To be or not to be … a patient: identity construction of healthcare professionals and patients in public online diabetes-related interaction[1]

Running head: **Identity construction in online diabetes-related interaction**

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Abstract

This study offers an analysis of medical and emotional identity features put forward by participants asking questions and providing answers in three types of public online diabetes-related interaction in Spanish (frequently asked questions, chat sessions and fora). The results show that many writers present themselves not as diabetics but as relatives of a diabetic, or else refrain from

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specifying their relation to diabetes. Furthermore, as no shared patient-professional identity is constructed, the healthcare relationship profiled is a rather traditional one. The differing natures of the platforms and genres are reflected in the identities constructed. In the FAQs a more impersonal or collective identity is apparent, whereas that constructed in the forum tends to be more personal, with more emotional aspects; the chat data occupy an intermediate position.

Keywords: identity, reference, online discourse, healthcare interaction, pragmatics, deixis, Spanish

1 Context and research aims

In this chapter, I present an analysis of identity construction in public online interaction on the topic of diabetes, with particular attention being paid to the identity construction of patients and healthcare professionals in this type of interaction. I also study whether this identity construction reflects a traditional patient-healthcare professional relationship or rather a relationship of co-responsabilisation (Salvador and Macián 2009). This chapter thus focuses on a very specific context in which identity and reference play a crucial role in constructing a professional relationship and in attributing responsibility.

In this section, I will briefly discuss the nature of diabetes and I will introduce the emergence of e-health and the co-responsabilisation of patients (1.1), leading into a discussion of the study's research aims (1.2). In Section 2, I will then present the methodology and data before, in Section 3, examining the representation of patients (3.1) and their relatives (3.2), and of healthcare professionals (3.3). Finally, I will offer some concluding remarks about identity construction in online interactions on diabetes (Section 4).

1.1 Context

Diabetes can take three forms. Type 1 diabetes typically appears at a young age. Patients play an active part in their treatment and in decision-making about it by, for example, self-controlling glucose levels in the blood and self-administering insulin injections. Type 2 diabetes is typically developed later in life and may be treated with pills or injections. Both these types are chronic health conditions which will affect patients for the rest of their lives. As a result, the condition may become part of their identity. Gestational diabetes, which occurs during pregnancy, does not necessarily become chronic but may do so. It has been shown in sociological research on chronic illness that adapting one's own biography (including one's conception of self) is one of the crucial factors in accommodating to such a condition (in addition to dealing with medical and emotional issues) (Corbin and Strauss 1988:50).

Thus, creating one's own biography and constructing a personal identity form part of the management of chronic illness. This makes the study of self-representation particularly relevant in the case of diabetes.

Additionally, in view of the significant changes the relationship between patient and healthcare professional seems to be undergoing, the study of other representation in medical interaction is becoming increasingly important. Indeed, a generally increased co-responsibilisation (Salvador and Macián 2009) of the patient can be observed in many medical interactions, as well as a rising demand for patient participation (Keel and Schoeb 2017). Similarly, it has been shown that treatment can be constructed as a "joint purpose" (Antaki and Crompton 2015). This is particularly relevant since, as well as the professional's communication with the patient (Haskard Zolnierek and DiMatteo 2009), the active involvement of the patient in decisions (Rollnick et al. 2008; Drew et al. 2001) plays a role in treatment adherence. The very active role that diabetics assume in their treatment on a daily basis underlines this and contributes to the significance of their co-responsibility. In view of its link with treatment adherence, the topic of self and other representation in the medical context is important not only from a discursive or linguistic point of view, but also from a medical or psychological one.

The data studied in this paper are taken from public online interactions, given the increasing importance of online communication for self-expression and identity construction, and for communication concerning healthcare issues. However, the role that the internet can legitimately play in healthcare is currently the subject of discussion. Some warn of the negative effects of “Doctor Google”; concerns in this regard relate to the ready availability of unmonitored and not necessarily reliable information, and to self-diagnosing by laypersons. And, in fact, studies on professionals’ practices to enhance therapy adherence have revealed a “low reported use of technology and other resources to support patients with medicines used in routine practice” (Clyne et al. 2016:8). Others, however, say that digital media have advantages in terms of facilitating access to information (Kerr et al. 2006), in public education and awareness raising, and in offering assistance for self-management (Pal et al. 2018). Indeed, the use of websites and apps in support of treatment or self-management is being studied with a view to meeting the ever-increasing demand for information and to reaching non-native speaker publics (De Wilde et al. 2019). Moreover, the internet also allows patients to contact other patients and to exchange experiences and ideas (Liu et al. 2017), which has been shown to be a way of obtaining more healthcare information and of supporting one another (Loader et al. 2002).

The healthcare professionals providing information in the data analyzed in this study work for official healthcare institutions, and two of the data sets were posted directly on the websites of official healthcare agencies, showing that they have thus opted for using new forms of digital communication in order to spread information. They therefore (at least implicitly) support the tendency towards valuing online communication as a useful extra tool in healthcare communication. The online interaction studied in this paper is public in nature, yet with varying degrees of general scope and (a)temporal scope, as we will see in Section 2, which introduces the data studied.

1.2 Research aims

This research is concerned with how the self and other are represented in public digital interactions on the topic of diabetes. It investigates the identity categories, of both patients and healthcare professionals, made relevant by participants asking questions in (the pre-expansion to) their queries and those categories subsequently exploited and made consequential by participants providing answers. In other words, it will look into those identity features put forward and commented upon by participants that play a role in the development of the interaction concerned. These include not only identity features strictly relevant from a medical perspective, but also more personal or emotional information. Furthermore, I will study whether the participants contribute jointly to constructing the identity of patients and healthcare professionals as a collective identity, or rather as separate entities, which are not co-responsible for the treatment. I will also look into differences in identity construction between the three interaction types discussed, namely an FAQ section, chat data and a medical discussion forum.

2 Methodology and corpus

The focus of this paper is on the way participants formulate and answer questions in the data studied and how this contributes to the construction of the self and other. In particular, I analyze how identity is constructed throughout entire interactions, rather than in individual utterances, by studying how the participants asking and answering questions present themselves – and, if they do so, others – indexically in the context of the interaction. In doing so, I draw on insights from pragmatics, conversation analysis, discourse analysis and discursive psychology, as well as on sociological research into healthcare interaction.

Identity being a multi-layered concept (De Fina 2010), the focus of this analysis will be on those identity features that are ascribed to the interaction's participants by themselves and by others. Thus, I will study those features that, in conversation analytic terms, are made relevant and consequential in the interaction. They are made relevant if they are somehow under discussion or taken up in the ongoing interaction, and they are consequential if they have "some visible effect on how the interaction pans out" (Antaki and Widdicombe 1998:5), for instance, by being commented upon explicitly in the unfolding interaction. Of course, this also implies that there are some features which participants decided not to make relevant, but which may be considered interesting for the interaction at hand. Not all participants, for instance, specify their personal relationship to diabetes, although this information may be useful in the interaction. The absence of such features will also be discussed. Indeed, as has been shown in studies on self-disclosure in blogs (see Salonen 2018), the information disclosed contributes to constructing an identity. In the data analyzed in this chapter, part of this disclosure is of course motivated by the wish to receive an adequate answer to a specific question, for which the participants may need to disclose identity features. Given the type of interaction under study, the relational pair (Sacks 1995:327) patient-healthcare professional seems to be the most evident one by which to categorize the participants, but we will see that it is by no means the only one appearing in the data.

As regards self-representation, I will look into self-definition and self-description through constructions with 1st person deictic forms. For other-representation, I will take into account interlocutor references but also address forms and ratification of an interaction participant by means of 3rd person forms. Spanish being a pro-drop language, both person reference expressed in the verb morphology and in explicit subject pronouns will be taken into account (yet, as we will see, the latter are extremely rare in these data).

These forms allow access to the construction of the contextual identity, as understood by Kerbrat-Orecchioni (2005:157), namely the elements of the global identity that are relevant in a given context of interaction. The mobilization of these features may be realized through linguistic and non-linguistic behavior. In the data used, the communication platform in itself implies that a focus on diabetes-related features is evident. Thus, various chat participants start talking about their treatment immediately, without explicitly specifying that it is for diabetes. Given that the chat is presented as exclusively dedicated to dealing with questions concerning diabetes, this contextual identity is in part predefined by the chat session.

The data used for this study, summarized in Table 1, are drawn from a public question-and-answer page (FAQs), a public chat session organized for World Diabetes day (subsequently published online as a pdf), and a public forum on medical topics. In the three genres, healthcare professionals answer questions from the general public (both patients and non-patients). In all cases, the contributors and readers were making a conscious effort to obtain information (cf. Antaki et al. 2006 concerning forum data). Initiating a question is thus always a "permitted" new action (Antaki et al. 2006:118).

All the interactions studied can be considered public. In the case of the chat and forum data, participants knew at the time of posting that their question (and answers to it) would be publicly available, which leads me to consider these interactions as public (cf. Spilioti 2017:194). Admittedly, those who asked a question that appears in the question-and-answer data may not have known that their question would end up on the FAQ page. However, the FAQs do not feature any information that allows us to trace them back to the original writer (name, pseudonym, place…). These data could therefore be made public while respecting the privacy of writers who may not have wished to make their questions publicly available. As regards the professionals figuring in the three data sets, all work for officially recognized organizations and/or hospitals. Any possible commercial bias inherent in interaction with private healthcare professionals is thus eliminated.

As I wanted to include comparable data (European Spanish, public online interaction involving healthcare professionals linked to official institutions), the data set is relatively limited. Consequently, the aim of this paper is to show different mechanisms at work and to illustrate varieties of identity construction rather than to offer quantitative comparisons of these phenomena.

Table 1 Summary of the data used in this study

Genre	**Q&A (FAQs)**	**Public chat for World Diabetes Day**	**Medical forum**
Source	Diabetes Madrid	Facebook page of the Valencian autonomous region healthcare agency (*Cuídate CV*)	Onmeda (diabetes thread and diabetes-related posts in other threads)

Healthcare professionals	Several Madrid-based doctors	Endocrinologist	Doctors and nutritionist
Words	2,193	5,148	8,937
Questions	15	13	17

The data sets differ mainly in two respects. The first is synchronicity, which is high for the chat session and can be low for the other genres. The second relates to the presence of hearers and bystanders in Goffman's terms. In the FAQ session, the question writer is presented as de-individualized, allowing anyone with the same concern to identify with that position. In the public chat session, the participants who ask and answer questions know that there is a group of unaddressed recipients, namely others logged in to the chat session at the same time, who are following the interaction and who may join it actively by formulating their own questions. While there is also a potentially large group of bystanders in the forum, these are not necessarily simultaneously present and do not necessarily make their presence known by posting or answering questions. They can choose simply to read the threads without participating. The forum is moderated, as is evidenced by the fact that messages containing publicity for medicines are explicitly condemned and their originators warned that repeatedly posting such messages will lead to them being blocked.

Since the questions and answers on the FAQ page are selected for their assumed representativeness, it is possible that the samples forming part of my data were edited prior to publication. However, the rather varied formulation and structure of the questions in this section (e.g. some are written in the 1st person, others not) suggest that they are at least based on real questions, though their brevity (as compared to the questions in the two other data sets) suggests that some editing has taken place. Even if edited, they still represent the way in which patient and healthcare professional identities are typically constructed according to the authors/editors of the FAQs.

While we might consider time constraints to have played a role in the chat session (as opposed to the two other sets), the answers given there are fairly elaborate and written in standard language, suggesting that time pressure did not have a major impact, at least as far as the extent and style of answers are concerned. The question-and-answer page and the chat session explicitly state that answers will be given by healthcare professionals, whereas the forum allows for any registered participant to contribute. Nevertheless, replies there are typically given by a healthcare professional, who is the most ratified participant (Goffman 1979) and often even explicitly selected by the question writer through the choice of address forms or by a requirement for specialist attention (see Section 3). Indeed, only two threads result in an exchange that goes beyond the initial question and answer to include responses from non-professionals (patients sharing experiences). Thus, while the forum would allow for more prolonged interactions, in practice it works in a fairly similar way to the chat session and to FAQs. The forum data included in the current study therefore differ from diabetes fora where the participants are mainly or exclusively patients and which have been shown to fulfill a supportive function (Loader et al. 2002), being used also to seek healthcare information (Liu et al. 2017).

The data were anonymized according to the guidelines described by Antaki (2002), which involves the use of pseudonyms for the names of participants asking questions and providing answers. They may contain non-normative language use, which has not been edited for the purposes of this study. Translations aim to convey the register of the original message.

3 Analysis

In this section, I first discuss patient representation (3.1), as realized both through self-representation and through other-representation by professionals or by non-patients commenting on patients. I will consider whether the patients are presented as individuals or as part of a group, the identity features made relevant, the way in which they describe their identity in relation to diabetes, and the degree to which they are represented as (co)responsible for their treatment. I will then proceed to discuss how patients’ relatives (3.2) and healthcare professionals (3.3) present themselves and how they are represented by the other participants.

3.1 Patient identity

Participants posing questions seem to opt for presenting their queries either as resulting from a personal concern (as a diabetic or a close relative of one) or as generic and abstract (using impersonal constructions or generalizing descriptions). While in the FAQs three questions (of the sample of 15) are formulated using the 1st person singular and two the 1st person plural, impersonal or generalizing constructions prevail in this data set, as illustrated by example (1). Self-representation is much more present in the chat and forum data, where the vast majority of questions are formulated in the 1st person singular, ranging from a merely metadiscursive presence (*querría preguntar…* 'I would like to ask…') to the author explicitly representing him-/herself as a diabetic, as in example (2).

(1) *¿Cómo se puede diagnosticar de forma precoz la diabetes?* (FAQs)
'How can diabetes be diagnosed at an early stage?'

(2) *Hola, soy un chico con diabetes de 28 años, qué actividad física me recomendarías?* (chat)
'Hi, I'm a 28-year-old guy with diabetes, what type of physical activity would you recommend to me?'

In only two cases, both among the FAQs, do questioners present themselves as representing the whole group of diabetics. In both questions, a construction specific to Spanish, Catalan and Occitan is used, namely a full subject NP immediately followed by a 1st person plural verb phrase (De Cock 2010), as in (3). This construction allows the speaker, on the one hand, to express membership of a group through the use of the 1st person plural and, on the other, to explicitly mention the group referred to (*las personas con diabetes* 'people with diabetes'). It is thus a way of creating an ingroup as opposed to an outgroup ('people who do not have diabetes') (cf. Duszak 2002: 6). Given its low frequency of less than 1.4% of 1st person plural forms in general corpora (De Cock 2014:156), it is noteworthy that precisely this rare construction is used. Clearly, the fact that it combines group membership with a fairly detailed description of the group makes it particularly suitable for the genre of FAQs.

(3) *¿Las personas con diabetes podemos utilizar viagra?* (FAQs)
'Can people like us with diabetes use Viagra?'

Note, though, that the clear presence of the writer signified by a 1st person singular form/pronoun does not necessarily mean that the questioner identifies him/herself as a diabetic. While on the forum six out of 17 writers of initial posts present themselves with the diagnostic label of diabetes, four threads were started by people using a 1st person singular form but identifying themselves as close relatives of a diabetic, as in (4).

(4) *Una persona muy cercana a mi tiene diabetes del tipo que se tiene que aplicar inyecciones de insulina 3 veces al día (...) Estoy preocupada porque su tratamiento lo lleva su médico de cabecera pero me pregunto, ¿dónde podría pedir una segunda opinión para no tener los niveles tan altos?* (chat)
‘Someone very close to me has diabetes of the type where she has to have insulin injections 3 times a day (…) I’m concerned because her family doctor is in charge of her treatment but I’m wondering where she could ask for a second opinion in order to not have such high levels?’

In the chat data, the initiators of four threads (of the sample of 13) do not specify their relationship to diabetes. Participants identify themselves as diabetics in five threads and as a close relative in four. The remaining four threads do not include any specification concerning a possible personal involvement. While the degree of detail included in some of these posts might lead us to think that the author does have a concrete person in mind, he/she does not make relevant any identity features linking him/her to diabetes and seems not to wish to present him/herself as (a close relative of) a diabetic. No declared close relatives feature in the FAQ data.

Since the FAQ data barely present individual patients, they do not offer any further identifying features. In the chat and forum data, however, further patient identity features are sometimes introduced by the patient or relative. These include, for instance, their name, gender (on some occasions inferable from the name), type of diabetes, age, time since diagnosis, or other health issues. In the forum data, the medical information provided may even be fairly specific, including glucose values in the blood, type of treatment, etc. Nine of 17 forum threads contain fairly specific medical information. In some cases, the writer also adds information concerning their personal attitude towards diabetes.

In the following, I will study in more detail how the relationship with diabetes is defined by the participant asking a question. The data show that both diabetics and close relatives use various constructions, ranging from *ser diabético* ‘to be a diabetic’, *tener diabetes* ‘to have diabetes’, or *con diabetes* ‘with diabetes’, to verbs that more clearly evoke the idea of an illness, such as *sufrir* ‘suffer’ or *padecer diabetes* ‘suffer from diabetes’. Finally, some question authors refer to the diagnosis, stating *le diagnosticaron* ‘they diagnosed him/her’. Unlike other expressions, especially *ser diabético*, which present the condition of being a diabetic as an intrinsic part of patient identity, constructions with *diagnosticar* rather suggest the idea of a label used by third parties. No clear correlation was found between the use of these two constructions and the author’s status (patient or relative).

In the forum and chat data, some contributors expand on their (emotional) relationship with diabetes or their emotional state when posting their question. Thus, both diabetics and close relatives sometimes explicitly mention that they are worried, as in example (5). Such personal or emotional information concerning illness identity is absent from the FAQ data, probably due to the fact that these were selected as prototypical questions of potential relevance for a variety of readers, and not merely for the person who asked the question.

(5) *Es la primera vez que escribo en el foro. estoy preocupada.* (forum)
'It's my first time writing in the forum. I'm worried.'

In the forum messages, which are typically longer, some members give an even more detailed account of their attitude towards diabetes itself. However, this appears always as a pre-expansion to a question that will concern more social or emotional aspects of being a diabetic, such as relationships or the possibility of moving abroad for professional reasons. Example (6) reflects the patient's struggle with her illness identity. It shows how a new event in her life (in this case the opportunity to work abroad) has led her to reconsider the impact of the chronic illness on her identity, which she had initially considered to be unaffected by her illness. This illustrates that the construction of the biography of the chronically ill person is an ongoing process, and that new events (such as this job opportunity) may bring patients to reconsider their identity with respect to their chronic disease even when they thought such biographical work had been completed (cf. Charmaz 1995:660). In (6), moreover, this reconsideration occurs at a stage in life when development of both overall and illness identity is crucial (Oris et al. 2016).

(6) *Desde que me diagnosticaron esta enfermedad, siempre me he dicho que no me impediría llevar una vida ``normal´´ y poder hacer cosas como el resto del mundo, pero estoy viendo que al final va a resultar así. De verdad que me gustaría muchísimo aprovechar esto, ya que únicamente tengo 19 años y algo así es difícil que vuelva a pasar por mi vida, soy joven y tengo muchas experiencias por vivir aún.* (forum)
‘Since they diagnosed me with this illness, I’ve always said to myself that it wouldn’t prevent me from leading a “normal” life and being able to do things like everybody else, but I’m coming to realize that that’s how it will be in the end. I’d really, really like to take this [opportunity] up since I’m only 19 years old and something like this is unlikely to happen in my life again, I’m young and I still have lots of things to experience.’

As we will see in the analysis of the answer given in (7), the healthcare professional explicitly acknowledges that this question is not merely about medical aspects of diabetes but also about the patient’s personal relationship with the condition, as he also does in some other interventions. Indeed, when we turn to the way in which patients (and their relatives) are represented in the answers, we will see that the professionals fully respect their choice whether to self-identify as a diabetic or not. In other words, they only make the patient identity relevant in their answer if it was made relevant in the question in the first place. This is logical from the perspective of medical ethics, since it respects patients' privacy.

In this regard, the forum and chat data vary. While the chat answers may refer to personal medical information (e.g. patient's age, how long he/she has been diagnosed with diabetes), they do not explicitly take up personal emotional information such as the expression of worries. The forum answers, by contrast, do address the emotional aspects of patients' and relatives' self-representation. In the case of patients, this may involve explicit discussion of aspects of illness identity made relevant by patients in the original questions. Thus, the doctor's reply (see example 7) to the concerns voiced in example (6) begins by explicitly acknowledging Cristina's worries (*entiendo tu inquietud* 'I understand your worries'). Her desire to live a 'normal' life is also taken up in the answer, which starts by pointing out the problems faced by anyone with a medical condition working in America, whether or not they are diabetic (*Todos, diabéticos o no* 'Everyone, diabetic or not'), before proceeding to more specific diabetes-related information. The professional thus underlines an identity Cristina shares with others. After extensive recommendations, the doctor closes the message by again addressing her desire to seize opportunities in life. In general, answers to forum posts such as (7) not only address the patient's medical condition but also the more emotional and personal concerns related to their condition, in acknowledgment of the identity struggle they are experiencing.

(7) *Hola Cristina,*

Entiendo tu inquietud por las incertidumbres que genera viajar a un país, como Estados Unidos, en el que ningún trabajador tiene derecho a seguro médico público antes de los 65 años. Todos, diabéticos o no, tienen que suscribir un contrato de asistencia médica con una entidad privada. *(...) Animo y no dejes que las dificultades que encontrarás en cualquier momento en tu vida te condicionen e impidan que hagas aquello que te ilusiona y motiva.*

Un saludo.

Dr. Miquel González

'Hi Cristina,

I understand your worries about the uncertainties that travelling to a country like the US entails, where no employee has the right to public health insurance before the age of 65. Everyone, diabetic or not, has to take out health insurance with a private company. (…) Think positive and don't let the difficulties that you may encounter at any time of your life define you and stop you from doing what thrills and motivates you.

Kind regards,

Dr. Miquel González’

Joint construction of responsibility or action with patients is very rare, but we do find examples such as (8). In this case, the specialist seems to oscillate between augmented inclusive uses of *we* (including the speaker, hearer and third persons) and pseudo-inclusive *we* (which actually addresses the hearer but does not include the speaker) (Cysouw 2003: 85; see also De Cock 2011, 2016). Insofar as the professional is answering a specific query about transgenerational transmission, posed by a writer whose father has diabetes 2, we can interpret the 1st person plural forms as pseudo-inclusive, i.e. they actually refer to the non-professional but are used to create empathy. Although they occur in many interactional situations (De Cock 2016), such uses have typically been associated with medical contexts (Brown and Levinson 1987:119). The use of the 1st person plural also allows the answer to be broadened from a specific case to the more general issue of preventing diabetes 2 (*hay algunas cosas que sí podemos hacer para intentar evitar que eso suceda* ‘there are some things we can do to try to prevent that happening’).

(8) *En cualquier caso esto [posibilidad de heredar diabetes tipo 2] es algo sobre lo que no podemos influir, al igual que con la edad las posibilidades son mayores. Sin embargo hay algunas cosas que sí podemos hacer para intentar evitar que eso suceda, y que si ocurre*

> *que sea más tarde y más leve: lo que podemos hacer es mantener el peso normal, sin engordar, hacer algo de ejercicio y comer equilibradamente una dieta mediterránea. (...) Así que ya sabes: a cuidarte, que es lo que debemos hacer todos en realidad, para mantenernos sanos.* (chat)
>
> ‘In any case, that [the chances of inheriting type 2 diabetes] is something we can’t influence, just like the fact that the chances [of getting diabetes type 2] increase with age. However, there are some things we can do to try to prevent that happening, and to ensure that, if it happens, it is as late and mild as possible: we can maintain a normal weight, avoid getting fat, take some exercise and eat a balanced Mediterranean diet. (…) So now you know what to do: look after yourself – which is what all of us should be doing, really, in order to stay healthy.’

In the closing utterance, the dichotomy between addressing the questioner’s specific situation and giving general information is resolved by the use of more explicit person reference; the professional first uses a direct 2nd person form of address (*ya sabes: a cuidarte* ‘now you know what to do: look after yourself’) but then makes explicit that the recommendation holds for everybody (*que es lo que debemos hacer todos en realidad* ‘which is what all of us should be doing, really’). Thus, both through the pseudo-inclusive *we* and through the explicitly generic closing statement (*todos* ‘all (of us)’), the professional downplays the specific label of the questioner as a person with a more elevated risk of developing type 2 diabetes, representing both her- and himself as part of one big community which should try to live a healthy life. This then seems to be a joint construction, involving not only the professional and the questioner, but society at large. Indeed, the identities of the participants originally asking the question (relative of a diabetic) and responding to it (the professional) are both backgrounded. The professional steps out of his expert role and presents himself as part of a larger community, where not only (potential) patients but everyone should look after themselves. Interestingly, as we will see in the analysis below, such joint responsibility is often constructed when close relatives of diabetics ask questions. They are accordingly addressed as playing an active role in treatment, especially in helping to maintain a healthy lifestyle.

3.2 Relatives' identity

As mentioned above, on various occasions the participants asking questions identify themselves as relatives of a diabetic. In such cases, self-description tends to be limited to the degree of kinship (e.g. sisterhood in example (9)). On the forum, the specialists systematically take up this relationship in their answer and acknowledge the writer as a concerned and valued interlocutor, emphasizing the importance of their support and concern for their diabetic family member, as in (10) (*tu preocupación por el bienestar de tu hermana* ‘your concern for your sister’s wellbeing’). In this sense, forum answers pay more attention to the emotional role of the family members, going well beyond a strictly medical answer as in the Q&A and the chat. Moreover, the healthcare professionals tend to construe the family members as involved persons with a role to play in the treatment or, at least, in supporting the patient by helping him/her to maintain a healthy lifestyle (e.g. eat healthy food, take exercise; *espero que esta información te sea útil para que (...) la ayudes (...)* ‘I hope that this information is useful for you (…) in helping her (…)’). In this way, the professionals construct a relationship of co-responsibility between patients and their family members.

(9) *Buenos días,*

a mi hermana embarazada de 6 meses le han diagnosticado diabetes gestacional. ¿Qué medidas generales tiene que seguir? ¿Qué normas de alimentación y dieta tiene que tener en cuenta? (forum)

‘Hello,

My sister, who is 6 months pregnant, has been diagnosed with gestational diabetes. What general measures must she take? What guidelines on nutrition and diet must she take into account?’

(10) *Buenos días, Maria Teresa,*

Muchas gracias por tu pregunta que pone de manifiesto tu preocupación por el bienestar de tu hermana. Espero ser capaz de

> *ayudarte para que tú puedas ayudarla a ella. (...) pero para ella es una suerte contar con tu interés y tu ayuda. Espero que esta información te sea útil para que, más allá de los aspectos teóricos, la ayudes compartiendo, por ejemplo, una comida o un paseo "saludables", siempre que os sea posible.* (forum)
>
> 'Hello Maria Teresa,
>
> Thank you very much for your question, which shows your concern for your sister's wellbeing. I hope I'll be able to help you so you can help her. (…) but she's lucky to be able to rely on your interest and help. I hope that this information is useful for you, apart from the more theoretical aspects, in helping her by, for instance, sharing a "healthy" meal or walk, whenever possible.'

Interestingly, in the rare cases of longer forum threads to which – in addition to the professionals – other patients also contribute, these patients similarly make the family relationship consequential by further discussing and emphasizing the importance of family members' support, as in example (11). This is also the only example in the data where a patient uses the explicit first person singular subject pronoun *yo*. While presence of the subject pronoun is generally much more frequently absent than present (see e.g. Travis 2007; Comajoan 2006; Enríquez 1984), this is even more true for the interactional settings analyzed in this chapter. Indeed, given the specific format, contributors already have the turn and do not need to claim it. Moreover, there is no need to affirm their identity or contrast it with others since they are often the sole interlocutor of the healthcare professional. It is then not surprising that this single use of *yo* by a patient appears in a thread with various contributors. By creating a contrast through *yo,* this contributor highlights that she is a diabetic herself (and intervenes in that capacity), as opposed to the participant asking the opening question of the thread, who is a relative of a diabetic. (The one other occurrence of a self-referring subject pronoun is uttered by a relative who contrasts her own help to a diabetic family member with the actions of the diabetic himself.)

In example (12), the doctor involved in the thread explicitly refers to the information provided by the patient in (11) and acknowledges her as qualified to comment on the topic due to her personal experience.

(11) [in reply to a worried son of an elderly diabetic father]

[response by another patient]

Yo soy diabética desde los 9 años y tengo 23. Tu apoyo es fundamental para tu padre, necesita saber que cuenta con tu apoyo incondicional. (...) (forum)

'I'm 23 years old and I've been a diabetic since I was nine. Your support for your father is essential, he needs to know that he has your unconditional support.'

(12) [subsequent response by professional]

> *Como muy bien te indica Lola, con experiencia en el manejo de su diabetes, tu apoyo puede ser muy importante para contribuir a concienciarle de la importancia de la alimentación para controlar mejor su enfermedad;* (forum)
>
> ‘As Lola, with her experience in managing her own diabetes, has pointed out very well, your support can be very important in raising his awareness of the importance of diet in keeping his illness better under control;’

This identity construction of the relative in (11) and (12) as not only an emotionally involved person but also as someone who has a concrete role to play in helping the patient manage diabetes is pervasive in the forum but absent in the chat data.

3.3 Healthcare professional identity

In this section, I study the way in which the healthcare professionals construct their own identity and how it is constructed by the other participants (patients and relatives). In the FAQs, professionals are not mentioned at all, perhaps because questions were edited before publication, although participants were explicitly informed that questions would be answered by a healthcare professional. So too were chat participants, who were told that a specific doctor would be answering questions during a particular session, making him/her the single, ratified interlocutor. Presumably as a result, the act of addressing a professional is frequently present in the chat data. In fact, most chat questions start with a greeting such as *hola* ‘hello’, and four out of 13 explicitly address the doctor by means of a vocative or ratify them in a more indirect way, e.g. by thanking them for devoting time to the session.

The situation on the forum is rather different. Here, any registered user may reply to a post, but users are informed that healthcare professionals participate in this particular sub-forum on diabetes – and, in fact, only two of 17 threads contain an answer by a layperson. The forum questions are not typically addressed to a specific interlocutor, although indirect strategies are sometimes used, such as the explicit mention of the need for a nutritionist in example (13).

(13) *quisiera saber que dieta puedo comer hace poco me dio pancreatitis y soy diabetico necesito la orientacion de un nutriólogo* (forum)
‘I would like to know what foods I can eat. Recently I got pancreatitis and I am diabetic. I need the guidance of a nutritionist.’

(14) *Mi hija de 13 años se tomo una curva de insulina y esta arrojo en ayunas 24.3 y en 120 min 453,es diabetes ????? cabe señalar que ella ya esta diasnostiada con resistencia de insulina* (forum)
‘My 13 year old daughter did an insulin curve, and it showed 24.3 on an empty stomach and 453 after 2 hours; is this diabetes????? I

should point out that she’s already been diagnosed with insulin resistance.’

Alternatively, as in (14), questions may be formulated in a sufficiently specific way, including detailed information about the results of blood tests, as to require a fairly high degree of specialization on the part of the interlocutor. Consequently, one could argue that these questions are implicitly addressed to professionals. Other than through the use of greetings, however, the participants asking questions do not tend to construct the identity of these, generally limiting their representation to the purely professional role.

In light of the above, the following discussion focuses on how healthcare professionals represent themselves in their own contributions. The vast majority of these are constructed in an impersonal way, describing treatment and diagnosis with a focus on the processes involved, not on the participants. References to the collectivity of healthcare professionals, as in example (15), where the author distinguishes family doctors from psychiatrists and psychologists, are rare. In cases such as (16), the reference made in describing the state of the art as regards diabetes research is vaguer; it may include all of society rather than just the medical profession.

(15) *Los compañeros psiquiatras y psicólogos clínicos son conscientes de que (...) somos los médicos de familia quienes ejercemos la*

mayor labor de detección (...) de una gran parte de los casos de ansiedad y depresión. (forum)

'Our colleagues who are psychiatrists and clinical psychologists are aware that (…) it is us family doctors who do the most work in detecting (…) a large proportion of cases of anxiety and depression.'

(16) *Los estudios con células madre en diabetes están actualmente en fase de experimentación animal, y por tanto, estamos aún muy lejos de que sea una posibilidad cercana para tratar esta enfermedad (...)* (FAQs)

'Studies of diabetes using stem cells are currently in the phase of animal testing, so we are still very far away from a possible treatment for this illness any time soon (…)'

As shown in the discussion of (8), emphasizing the need of society at large for a healthy lifestyle is a way of construing shared responsibility and shared identity between diabetics, non-diabetics and professionals, and of blurring the professional identity. Interestingly, the clearest example of creating a shared identity with a questioner is not realized within a patient-professional dyad. Rather, example (17) is part of a forum healthcare professional's reply to a participant who is worried about his diabetic father. The professional utilizes an inclusive *we*, creating a shared identity not in terms of a doctor-patient relationship but in terms of the shared identity of two sons of (elderly) parents.

(17) *Con los años nos vemos obligados a desarrollar hacia los padres una "piedad filial" que debe contribuir a entenderles, aceptarles y ayudarles mejor.* (forum)
'Over the years, we find ourselves obliged to develop a kind of "filial devotion" towards our parents, which must contribute to understanding them, accepting them and helping them better.'

Moreover, this is the only instance where a personal identity feature of the professional, albeit a very general one, is made relevant. It is also the clearest case of shared responsibility constructed between a questioner and the responding participant. This makes the fact that it does not pertain to the patient-professional relationship particularly striking.

4 Conclusion

In this paper, I have discussed how patients and healthcare professionals construct the identity of the self and other in three types of public online interaction about diabetes. The three data sets – FAQ, chat and forum – have in common that the contextual identity is to a large extent predefined by the platform. My results suggest that participants asking questions in fora, chats or FAQs do not tend to present themselves as diabetics but usually adopt a wording that barely stresses identity features relating to diabetes. When participants do refer to such identity features, they may pertain to a diabetic or to the relative of a diabetic. In all data sets, writers overwhelmingly appear to use either impersonal and generic constructions or highly individual representations, rather than constructing collective identities.

When participants asking questions explicitly portray themselves as diabetics or as close relatives of diabetics, they often include further detailed medical information and, especially on the forum, more emotional identity features, such as their attitude towards the illness. The healthcare professionals only refer to features that have previously been made explicitly relevant by the participants, thereby respecting their privacy choices. The specifically emotional features of both diabetics and their relatives are highlighted primarily in the forum data. This fact may be related to a difference in perceptions of the platforms' public nature; the forum does not aim at being generalizable (as is the case for FAQs) nor does it imply the simultaneous presence of a large group of readers (as in the chat session). Overall, few collective identities are being constructed and even fewer with the aim of creating the impression of co-responsibilisation between diabetics and professionals. Such joint responsibility is, however, constructed with relatives of diabetics, emphasizing that they can actively play a part in helping the patients with their treatment.

The healthcare professionals present themselves, and are referred to by other participants, in their professional capacity only. On the very rare occasions when professionals stress collective identity features that they share with patients, they try to construct the image of a more general collective societal responsibility for a healthy lifestyle, thus going well beyond the relationship between patient and healthcare professional. All in all, like the patients, the healthcare professionals are presented in a fairly traditional way.

The differences in identity construction between the three types of public online discourse studied seem to be related to their different degrees of atemporality and generalizability. Thus, the FAQs prefer impersonal constructions and are the only genre where at times a collective identity of diabetics is constructed. Other personal identity features remain absent as they would interfere with the aim of offering generalizable answers to frequently asked questions. The forum, on the other hand, includes the most personal information as well as the most indications about participants' emotional identity features, which are also more clearly taken up by the participants providing responses. The chat session occupies an intermediate position. Writers clearly identify as individuals and make personal identity features relevant. However, the nature of the interaction implies a large group of 'bystanders' and a short time span, which may explain why fewer emotional characteristics are mentioned.

While the healthcare professionals in these data use online communication as a means of spreading information about diabetes, the focus seems to be mainly on more generalizable information and less on a personalized approach. With the exception of the forum data, professionals emphasize above all medical identity features and pay much less attention to personal or emotional ones, despite their importance for the patient's personal biography and, therefore, for his/her diabetes management.

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