to investigate how female physicians enact different roles in an industry where they are granted significant power and status- things that differ somewhat from many other gendered roles. Even more interesting is the examination of how roles change based on the context and relationship. This study highlights the centrality of communication within role enactment in an attempt to explore how female physicians develop and change their roles. Based on the previous literature, the question to be investigated in this study is:

RQ: How do female physicians enact different roles as they participate in a variety of contextual interactions in the workplace?

QUALITATIVE METHODS

Participants

Female physician participants were recruited by a gatekeeper; a practicing female physician for 17 years in the Washington State community in which this study took place. The gatekeeper helped provide access to the population of female physicians who participated in this study. Participants consisted of five female physicians. Participants were of mixed ethnic backgrounds, with ages ranging from 30 – 60. Each female physician specialized in a different field of medicine and worked at a different medical clinic. The participants' specialties consisted of: Oncology, Dermatology, Obstetrics and Gynecology, Ophthalmology, and General Surgery. Each participant has been practicing medicine in the Washington State community in which the study took place for at least two years.

Patient participants were recruited in physicians' respective clinics as they checked in at the admissions desk. All patients were recruited on a convenience basis (i.e. if they happened to be on the patient roster on the day when physicians were being observed). Patient participants were invited to participate by clinical staff and the physician. Interactions in the exam room were observed with the consent of both patient and physician. (See Appendix for patient consent forms)

Observation

This study utilized the method of observation to gather data on how female physicians enact different roles based on various workplace relationships and contexts. The method of observation provides rich insights by focusing on actual practice, on site, through immersion in the field (Tan, Wang, & Zhu, 2003). Close contact and immersion in the lives of participants is essential for understanding the meaning of actions, the situation, and the process in which actors construct the situation through interaction (Blumer, 1986).

Observation is also based on interpretation. According to Schensul, Schensul, and LeCompte (1999), observation is always filtered through the researcher's interpretive frame. Prus (1996) maintains that,

> Researchers using a symbolic interactionism lens should be cognizant of: the intersubjective nature of human behavior; the viewpoints of the actors involved in the situation; the interpretations that the actors attach to themselves, other people and other objects that they interact with; the ways in which the actors do things on both an individual and interactive basis…sequences of interactions that the actors develop and experience over time (as cited in Tan, Wang, & Zhu, 2003, p. 5-6).

Being aware of one's own interpretive orientation and/or biases, as well as the intersubjective nature of human life, is an important implication for observational study (Tan, Wang, & Zhu, 2003). To understand how female physicians enact various roles throughout different contexts, five different physicians were observed in their respective

medical clinics. Observation lasted for one week, approximately 30-40 hours. Observation occurred at five different medical clinics located in Washington State. Prior to observations, permission letters were signed by all participants. These forms gave the researcher access to each participant's respective medical clinic (see Appendix for permission letters). Additionally, all physicians signed informed consent forms prior to being observed in the clinic (see Appendix for physician consent forms).

Observations provided the researcher with an opportunity to collect data from which a richly detailed account of the process of female physician role enactment and how physician's roles change based on the context of the interaction can be made. The observations focused on the interaction between physicians and patients, physicians and staff, and physicians and colleagues (other physicians). Observations also focused on how physicians enact roles throughout interactions. Particularly, observations focused on the context of the interaction and specific role-related behaviors utilized by physicians.

Prior to observation, consent forms were provided to all individuals that participated in the study (see Appendix for staff consent forms). Observations were conducted in high traffic locations, such as nurse stations and admissions desks. In addition, observations were conducted in examination rooms. Physicians were observed and followed throughout the clinic as they went about their scheduled day. Observations consisted of accompanying physicians as they worked in their office, went to lunch, went from exam room to exam room, interacted with staff at the nurses' station, and went over patient charts.

During the data collection process the researcher observed various interactions. Interactions ranged from: the intimate interaction between physician and patient in the exam room to brief greeting exchanges, discussion about non-work related issues to brief and lengthy exchanges between physician-patient, physician-staff, and physician-physician.

Throughout the observation process, field notes were taken. Field notes involve detailed and concrete observation and recording on a regular basis (Schensul, Schensul, & LeCompte, 1999). Field notes consisted of detailed descriptions and initial theorizing and accounting for events observed pertaining to female physician behaviors, physicians' interactions, and the physical environment of each medical clinic. Field notes were transcribed upon completion of the observed shift. Transcription of field notes entailed transforming shorthand notes into more detailed and elaborate descriptions. After each day of observation, field notes were reviewed for emergent themes regarding physician's role enactment.

Interviews

In addition to observation, semi-structured interviews were conducted with each of the five female physician participants. These interviews helped develop hypotheses and general probes for description and interpretation of less understood topics (Johnson, 1998; Schensul, Schensul, & LeCompte, 1999). Interviews lasted about 10 minutes (due to time constraints) and consisted of five questions.

Interview questions addressed the following topic areas: motivation to become a physician, communication behaviors, and role conflict (see Appendix for interview questions).

Interviews were conducted at times and locations convenient to the participants and in a private and confidential atmosphere. Interviews were audio taped and transcribed using pseudonyms. The pseudonyms used in this study were taken from famous, historical women who were involved in some aspect of the medical field.

In addition to interviews, member-checking also helped clarify observations. Member-checking is when data and interpretations are tested with members of the group from whom that data was obtained (Cohen & Crabtree, 2006). Member-checking was based on particular observations. Member-checking helped to clarify observations; allowed participants to correct errors and challenge wrongly perceived interpretations; helped facilitate understanding of physician's motivations for specific actions, as well as the function of their actions; and helped to confirm aspects of preliminary data (Cohen & Crabtree, 2006).

Further, interviews and member-checking helped to complement and corroborate observational findings (Apker, 2001). Observation, interviews and member-checking helped to provide a more detailed account of how physicians enact different roles as they participate in a variety of interactions. Through the combination of these two methods, I believe that I was able to approach a credible answer to my research question.

Analysis

<u>Coding Scheme</u>

Behavioral field note items were coded by utilizing a modified version of the Roter Interaction Analysis System. The Roter Interaction Analysis System (RIAS) is a method of coding doctor-patient interaction during medical visits (Roter, 2006). For the purpose of this study, the RIAS was used as a method of coding all physician interactions within the clinical setting. The RIAS coding approach is tailored to dyadic exchanges, where all dialogue exchange is then coded into categories. The RIAS uses utterances, or small meaningful strings of words, as the unit of analysis.

Traditionally, the Roter Interaction Analysis System is used for coding audiotape and videotape interactions. In this study, a modified version of the RIAS was used to code from observation and interview transcripts. On the basis of previous research and items obtained in the current study, categories were reduced to 19 verbal and nonverbal behavioral items. Coded items and categories were inductively created from the researcher's experiences in the field as well as deductively applied from modified RIAS categories. Coded items and categories are shown in Appendix, Table 2.

Throughout the analysis process, coded items and themes were examined for frequency and patterns in female physicians' communication behaviors began to emerge. Specific communication behaviors or role-related behaviors became associated with specific contextual interactions. Thus, physician roles became identifiable within particular contexts. After identifying patterns in interaction and physician's communication behaviors, "physician's roles" were developed.

"Physician's roles" were developed through the identifiable patterns of the coded and

categorized interactional items.

FINDINGS AND INTERPRETATION

In this study, four key roles were identified by the researcher (see Table 1 on page, 38). Roles were identified based on the context of female physician interactions and physicians' communicative behaviors. Patterns in female physician role enactment began to emerge as physicians participated in various interactions with patients, staff and other physicians. The results of this study illustrate that female physicians enact one or more of the four roles identified, depending on the interaction in which they are participating.

The first role identified was *The Advocate*. *The Advocate* role is enacted through communicative behaviors such as: teaching, educating, empowering others, providing general explanations for issues, reassuring, and counseling. The second role identified was *The Technician*. *The Technician* role involves: precise, focused, direct, competent communication with others, as well as being task-oriented, determined, and providing technical explanations. The third physician role that emerged was *The Gentle One* role. The enactment of this role entails: compassion, empathy, being apologetic, using a soft voice, and touching others. The final role that emerged was *The Friend*. During the enactment of *The Friend* role, physician's communication tended to be: friendlier, relaxed, and comfortable, often times using narratives, jokes, and self-disclosing.

Table 1: Identified Physician Roles.

ROLES	DESCRIPTION OF ROLE
The Advocate	Empowering, teaching, reassuring, educating, counseling, providing general explanations.
The Technician	Precise, competent, focused, determined, task-oriented, direct, technical expressions/ explanations.
The Gentle One	Compassionate, touching, apologetic, soft voice, empathetic.
The Friend	Friendly, relaxed, jokes, comfortable, outgoing, use of narratives, self-disclosure.

In addition, five themes emerged regarding *how* female physicians enact the different roles, and in what interactional context those roles are enacted. The first theme is the focus on patient understanding. It was during these times when a physician was most likely to enact *The Technician* role, followed by *The Gentle One* role or *The Friend*. The second theme that emerged during physician-patient interaction was the empowerment of the patient. Within these specific interactions, female physicians enacted *The Advocate* role. Through the enactment of *The Advocate* role, female physicians empowered their patients to make their own medical treatment decisions. The

final theme that emerged during physician-patient interactions was physician adaptation to patients' communication. During these interactions physicians roles clearly changed from *The Technician*, to *The Friend* or *The Gentle One* depending on the patients communication style.

In female physician-staff interactions, one theme emerged, the importance of technical knowledge and appreciating staff. During more technical interactions with staff, physicians enacted *The Technician* role. Often times physicians roles would change to *The Friend* or *The Gentle One* when the context of physician-staff interactions took place outside of the examination room or in the hallway.

During female physician-physician interactions the theme that emerged was the focus on technical aspects of the job. During these physician-physician interactions, female physicians enacted *The Technician* role or *The Friend* role.

The resulting themes section is organized into three different interactional sections, female physician-patient interaction, female physician-staff interaction and female physician-physician interaction. Within the female physician-patient interaction section, there are three main role enactment themes.

Themes

Female Physician-Patient Interaction

Focus on patient understanding. All of the female physicians observed were committed to taking the necessary time to thoroughly explain the patient's medical issues. Patient understanding became the focus of the physician. Physician's explanations

were lengthy or short depending upon the amount of time it took for the patient to understand what was happening with his or her body. Throughout the explanation process, physicians began enacting *The Technician* role. Dr. Barton explains how lengthy explanations can create issues in her schedule.

> Because I do like to explain things to patients and take time with them, my schedule runs behind. It's just a balance between choices that you make. If I have somebody with a very complicated issue, I am very aware that the rest of my schedule is going to become behind but I have to make sure that I am taking the time for that patient. And most of my patients know me, so when that's happening they have been in that situation before and they understand, you might notice even with the last few patients, even though they were waiting here for a long time, getting into their lunch, they were all very understanding about it because, they know that I would do the same thing for them.

In this instance, Dr. Barton makes it clear that taking the time to focus on the patient and explain his or her medical issue is her number one priority. Although lengthy medical explanations may cause her to run behind, taking the time necessary for each patient is important in her practice.

Dr. Barton uses multiple communicative behaviors during explanatory interactions with her patients. For example, during a patient examination, Dr. Barton is focused and precise. While examining the patient, she explains what she is doing. After she is done with the examination she says "I am going to take a moment to write some

things down." She remains quiet when writing on the patient's chart and then proceeds to say, "Ok, I am ready to talk to you about…" Dr. Barton sits close to the patient and maintains eye contact. As she explains what she saw during the exam, she uses multiple gestures and her voice becomes louder. Dr. Barton uses a diagram to help facilitate patient understanding of what she is saying. After each sentence, Dr. Barton pauses so the patient can have a better understanding of what she is saying. Dr. Barton also explains the treatment option she believes would be best for the patient and why she thinks it would work, while using phrases such as "…and I'll tell you why." As she explains herself, she leans forward closer to the patient. Dr. Barton also repeats what she says to facilitate patient understanding. After she finishes her explanation, she asks the patient "What are your feelings about that?" Throughout the explanation process, it is apparent that Dr. Barton is enacting *The Technician* role as evident in the use of her communicative behaviors.

Dr. Walker uses the same role-related behaviors as Dr. Barton when enacting *The Technician* role during explanations with her patients. When explaining the use of medications, instructions for patients, or medical issues, Dr. Walker is competent and direct. Dr. Walker nods her head and uses many gestures as she explains to patients for understanding. She focuses on the patient and maintains eye contact throughout her explanation. All of these communication behaviors demonstrate the role of *The Technician*.

Dr. Blackwell also takes on *The Technician* role when communicating to a patient for understanding. Dr. Blackwell uses eye contact, gestures, and diagrams to explain to

one of her patients potential problems associated with the patient's symptoms. Dr. Blackwell is direct with her patient and is extremely competent. In one situation, Dr. Blackwell was concerned about the outcome of symptoms a patient was experiencing. She used the patient's x-ray to help explain the situation. While she held up the x-ray, Dr. Blackwell pointed to areas of concern. She explained each of her concerns while making direct eye contact with the patient. I believe that the direct communication exhibited by Dr. Blackwell demonstrates that she is competent and puts the patient at ease.

After it appeared that patients understood what the female physicians were communicating to them, female physician's roles changed from *The Technician* to *The Gentle One* or *The Friend*. During *The Gentle One* role, female physician's communication changed to a compassionate and understanding style. Often times during this new role enactment, physicians used words such as "sweetie," "baby," and "beautiful." Female physicians also touched patients more as they enacted the new role. Female physicians touched patient's legs or backs in a friendly, caring way. In one situation, Dr. Blackwell picked up a patient's baby and kissed the baby on the head. It was also very common for female physicians to touch a patient's leg or back when sensing that the patient was scared or in pain.

Dr. Walker explains the importance of physical touch with patients in her practice.

In terms of my interactions with patients, I like to make sure to show them that I am thinking about them and their problems. I try to focus on them and what they're telling me and what's going on. I also like to make it as

friendly an interaction as possible so that they feel good about themselves when they leave. If you'll notice about skin diseases, I like to touch my patients, because a lot of times with skin diseases they are very, very shy about their bodies. They are upset about how they look and especially patients with …I like to touch them. Because I really feel like they need to know that. A lot of times people stay away from people with skin diseases because they feel like they're contagious. So, I feel like I need to make sure, it also helps me, too. I always try to make those interactions focus on the patient and try to figure out what's bothering them, so they leave, I hope like feeling…whether or not I am able to help them, I want them to feel good.

This kind of behavior certainly illustrates a shift from *The Technician* role to *The Gentle One* role. These examples demonstrate how *The Gentle One* role is constructed through the role-related behaviors described above.

In an attempt to reach an even deeper understanding between physician and patient, female physicians often used narratives, enacting *The Friend* role. During this time of role enactment, communication was more relaxed and friendly. In one instance, Dr. Walker tells a patient about her daughters and family travels. The use of female physician narratives seems to create a more relaxed and open atmosphere. I found that many of the female physicians I observed often referred to personal examples or used personal stories in order to make the patient more comfortable. It seems that once the "business" of why the patient is seeing the physician is over, the communication between

female physician and patient becomes more comfortable. Dr. Dix describes how making the patient feel comfortable through communication is key to a successful recovery.

> I've heard a lot of people describe me in the same way so, like "oh, you're very energetic," "you're so personable, everyone is comfortable with you." I can't really say if that's true or not, because I'm just me. But definitely I know that patients like talking to me and a lot of patients say that they're comfortable with me immediately, which is good because being comfortable with your doctor is very key. Because a lot of getting better and healing has to do with the mental process and patients need to be happy and they need to be in a state of mind where they're like, "I'm gonna get better," and if they're not happy then its uh, happens less, and if it does happen it takes longer to happen. Patients say they're happy and comfortable with me quickly and that to me is key.

The use of narratives, as well as being understanding and compassionate is seemingly an important part of what the female physician participants do. Physicians need to be competent and precise when addressing a patient problem. As soon as it seems the patient understands, female physicians take on a different role. The role of *The Friend* and *The Gentle One* are very important roles for physicians to play. Through the enactment of these roles, physicians show compassion, understanding, and caring. When a physician is telling a personal story or laughing at a patient's joke, it brings the physician down on a more personal level with the patient.

While it is important to enact different roles in order to facilitate patient understanding, it is even more important to provide patients with medical knowledge pertaining to their health, in order to empower them.

    <u>Empowering the patient.</u> A second theme that emerged throughout the analysis of female physician-patient interactions was the empowerment of patients. In many instances, physicians took on the role of *The Advocate*, educating their patients about preventative measures and empowering them to make their own decisions about their health care. Dr. Walker explains how it is important to help educate patients.

> The best way to help people is to help them help themselves, so that you
>
> know you empower them with knowledge and you're straightforward with
>
> them… And help them figure out what is wrong and what the problem is.
>
> Help them work their way through it.

Dr. Walker explains that it is important to empower the patient by teaching and educating them about problems they are facing. It is through this interaction that physicians begin to enact *The Advocate* role.

    Dr. Anderson explains how enactment of *The Advocate* role also entails being a counselor. Throughout interaction with a patient, it is important to try and understand what is happening medically with the patient and empowering them to decide where they want to go with their treatment.

> I am a patient advocate. I'm kind of the one that is supposed to look out
>
> for the person that I'm taking care of. So, I am a teacher and a counselor,

all of those things. Um, and primarily an advocate, to make sure

everything that we do is primarily the best for that person. And not in a

materialistic sort of way, but from lots of different standpoints, from a

medical standpoint, from a social standpoint, and kind of taking into

account what's going on with them and really kind of helping them decide

what they want to do. Teaching them mainly, being there for them.

Dr. Barton explains that part of her role as a physician is showing patients that she is on

their side, which is an important aspect of *The Advocate* role. Dr. Barton explains the

importance of constant communication when enacting the role of *The Advocate* during

patient interactions.

Well, I do think I care a lot about my patients, and I am hoping that the

patients see that. It helps them to know that the physician really cares

about them and is on their side. Um, and I think with the type of patients

that I see…that the communication aspect is very important. With constant

communication during the visit I can address their fears and also give

them the sense of what their prognosis is…giving them the opportunity to

make sure that they have their questions answered.

With constant explanatory communication, listening, and addressing patient concerns,

Dr. Barton enacts the role of *The Advocate* during patient interactions.

Empowering patients is an important element of the enactment of *The Advocate*

role. Many physicians empower their patients by allowing them to make their own

decisions rather than dictating decisions to them. Physicians tried to provide patients with

enough information to allow them to make their own treatment decisions during the enactment of *The Advocate* role. An instance of this is when Dr. Walker interacts with a patient in the examination room.

During the exam, the patient explains to Dr. Walker that previously prescribed medications are not working. Dr. Walker acknowledges the patient's concern and explains about a different medication and how it might be more beneficial for the patient. After explaining and educating the patient about the new medication, Dr. Walker asks the patient "Does that sound ok?" The acknowledgement of patient concerns, explanation and education regarding concerns, and allowing the patient to decide whether they would like to proceed with the new treatment direction that the physician proposes is the communicative process of the enactment of *The Advocate* role.

When faced with difficult diagnostic situations, Dr. Anderson takes on *The Advocate* role as well. In one instance, Dr. Anderson must tell a patient about specific test results that she just received. Dr. Anderson explains the test results to the patient in the examination room. After acknowledging the patient's concern regarding the test results, Dr. Anderson explains the different treatment options available. As Dr. Anderson explains the specifics of the treatment options, she uses many gestures, constant eye contact with the patient, and nods her head during the explanations. After explaining all available treatment options to the patient, Dr. Anderson acknowledges that "This is a lot to think about…you need to know what you're faced with." Dr. Anderson makes a suggestion for what the patient "might want to do," but leaves the treatment decision up to the patient. This physician-patient interaction example illustrates how Dr. Anderson

enacts *The Advocate* role as she counsels and educates the patient, empowering the

patient to make his or her own treatment decisions. While physicians had overarching

goals of informing and empowering the patient, they often needed to adapt their role in

response to the perceived needs of the patient.

Adapting to the patient. Theorists have argued that individuals develop and

change their roles through communication with other organizational members (Apker,

2001; Graen, 1976). Some scholars believe that communication enables individuals to

enact various roles and allows other organizational members to define and respond to role

behaviors (Apker, 2001). Our interactions with others allow us to adapt our behaviors and

roles, based on our interpretations of others communication. This was evident throughout

the female physician-patient interactions.

Dr. Anderson explains how it is important to 'mirror' patients in order to help

them feel more comfortable.

> I think that I have a tendency to mirror patients sometimes. A lot of
>
> patients we have seen here today have been very relaxed, and they are old
>
> time patients. They know me very well, a lot of them I see on a regular
>
> basis, I treat and so… Generally when I first see a patient, it's a more
>
> formal kind of thing. Trying to sort out what's happening and how their
>
> communication style is. I think that a lot of times what I try to do is mirror
>
> the way they are. I think they are more comfortable that way, up to a point.
>
> It helps them feel that I'm on their side. So, people who are, very formal
>
> and I feel like they have a sense of wanting things on a dotted line and that

kind of thing, I am much more formal, I don't joke around as much and

kind of make sure that they know I am paying attention to what they want.

Dr. Anderson's example illustrates that through an interpretation of patients'

communication styles and behaviors, she can adapt her own role behaviors to create a

more effective interaction.

Dr. Dix also adapts her role behaviors based on her interpretation of her patient's

communication. An example of this is during a follow-up exam with one of her patients.

As the patient enters the exam room, Dr. Dix takes on *The Friend* role. She begins by

discussing the weather and paying the patient compliments. As the patient begins

describing problems associated with her surgical wound, Dr. Dix quickly adapts her

behaviors and changes her role from *The Friend* to *The Technician*. Dr. Dix becomes

focused on what the patient is saying, maintains eye contact, and nods her head while

listening to the patient. Dr. Dix quickly provides an explanation for the patient's

problems. As the exam ends, Dr. Dix changes her role from *The Technician* and begins

enacting *The Gentle One* as she proceeds to touch the patient's back and open the exam

room door. Dr. Dix leads the patient out of the exam room and down the hall to show the

patient a specimen taken from the patient during surgery. When the patient sees the

specimen, the patient begins to laugh. Dr. Dix begins to laugh in response to the patient

and her communication becomes very casual. Dr. Dix's role changes to *The Friend* as the

patient's communication becomes casual and relaxed. This example shows that Dr. Dix

changes and adapts her role based on the patient's behavior.

Dr. Barton also adapts her role based on her patient's communicative behaviors.

In one instance, Dr. Barton is interacting with a patient who is experiencing other medical issues outside of her specific field. In this situation, the patient is seeing another physician concerning his or her other medical issues; however, Dr. Barton is still concerned for her patient's overall well-being.

Dr. Barton enters the exam room smiling and begins asking the patient how he/she is doing. The patient's response is that he/she is having a difficult day and is in pain. Dr. Barton quickly enacts *The Gentle One* role and touches the patient's leg, while sitting close to the patient and maintaining eye contact. After the initial introduction, Dr. Barton begins examining the patient. When Dr. Barton finishes the examination, she enacts *The Technician* role as she directly explains the patient's medical issues. After she finishes with her explanation, Dr. Barton sees that the patient is still in pain. Dr. Barton's role changes from *The Technician* to *The Gentle One*. Dr. Barton touches the patient's leg and nods her head. In doing so, Dr. Barton is exhibiting compassion for her patient who is clearly in pain. Knowing that her patient's pain is associated with medical issues outside of her specialty, Dr. Barton inquires about how the patient's health is doing overall. This shows that Dr. Barton is empathetic and has compassion for the patient's other medical conditions.

Physicians clearly adapt their behaviors based on their interpretations of others behaviors. Adapting and changing one's role allows physicians to communicate more effectively with patients and allows them to relate to patients better. Dr. Dix describes why adapting to patients makes her an effective physician.

You have to be able to see where a patient's coming from and be able to

adapt where you're coming from. To me, I can figure out people pretty well and once you figure out where people are, where the patient's coming from, if they're scared, whatever it is about them and you can relate to them and make it palpable to them…You definitely can't treat them all the same… And you just have to relate to them and you can figure it out pretty fast…and you just adapt to that. That's why you just have to sort of listen to your patients and watch them; you take cues from your patient.

It is also important for Dr. Blackwell to adapt to her patients. Dr. Blackwell laughs, jokes, and is animated with many of her patients. But it is her ability to adapt to patients that makes her an effective communicator. Adapting your communication to mirror those used by a person with a different style is key to effective communication (Hamilton & Parker, 1990). This is evident during an interaction that Dr. Blackwell has with one of her patients. Before entering the exam room, Dr. Blackwell jokes in the hall with another patient. Dr. Blackwell is clearly enacting *The Friend* role in this instance. Her pitch rises and she is very animated, while she puts on Chap Stick and congratulates a patient about the upcoming arrival of a baby. As she leaves the hallway and enters the exam room, she stands close to the waiting patient and in an upbeat voice she asks the patient how she/he is doing. As the patient replies, it is evident that the patient is more reserved and calm. Dr. Blackwell changes her role from *The Friend* to *The Technician*. Dr. Blackwell's communication becomes more focused and direct as she addresses the patient's medical issues during the exam.

This example illustrates how Dr. Blackwell changed her role based on the

patient's communicative behaviors.

Further, this example exhibits the communicative processes involved as Dr. Blackwell enacts different roles.

Female Physician-Staff Interaction

Many of the interactions that physicians participate in on a daily basis involve the nursing staff. Physicians are constantly interacting with nurses and staff in a variety of contexts. Nurses and staff members are essential to the success of many physicians' practices.

One of the themes that emerged during female physician-staff interactions was the need for staff to have technical knowledge of the job, balanced with physicians' appreciation of the staff. Dr. Barton explains how important it is to have a well-trained staff in her practice.

> Well you know, I think it's a very simple thing, even with our staff, trying
> to say please and thank you, saying the same things over and over again, it
> is very important. We are really lucky because we have a well-trained
> staff; they often know what to do even before I ask them to. And
> sometimes if I am running late, like today, I kind of have less of a chance
> to communicate with them, in terms of what I need them to do, so they
> have to know things automatically or I have to ask questions very quickly
> and I consciously try to squeeze in a please or thank you, and I don't
> always remember to do it, but at least I try to.

This example not only highlights the importance of well-trained staff in the clinic, but also the different roles that Dr. Barton enacts as she interacts with her staff. In the beginning of her example, she explains that it is important to say 'please' and 'thank you' to her staff. Being polite to staff shows a conscious effort to be appreciative for their work. This type of communicative behavior exhibits the enactment of *The Gentle One* role. Dr. Barton also explains that sometimes communication with her staff is very quick and focused when she is running late, thus she enacts *The Technician* role.

Another example of Dr. Barton's role change is during a patient exam. Like most of her patient exams, one of her nurses is present in the exam room with her. This is a post-op exam, so Dr. Barton begins asking the patient how he/she is doing post surgery. While Dr. Barton is inquiring about the patient's recovery, the nurse sits quietly at the desk table located in the exam room. When Dr. Barton proceeds to examine the patient, she begins dictating (describing to the nurse what she is seeing, so the nurse can write it on the patient's chart) to the nurse. Dr. Barton begins enacting *The Technician* role as her communication with the nurse becomes direct, focused, and technical. After Dr. Barton is done dictating and conducting the patient exam, she thanks her nurse in a soft voice, thus enacting a new role, *The Gentle One*. In her interaction with her nurse, Dr. Barton's role changes from *The Technician* to *The Gentle One*. This role enactment change occurs because the context of the interaction changes.

Dr. Blackwell's interaction with staff varies from the example of Dr. Barton's interaction. In one example, Dr. Blackwell enacts *The Friend* role as she interacts with office staff and nurses. In this scenario, Dr. Blackwell is in the hallway of the clinic

standing at the hallway table writing on a patient's chart. Standing behind her is one of the clinical nurses. Dr. Blackwell turns around and in a high-pitched, friendly voice says "Hi." Dr. Blackwell goes on to joke with the nurse about a hole in Dr. Blackwell's sock. Dr. Blackwell then walks over to the nurse's station and again, in an upbeat friendly voice, says "Hi ladies." Dr. Blackwell maintains her smile throughout, as she tells the nurses about a prescription a patient needs. She thanks the nursing staff with a smile and walks away. Throughout this example, Dr. Blackwell is clearly enacting *The Friend* role as she interacts with various clinical staff members.

> Dr. Walker explains how she tries to have friendly interactions with her staff:
> With my staff, I try to be friendly and make sure that they're not feeling
> too stressed or overwhelmed. It can be very stressful and busy, but we also
> have things we need to get done. And I may be more direct like I need this
> or I need that, but I try not to bark orders too loudly or sound like I'm
> stressed. I do get stressed when I get behind because it makes everyone
> really unhappy.

Dr. Walker's example points out that during her interactions with staff she tries to enact *The Friend* role. This example also illustrates that when work needs to be done or she is running late, she begins enacting *The Technician* role. Dr. Walker explains that she becomes more direct and task-oriented with her staff when she becomes stressed.

During some of her interactions with staff, Dr. Walker also enacts *The Gentle One* role. An example of this is when Dr. Walker asks one of her nursing staff for an instrument. The nurse is clearly having a difficult time finding the instrument. In a soft

voice, Dr. Walker apologizes to the nurse. This is one of the many examples where Dr. Walker apologizes to nursing staff for seemingly making an aspect of the nursing staff's job difficult.

> When interacting with nurses Dr. Anderson has a different frame of reference:
> When I am talking to nurses, I have a different frame of mind, frame of reference because I was a nurse. I feel very much how and where they are coming from...I know what their focus is and I think that their work is very, very important and I think that I couldn't do what I do, without them doing what they do…but I think especially in our office and we have so many things, and there is a lot of emotional angst that is going on, the nurses do an enormously wonderful job and I try to convey my respect for that, because they have a lot to add to what I do.

Given that Dr. Anderson was a nurse before she became a physician, her interactions with nursing staff are more empathetic. Dr. Anderson also explains that her staff enables her to do what she does. Further, she tries to communicate her respect for the job that her staff does. Conveying her respect for staff shows that she is appreciative of what they do. Through these communicative behaviors, Dr. Anderson enacts *The Gentle One* role during various interactions with staff.

Female Physician-Physician Interaction

Although sensitive to the needs of patients, physicians consider their primary responsibility to be the diagnosis and treatment of disease processes (Horman, Campbell

& DeGregory, 1987). From this perspective, interaction with other physicians is an important element in this process. According to Dr. Bohannon, a long time practicing female physician, "other physicians provide expertise, second opinions, reinforcement and assurance" (Personal communication, May 1, 2009).

One of the themes that emerged during female physician-physician interaction was that interactions were based on technical aspects of the job. It was evident throughout observation that female physician-physician interaction is an important part of the medical profession. Physicians provide advice and expertise in areas unfamiliar to other physicians. Therefore, interaction with other physicians is important in the diagnosis of patient diseases.

In one communication episode, Dr. Dix is in her office working on the computer. Dr. Dix's colleague enters the office and proceeds to sit down at the adjacent desk. Dr. Dix's colleague begins telling her about one of his patients. As Dr. Dix's colleague explains problems the patient is experiencing, Dr. Dix is focused as she shakes her head and listens. Her colleague soon asks Dr. Dix her advice on the patient and the problem. Dr. Dix is competent, focused, and technical in her reply. Dr. Dix turns around at her desk, making direct eye contact with her colleague. Dr. Dix's response is quick and precise, while using technical medical jargon. Dr. Dix also uses various hand gestures, while shaking her head and nodding when talking. Dr. Dix enacts *The Technician* role as she interacts with her colleague regarding a problem a patient is experiencing. Dr. Barton's communication with other physicians is also technical.

Well when I communicate with physicians, it's usually with physicians

that are referring me to difficult patients and so, when I speak with them,

it's a lot more technical.

Because many of their interactions are professionally based, such as referring patients to colleagues, physician-physician interactions are seemingly more technical.

Dr. Anderson explains how her interactions are not only technical, but how she tries to make other physicians jobs easier.

With other doctors, I tend to be aware of what their experiences are and I have a lot of respect for their area of expertise. I try to make sure that I make their work as easy as possible. When I was an intern…we had a meeting with my team at the beginning of each rotation and toward the end of my internship… I got really comfortable with what I was doing and tried to convey to the resident that my job was to make his job easier…that he didn't have to do anything. And that's kind of the way that I think of it, say, when I send somebody to another subspecialist. I want to make sure that they don't have anything missing, that they have everything they need to do their job, because their time, like my time, is very important.

In Dr. Anderson's example, she explains that she likes to make other physicians' work as easy as possible. This is because she understands their time is very important, like her own. Dr. Anderson can empathize with other physicians and relate to their experiences.

Not all observed physician-physician interactions were based on technical aspects of the physician's job. Some of the observed physician-physician interactions were friendly and relaxed. One example is when Dr. Dix speaks on the phone to another

colleague. Dr. Dix begins the phone conversation by saying "Hello Dr. (last name), this is Dorothea." By addressing her colleague as Doctor, Dr. Dix displays her respect for her colleague. As the phone conversation continues, Dr. Dix is very casual and friendly. Often times Dr. Dix makes a joke and uses phrases such as "you suck," and "shut up." Throughout the conversation, Dr. Dix laughs and uses a lot of vocal inflection. It is evident from her communication during her phone conversation with her colleague, that Dr. Dix is enacting the role of *The Friend*.

Summary of Findings

This research sought to discover how female physicians enact different roles as they participate in a variety of workplace relationships and contexts. Five main themes were discovered regarding physician role enactment: focus on patient understanding, empowerment of the patient, adapting to the patient, technical and appreciative, and technical aspects of the job. The resulting themes highlight the centrality of communication and the importance of interaction for role enactment. The findings also support previous scholarship in that individuals constantly enact roles through interaction with others (Zurcher, 1983).

The results of the study found that female physicians enact different roles as they participate in various interactions with patients, staff, and other physicians. Physician roles are identified based on the specific context of the interaction and through physician's communicative behaviors. Four physician roles were identified in this study; *The Advocate, The Technician, The Gentle One*, and *The Friend*. Each physician was

found to enact these roles during her interactions within the clinic.

<u>Female Physician-Patient Interaction</u>

One of the main themes that emerged from physician-patient interaction was the physicians' focus on patient understanding. In order to help facilitate patient understanding, physicians often used lengthy explanations. During this time, physicians enacted the role of *The Technician*. Physicians' communication was direct, focused, and often used gestures and diagrams. This type of communicative behavior exhibited the physician's competency and put the patient at ease. A physician's role often changed to *The Gentle One* or *The Friend* after it appeared that the patient understood the physician's explanation. During this new role, physicians often touched their patients. They would touch patients' legs or backs, in a non-exam related, appropriate way. Physicians would also joke and laugh with their patients. Consistent with interactionist theory, it seemed that physicians took cues from their patients when undertaking a particular role. Often times a patient would make a joke and laugh, in response the physician would laugh as well. Physicians also seemed to make more jokes when their interaction with their patients was perceived to be more social and comfortable.

Of greater interest was the enactment of *The Friend* role during difficult and tense moments in the interaction. Many of the female physicians observed often used a joke or smile to ease tension. Some physicians made a joke about the treatment process a patient might need to go through or the way a wound was looking post-surgery. An example of this was when a patient was telling Dr. Dix about concerns she/he had related to her/his family's long history of medical issues. Dr. Dix replied, "Well other than your family's

phenomenal family history…" with a laugh and a smile.

From an outsider's perspective, it would seem as though physicians were being callous or insensitive: however, it was quite the opposite. Physicians seemed to use this type of communicative behavior to put the patient at ease. When it was clear that patients were upset, physicians smiled and said a small joke in an effort to let the patient know that everything would be alright and it might not be as bad as it sounds. Physicians' role-related behaviors exhibited understanding and care for patients during a difficult time in the interaction.

Another important theme that emerged in this study was how female physicians enacted *The Advocate* role. An important function of *The Advocate* role is educating and teaching. Physicians seemed to take on *The Advocate* role when empowering patients to make their own decisions regarding their health. Part of empowering the patient is educating the patient about their medical issues. Empowerment also comes from teaching the patient preventative measures. Through education, teaching, and counseling, female physicians empowered patients to make their own decisions regarding their treatment.

Another emerging theme was the adaptation to patient's communication behavior. Theorists have often argued that individuals develop and change their roles through communication with other organizational members (Apker, 2001; Graen, 1976). This was true of the female physicians observed. Many of the physicians seemed to take communication cues from their patients during interactions. When interactions became more serious and patients were describing problems, many of the physicians enacted *The Technician* role. Physicians became focused, listened intently, maintained eye contact,

sometimes squinted their eyes and nodded their heads as they listened. Physicians were often precise and competent in their replies to patient problems. Sometimes after the physician's response, patients would make a joke and laugh. Physicians often adapted their behaviors and would begin to laugh, thus enacting a new role.

One physician participant said that she often mirrored her patient's communication style. When she sensed that a patient had a more formal communication style, she would adapt her own style and begin communicating in a formal way. Adapting her communication style was an effort to make the patient more comfortable and feel like she was on their side.

Female Physician-Staff Interaction

Physician interaction with staff occurs on a daily basis. The results of this study found that physician-staff interaction is important to the success of any medical practice. Of greater interest is how physicians enact different roles as they interact with staff members. One of the main themes that the study found regarding female physician role enactment within physician-staff interaction was that female physicians often played the role of *The Technician*. Physician-staff interactions tended to be more technical. Physicians often used technical terms when interacting with staff. Their communication tended to be more directive, focused, and task-oriented. Many of the physician-staff interactions took place in the exam room when a nurse was assisting the physician or at the nurses' station when the physician was requesting an instrument. Therefore, based on the context of the interaction, physicians tended to enact *The Technician* role.

Not all physician-staff interactions were based on technical aspects of the job. In some cases physicians enacted *The Gentle One* role when interacting with their staff. One physician tended to apologize to her staff when she felt like she was making their job more difficult, for example, asking for an instrument that was difficult for staff to find, or asking her staff to call a demanding patient.

Other physicians enacted *The Friend* role when interacting with staff. One physician joked with staff members in the hall during her breaks between patients. She would smile and laugh with staff. She would also tell non-work related stories with nurses at the nursing station.

Female Physician-Physician Interaction

A final theme that emerged in this study was the focus on technical aspects of the job. This study found that many of the physicians observed enacted *The Technician* role when interacting with other physicians. Although physician-physician interaction observations were limited, interview findings corroborate observations. Many of the physicians stated that their interactions with other physicians were more technically based. This is due to the fact that many of their interactions with other physicians are based on referrals or medical advice.

One physician enacted *The Technician* role when interacting with her colleague. In the interaction, her colleague was describing a patient's medical problems. After he/she was done describing the problems, her colleague asked for her medical advice.

She quickly became focused, technical, and precise in her response. Thus, she enacted *The Technician* role in this particular interaction with her colleague.

The results of the study illustrate *how* female physicians enact different roles as they participate in a variety of workplace relationships and contexts. In this study, communication is found to be central in the process of physician role enactment. The five themes that emerged from this study highlight the importance of communication and interaction for role enactment.

DISCUSSION

Prior theorists have argued that roles are constructed and shaped through communication (Apker, 2001). Additionally, scholars believe that we develop and change our roles through communication and interaction with other organizational members (Apker, 2001; Graen 1976). Further research indicates that roles are enacted and understood as part of ongoing, social interaction (Apker, 2001; Weick, 1979; 1995). This study supports this line of scholarship and also shows that, within the clinical setting, female physicians change their role based on specific interactions with patients, staff, and other physicians. In addition, research findings also indicate that physicians adapt their behaviors, based on the interpretations of other's communication behaviors (both verbal and non-verbal). Thus, various themes have been identified regarding *what* roles female physicians enact and *how* female physicians enact different roles as they participate in various workplace interactions.

Four "physician's roles" were identified as primary themes: *The Advocate*, *The Technician*, *The Gentle One* and *The Friend*. Physicians enacted these roles, based on the context of their interactions with patients, staff, and other physicians. The results of this study found five main contextual themes in which physicians enacted one or more of the four roles. These themes exist within female physician-patient interaction, female physician-staff interaction, and female physician-physician interaction. During female

physician-patient interaction, three contextual role enactment themes emerged: focus on patient understanding, empowerment of the patient, and adapting to the patient. During female physician-staff interactions, emphasis was placed on technical knowledge of the staff and physicians appreciation for the staff. Finally, during female physician-physician interactions, the focus of the interaction was on technical aspects of the job.

Throughout the identification of "physician's role" and the resulting themes, interaction and communication are seen to be central for role enactment. The results indicate, along with previous research, that "physician's roles" are given meaning and produced through interaction with others. Results also contribute to previous symbolic interactionist scholarship, where emphasis lies in the mediating importance of the meaning of stimuli, which arises out of interaction (Longmore, 1998).

It is also through interaction with patients, staff, and other physicians that female physicians interpreted other's behaviors, adapted their own behaviors and enacted appropriate roles. This connects with previous research in that communication enables individuals to enact different roles and allows other members to define and respond to role behaviors (Apker, 2001).

The roles physicians enacted throughout this study were dependent on the context of the interactions. Previous scholars have argued that roles are behavioral processes that are best understood as the enactment and product of social interaction (Apker, 2001; Zurcher, 1983). The behavioral roles that were identified in this study emerged from such social interactions.

It was based on female physicians' verbal and nonverbal role-related behaviors within specific contextual interactions with various individuals that roles such as *The Technician*, *The Advocate*, *The Gentle One*, and *The Friend* became identifiable.

Previous literature has examined how individuals develop and change their roles through communication with other individuals (Apker, 2001; Graen, 1976). This study found that female physicians change their roles based on the context of the interaction. The resulting themes highlight the importance of the context of interactions in the enactment of physician roles. For example, it was found that when female physicians were communicating with a patient for understanding, most of the observed physicians enacted *The Technician* role, followed by *The Friend* or *The Gentle One*. Of greater interest was the process by which these different roles were enacted by female physicians. Female physicians enacted various roles through the use of different verbal and nonverbal communicative behaviors. The overt role-related behaviors of the female physicians correlate with previous research pertaining to role playing. Scholars have defined role playing as the overt enactment of one's role as appropriate to a given situation (Kelley, Osbourne, & Hendrick, 1974).

Prior research has explored how roles become known. Results of this study support the idea that physician socially construct the roles that guide their interactions. Scholars have defined social construction as a process of social interaction by which individuals acquire and learn skills, knowledge, language, beliefs, and values (Longmore, 1998). Contemporary symbolic interactionists also emphasize that individuals enact socially constructed roles (sex roles, family roles, work roles) (Longmore, 1998). This

study contributes to this line of scholarship in that female physicians were able to enact roles in particular contexts because of experiences and expectations of appropriate behaviors. Some of the female physicians enacted *The Gentle One* role during times that patients seemed in pain. Individuals are socialized to exhibit compassion when interpreting that an individual is in pain. Compassion through the enactment of *The Gentle One* role is exhibited through verbal and nonverbal communicative behaviors such as touching.

Further, according to Biddle (1979), individuals are exposed to experiences that lead them to form similar expectations for their own roles, which in turn lead them to exhibit appropriate role behaviors. Based on female physicians' experiences, they are able to enact appropriate role behaviors when they enter into a specific contextual interaction. It is through interaction with patients, staff, and other physicians that female physicians' enacted roles become objectified features of the social world and become identifiable to others.

Scholars have found that schema scripts provide an exploratory dimension to the concept of roles (Giola & Poole, 1984). Much like the socialization of roles, a schema script is held in an individual's memory. It describes behaviors appropriate for a particular context. Although this study did not explore female physicians schema scripts, scripts do provide an exploratory explanation of how individuals act within an organization.

The findings of this study connect with previous research conducted on schema scripts. The results of the study illustrate that female physicians interpret or take cues

from others during interactions. Thus, female physicians will adapt their own behaviors in order to enact appropriate role behaviors. Scholars have found that individuals will perform a schema script based on the processing of conscious or unconscious organizational cues given off by another during an interaction (Giola & Poole, 1984). Both scripts and roles are cognitive and behavioral structures that provide a framework for appropriate behavior in a specific context. This study's findings about female physician role enactment complement the notion of schema scripts.

The results of this study also contribute to previous literature concerning gendered communication. With this study's focus on female physicians, it is difficult to overlook the impact of gender roles on communication. In the past, scholars have found that women use more emotional language as well as using words such as "lovely," "nice," and "pretty" (Kelly, 1991). This contributes to the claims that feminine communication is more expressive. In this study, female physicians often used words such as "beautiful," "lovely," and "amazing," during times that they were complimenting a patient or examining a wound that was healing nicely. Scholars have also found that women's pitch levels expand as women express themselves (Kelly, 1991). This was also evident in this study's findings. When female physicians were enacting *The Friend* role, often times their pitch levels raised. When female physicians changed their role from *The Friend* to *The Technician*, the pitch of their voice lowered.

Nonverbal communication is an important element of female physician role enactment. Previous scholars have said that women tend to use smaller gestures than men, as well less space (Evans & Howard, 1973). The findings show that the female

physicians observed actually used many gestures when explaining to patients for understanding. When female physicians enacted *The Technician* role, they often used many hand gestures in order to explain a patient's diagnosis.

Other scholars have highlighted the importance of eye contact in the maintenance of interpersonal relationships. Researchers have found that women tend to look at another person during conversation more than men do (Payne, 2001). In this study, all of the female physicians maintained eye contact with patients, staff and other physicians when enacting *The Technician* role, *The Gentle One*, or *The Advocate*. Eye contact seemed important in the enactment of most roles, depending on the context of the interaction. Especially during patient exams, eye contact with patients seemed to help establish the interpersonal relationship between female physician and patient.

Payne (2001) has also found that women tend to initiate hugs, touches that express support, affection, and comfort with others. The findings of this study found that female physicians tended to touch patients on their legs, back, or shoulders in a non-exam related way throughout their interactions. Through this nonverbal behavior, female physicians were enacting *The Gentle One* role.

The findings of this study indicate that female physician's enact a number of different roles throughout various interactions. These roles change based on the context of the interaction and are enacted through different role-related behaviors. It is within female physicians' interactions that physicians interpret others' behaviors, adapt their own, and enact new roles. These roles are embedded in the social network and become identifiable to others. Although female physicians may enact roles consciously or

unconsciously, this study's findings create awareness for those little known roles that are embedded within the institutional walls of the clinic.

Further importance of this study has to do with women in the workforce. Many women are faced with the challenge of balancing feminine and masculine communication styles (Kelly, 1991). This challenge is especially likely in areas where women are granted significant power, such as physicians.

In most contexts, decisiveness, assertiveness, taking initiative, and taking charge are vital for successful leadership (Kelly, 1991). However, females who exhibit these behaviors are often chastised for being unfeminine, bitchy, bossy, and pushy (Kelly, 1991). In many cases, physicians are expected to be competent, technical leaders. Female physicians are often faced with the challenge of being competent, assertive, and direct, while maintaining compassion for others. This study helps us understand how women negotiate those oppositional roles. In the case of the female physicians observed in this study, they negotiated these issues by changing their roles based on the context of their interactions. Female physicians tended to enact whatever role was appropriate for the given context, regardless of if it was a stereotypical masculine or feminine role.

Limitations

There are a number of limitations to this study. The first significant limitation was the amount of time spent in the field. Due to external circumstances and time constraints, observations were limited to 30-40 hours spent in the field for the duration of one week. Although the number of hours spent in the field provided a useful 'snapshot' of the

process of female physician role enactment and experiences, more time observing and recording female physician interactions would have provided an even richer, more detailed description of their organizational interactions.

The second limitation was the number of participants. It was the aim of the study to understand and interpret how female physicians enact different roles. In addition, this study was an exploratory study which had the aims of identifying types and processes that could be tested in subsequent research. Because this study does not attempt to generalize the findings across all women who are physicians, five participants seemed sufficient.

The current study has a number of limitations regarding role enactment. The focus of this study was finding themes regarding *what* roles female physicians enact and *how* those roles are enacted. The findings show that the roles participants enacted were similar in the same contextual interactions. With a larger sample size, other roles may emerge beyond the four roles identified in this study. Thus, the results of this study are limited in scope. Further, the focus of this study was not about others' perceptions of physician's roles, but the researcher's interpretation of interactions and physicians' role-related communicative behaviors.

An additional limitation of this study was within the method of observation and interviews. Because individuals are aware of being observed, they may alter their communication behaviors. As a result, findings may not be based on an individual's behaviors in a natural or unobserved context. Limitations also lay in the method of interviews. During this study, interviews were conducted with each of the participants.

Interviews consisted of five questions and lasted for 10 minutes. Due to physicians' schedules, time constraints, and location of research sites (in the State of Washington), follow-up interviews were not conducted. Follow-up interviews would have helped to clarify previous interview questions and provided greater detail about physician interactions and experiences.

Finally, results of this study were based on interpretation. As with any observational study, observations are filtered through the researcher's interpretive frame and those imposed by the theories one uses to identify and interpret data (Schensul, Schensul & LeCompte, 1999). Thus, biases and values exist prior to observation in the field.

CONCLUSION

This study sought to go within the institutionalized walls of the medical clinic and explore how female physicians enact different roles as they participate in various interactions. Further, the study attempted to understand how roles embedded within the social network are constructed through communication with other organizational members. Findings from the study indicate that different roles emerge depending on specific contextual interactions. It is through interaction with others that roles are produced and understood. Additionally, enacting various roles within interactions allows others to define and respond to role behaviors.

The results suggest that female physicians enact roles through various communicative behaviors. In the study, various role-related behaviors were identified and explored. The findings indicate that the use of certain role-related behaviors during specific interactions led to role enactment. It was found that female physicians enacted four different roles throughout a variety of interactions. During these clinical interactions, physicians interpreted others' behaviors, adapted their own behaviors and enacted appropriate behaviors dependent on the specific interaction. Throughout interactions with patients, staff, and colleagues, it was evident that physicians changed their roles based on the context of the interaction.

The research findings also support previous scholarship concerning the social construction of roles. Roles are learned and become identifiable through the process of socialization. It is through our interactions with others that roles are given meaning and appropriate role behaviors are learned. Further, through social discourse, physician's roles are objectified and become features of the social network. Thus, we are able to identify the roles that physicians are enacting.

This study also contributes to research on role enactment by exploring *how* and by what communication processes female physicians enact roles. Although the study does not attempt to generalize its findings, it does provide a rich description of the process of physician role enactment within the specific observed clinical settings. Additionally, this study creates awareness among physicians about the little known roles one enacts that are embedded within one's social network.

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APPENDIX

Documents Used in Study

Patient Informed Consent Form

CONSENT TO BE A RESEARCH PARTICIPANT
BOISE STATE UNIVERSITY

A.   PURPOSE AND BACKGROUND

Katie Bohannon Booth (Graduate Student) of the Department of Communication at Boise State University is conducting a thesis project entitled "**The role of a female physician**." This study aims to understand how female physicians enact various roles as they participate in a variety of contexts and relationships.

B.   PROCEDURES

Your participation will involve:

Allowing me to observe the communicative interaction between yourself and the physician. As a participant, you will *not* be a focus in this study or directly observed.

In order to research the role of a female physician, I need to witness physician-patient interaction, physician-staff interaction and physician-physician interaction.

As the researcher, I will *not* access any confidential medical records. Any confidential information that is exchanged between yourself and the physician at any time during this study will not be used as data in this research project.

Throughout the observation of the interaction, the researcher will be taking field notes. The researcher's field notes will *only* focus on the physicians communicative behaviors throughout the interaction.

All research will be performed at various medical clinics in Washington. The total time for observation will vary depending on your interaction with the physician.

C.   RISKS/DISCOMFORTS

1. Confidentiality: Katie Booth will *not* access any confidential medical records. Any confidential information that is exchanged between yourself and the physician at any time during the study will not be used as data in this research project.
2. Personal identities and personally identifiable information are protected. The field of medicine and medical clinic will be kept confidential as well. No individual or medical clinic will be used in any reports or publications that may result from this study.
3. The observation of daily interactions may make the participant feel

uncomfortable. *At any time*, the participant may ask Katie Booth to cease observation, *even if* the participant has signed a consent form and agreed verbally. The participant may withdraw from observation, *at any time*, before or even during observation of interaction.

4. Patient vulnerability: At any time that an individual might feel uncomfortable the patient or the physician may ask the researcher to leave the room. Katie Booth will exhibit non-threatening body language (e.g. sitting in the corner of the room, keeping distance from the patient and physician, minimal gestures and or body movement, legs crossed). Katie Booth will also avert eyes, and avoid any inappropriate eye contact as to reduce the feeling of vulnerability. Katie Booth will use limited comments when spoken too.

D.   BENEFITS

The information provided by this study will help create awareness among physicians about how physician roles are enacted, while participating in a variety of contexts and relationships. The study will help facilitate understanding about how we change roles based on our interactions. With an awareness of what roles physicians enact, physicians will be able to communicate in a variety of contexts, more effectively and efficiently. This can lead to physicians providing better services within their profession. Your participation in this study, also allows physicians to become aware of their communication with you, the participant. Thusly, helping to facilitate more effective communicative behaviors for physicians in physician-patient, physician-physician and physician-staff interaction.

E.   COSTS

There will be no costs to you as a result of taking part in this study, other than the time spent to participate.

F.   PAYMENT

There will be no payment for participation in this study.

G.   QUESTIONS

If you have any questions or concerns about participation in this study, you should first talk with the investigator (Katie Bohannon Booth, Boise State University, Department of Communication
1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404, or Dr. Heidi Reeder, Boise State University, Department of Communication 1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404) If for some reason you do not wish to do this, you may contact the Institutional Review Board, which is concerned with the protection of volunteers in research projects. You may reach the board office between

8:00 AM and 5:00 PM, Monday through Friday, by calling (208) 426-5401 or by writing: Institutional Review Board, Office of Research Compliance, Boise State University, 1910 University Dr., Boise, ID 83725-1138.

Should you feel discomfort due to participation in this research you may contact the Washington State Department of Social and Health Services, 1-800-737-0617.

H.   CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as an employee of your clinic of employment or your status as a patient of the respective medical clinic in which you are being observed.

I give my consent to participate in this study:

Signature of Study Participant   Date

Signature of Person Obtaining Consent   Date

THE BOISE STATE UNIVERSITY INTSTITUTIONAL REVIEW BOARD HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICPANTS IN RESEARCH.

Physician Permission Letter

April 13, 2009

Katie Bohannon Booth
Department of Communication
Boise State University 1910 University Drive
Boise, ID, 83725

Dear Katie Booth

I have reviewed your request regarding your study and am pleased to support your thesis project entitled "The Role of a Female Physician". Your request to use the clinic as the site of your thesis study as well as observe and conduct a 10-20 minute interview with me (the physician participant) in clinic is granted. The study will include observing the communicative interaction between me (physician)-patients, me (physician)-staff and me (physician)-other physicians within the clinic. This authorization covers the time period of spring 2009. We look forward to working with you.

Sincerely,

Dr._____

If not in private practice, administrative approval is needed as well.

_____
Name

_____
Administrative Title

Physician Informed Consent Form

CONSENT TO BE A RESEARCH PARTICIPANT
BOISE STATE UNIVERSITY

A.   PURPOSE AND BACKGROUND

Katie Bohannon Booth (Graduate Student) from the Department of Communication at Boise State University is conducting a thesis project entitled "**The role of a female physician**." This study aims to understand how female physicians enact various roles as they participate in a variety of contexts and relationships.

B.   PROCEDURES

If you agree to be in this study, the following will occur:

You will be observed for the duration of up to eight hours, at clinic or the hospital. During that time the researcher will be taking field notes.

You will be interviewed for 10 minutes by the researcher. The interviews will be audio taped.
The researcher will listen to and transcribe the audio taped interviews.

Transcribe interviews and field notes will be analyzed in order to identify patterns of roles female physicians enact throughout their interactions.

All research will be performed at various medical clinics located in Washington. The total time for observation and interviews may take up to eight hours.

You understand that as a Graduate Student, I will respect your discretion/ better judgment if you feel that it would be in the best interest of the patient not to be observed.

C.   RISKS/DISCOMFORTS

5. Confidentiality: Only Katie Booth will have access to recordings and transcripts. Recordings provided by myself will be transcribed using pseudonyms such that personal identities and personally identifiable information are protected. The field of medicine and medical clinic will be

kept confidential as well. All of these forms will be stored in a computer password protected system in order to protect them from disclosure.
6. The recordings provided will be destroyed at the conclusion of the study.
7. No individual or medical clinic will be used in any reports or publications that may result from this study.
8. Vulnerability Risks: Having daily interactions observed might make you/ the participant uncomfortable and at any time you may withdraw from participation.

E.   BENEFITS

The information provided by this study will help create awareness among physicians about how female physicians enact different roles, while participating in a variety of contexts and relationships. The study will help facilitate understanding about how we change roles based on our interactions. With an awareness of how physicians enact different roles, physicians will be able to communicate in a variety of contexts, more effectively and efficiently. This can lead to physicians providing better services within their profession.

E.   COSTS

There will be no costs to you as a result of taking part in this study, other than the time spent to participate.

F.   PAYMENT

There will be no payment for participation in this study.

G.   QUESTIONS

If you have any questions or concerns about participation in this study, you should first talk with the investigator (Katie Bohannon Booth, Boise State University, Department of Communication
1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404, or Dr. Heidi Reeder, Boise State University, Department of Communication 1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404) If for some reason you do not wish to do this, you may contact the Institutional Review Board, which is concerned with the protection of volunteers in research projects. You may reach the board office between 8:00 AM and 5:00 PM, Monday through Friday, by calling (208) 426-5401 or by writing: Institutional Review Board, Office of Research Compliance, Boise State University, 1910 University Dr., Boise, ID 83725-1138.

Should you feel discomfort due to participation in this research you may contact the Washington State Department of Social and Health Services 1-800-737-0617.

H.   CONSENT

You will be given a copy of this consent form to keep.

PARTICIPATION IN RESEARCH IS VOLUNTARY. You are free to decline to be in this study, or to withdraw from it at any point. Your decision as to whether or not to participate in this study will have no influence on your present or future status as a physician or the clinic in which you practice.

I give my consent to participate in this study:

Signature of Study Participant	Date

I give my consent to be audio taped in this study:

Signature of Study Participant	Date

Signature of Person Obtaining Consent	Date

THE BOISE STATE UNIVERSITY INTSTITUTIONAL REVIEW BOARD HAS REVIEWED THIS PROJECT FOR THE PROTECTION OF HUMAN PARTICPANTS IN RESEARCH.

Staff Informed Consent Form

CONSENT TO BE A RESEARCH PARTICIPANT
BOISE STATE UNIVERSITY

A.   PURPOSE AND BACKGROUND

Katie Bohannon Booth (Graduate Student) of the Department of Communication at Boise State University is conducting a thesis project entitled "**The role of a female physician**." This study aims to understand how female physicians enact various roles as they participate in a variety of contexts and relationships.

B.   PROCEDURES

Your participation will involve:

Allowing me to observe the communicative interaction between yourself and the physician. As a participant, you will *not* be a focus in this study or directly observed.

In order to research the role of a female physician, I need to witness physician-patient interaction, physician-staff interaction and physician-physician interaction.

As the researcher, I will *not* access any confidential medical records. Any confidential information that is exchanged between yourself and the physician at any time during this study will not be used as data in this research project.

Throughout the observation of the interaction, the researcher will be taking field notes. The researcher's field notes will *only* focus on the physicians communicative behaviors throughout the interaction.

All research will be performed at various medical clinics in Washington. The total time for observation will vary depending on your interaction with the physician.

C.   RISKS/DISCOMFORTS

9. Confidentiality: Katie Booth will ***not*** access any confidential medical records. Any confidential information that is exchanged between yourself and the physician at any time during the study will not be used as data in this research project.

10. Personal identities and personally identifiable information are protected. The field of medicine and medical clinic will be kept confidential as well. No individual or medical clinic will be used in any reports or publications that may result from this study.

11. The observation of daily interactions may make the participant feel uncomfortable. ***At any time***, the participant may ask Katie Booth to cease observation, ***even if*** the participant has signed a consent form and agreed verbally. The participant may withdraw from observation, ***at any time***, before or even during observation of interaction.

12. Patient vulnerability: At any time that an individual might feel uncomfortable the patient or the physician may ask the researcher to leave the room. Katie Booth will exhibit non-threatening body language (e.g. sitting in the corner of the room, keeping distance from the patient and physician, minimal gestures and or body movement, legs crossed). Katie Booth will also avert eyes, and avoid any inappropriate eye contact as to reduce the feeling of vulnerability. Katie Booth will use limited comments when spoken too.

F.   BENEFITS

The information provided by this study will help create awareness among physicians about how physician roles are enacted, while participating in a variety of contexts and relationships. The study will help facilitate understanding about how we change roles based on our interactions. With an awareness of what roles physicians enact, physicians will be able to communicate in a variety of contexts, more effectively and efficiently. This can lead to physicians providing better services within their profession. Your participation in this study, also allows physicians to become aware of their communication with you, the participant. Thusly, helping to facilitate more effective communicative behaviors for physicians in physician-patient, physician-physician and physician-staff interaction.

E.   COSTS

There will be no costs to you as a result of taking part in this study, other than the time spent to participate.

F.   PAYMENT

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1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404, or Dr. Heidi Reeder, Boise State University, Department of Communication 1910 University Drive Boise, Idaho 83725-1920 Phone: 208-426-2404) If for some reason you do not wish to do this, you may contact the Institutional Review Board, which is concerned with the protection of volunteers in research projects. You may reach the board office between 8:00 AM and 5:00 PM, Monday through Friday, by calling (208) 426-5401 or by writing: Institutional Review Board, Office of Research Compliance, Boise State University, 1910 University Dr., Boise, ID 83725-1138.

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I give my consent to participate in this study:

Signature of Study Participant	Date

Signature of Person Obtaining Consent	Date

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Physician Interview Questions

1. Looking back, what was your motivation to become a physician?

2. How would you describe yourself as a physician?

3. Tell me about how you interact with patients, nurses and other physicians?

4. What are some traits that you possess that might be counteractive to your work-or might limit your work?

5. Tell me about a time when you experienced role conflict? For example, your child was home sick, yet you had to go into work and deal with a difficult patient, etc.

Table 2: Physician Interaction Codes and Categories.

Personal	Personal Remarks, social conversation
Laughs	Laughs, tells jokes
Concern	Shows concern or worry
R/O	Reassures, encourages, shows optimism
Smiles	Smiles and nods
BCR	Back-channel responses
Touching	Touching (non-exam) related
Proximity	Sitting or standing in close physical proximity
EC	Eye contact
Comp	Gives compliment
SD	Self-disclosure statements
Sigh	Sigh, deep breath, exasperated
Directs	Directs behavior
Instruct	Gives instructions, explanations
Requests	Requests information or instruments
Clarify	Asks for clarification, understanding
Gesture	Gesturing during interaction

TL	Technical language
NT	Non-technical language