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# Doctors' voices in patients' narratives: coping with emotions in storytelling

Gabriele Lucius-Hoene,<sup>1</sup> Ulrike Thiele,<sup>2</sup> Martina Breuning<sup>1</sup> and Stephanie Haug<sup>1</sup>

## Abstract

**Objectives:** To understand doctors' impacts on the emotional coping of patients, their stories about encounters with doctors are used. These accounts reflect meaning-making processes and biographically contextualized experiences. We investigate how patients characterize their doctors by voicing them in their stories, thus assigning them functions in their coping process.

**Methods:** 394 narrated scenes with reported speech of doctors were extracted from interviews with 26 patients with type 2 diabetes and 30 with chronic pain. Constructed speech acts were investigated by means of positioning and narrative analysis, and assigned into thematic categories by a bottom-up coding procedure.

**Results:** Patients use narratives as coping strategies when confronted with illness and their encounters with doctors by constructing them in a supportive and face-saving way. In correspondence with the variance of illness conditions, differing moral problems in dealing with doctors arise. Different evaluative stances towards the same events within interviews show that positionings are not fixed, but vary according to contexts and purposes.

**Discussion:** Our narrative approach deepens the standardized and predominantly cognitive statements of questionnaires in research on doctor–patient relations by individualized emotional and biographical aspects of patients' perspective. Doctors should be trained to become aware of their impact in patients' coping processes.

## Keywords

Narrative, coping, patients' perspective, chronic pain, type 2 diabetes

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## Introduction

### *Patients' perceptions of their doctors: two different approaches*

How patients perceive their encounters with doctors has been a major topic in the medical field.<sup>1,2</sup> Methods range from questionnaires about mutual perceptions and evaluations, where patients' views and evaluations of their doctors show up as condensed judgments on lists preset by the research paradigm,<sup>3</sup> to video analysis of real encounters<sup>4</sup> as objective approaches.

Narrative medicine,<sup>5,6</sup> in contrast, favors storytelling as a means of reconstructing patients' subjective experiences and their emotional impact. Narratives draw from the tellers' own relevancies and provide biographically contextualized meaning-making processes. We want to contribute to the discussion about the patients' perspectives on their doctors and their roles in dealing with illness by supra-analyzing (p. 38)<sup>7</sup> narrative data from a corpus of in-depth interviews with patients with chronic pain and diabetes 2. The narratives contain many accounts about meetings with doctors. Looking closely at meanings given to these accounts and rhetorical strategies provides a personalized and many-layered picture of how doctors are perceived. A narratological approach can deepen the standardized and predominantly cognitive approach of questionnaires.

### *Reported speech as a display of tellers' own emotions and their feelings towards other actors in storyworlds*

As 'narrative is not merely a looking back at action, but is itself an action' (p. 9),<sup>5</sup> not only the content, but also the way stories are constructed as performances in an interaction can give insights into the teller's world. How patients verbally *construct* their doctors by literally giving them a

voice in narrated scenes of encounters shows us how patients make them appear as specific actors in their experiences of illness. *What* the doctors are made to say in reported discourses with the patients and *how* their remarks are evaluated by way of contextualization cues lead to insights about their perceived characters, functions and roles in patients' worlds.

Reported talk in oral storytelling has been given a lot of attention under various perspectives<sup>8</sup> ranging from Bakhtin's notion of polyphony<sup>9</sup> to performative aspects of storytelling as re-enactments of experience.<sup>10</sup> In everyday storytelling, attributing quotations to actors within a storyworld is a powerful means of bringing them to life and displaying authenticity. For the listener, the re-enactment of the story provides an illusion of 'factuality'. As it claims to re-stage the event 'just as it happened', quoted speakers of the storyworld position and unveil themselves by their own voices. Not only what they (seemingly) say, but also how they say it (or, respectively, how the narrator vocalizes their quotes) – both aspects serve to characterize and position the speakers by way of giving their voices a special mode.<sup>11,12</sup> The listeners can form their own opinion about the doctor on the basis of 'what he or she actually said'.

But, as Tannen points out, "Even seemingly 'direct' quotation is really 'constructed dialogue', that is, primarily the creation of the speaker rather than the party quoted" (p. 103).<sup>12</sup> As our memories of events are never sufficiently precise to guarantee the correctness of quotes, tellers of reported speech actually make up what they think they remember, using the fuzziness of their memories to construct their actors in a way which fits with their emotional situation and strategic aims in the very moment of storytelling. Thus, patients' reconstructions of doctors' speech acts are polyphonous and convey meaning into the doctor's quote,

namely they reveal the patients' evaluation of the doctor. The doctor's impact in patient experiences is shown not by labelling, but actually by performing. As this kind of characterization has significantly more to do with emotions than abstract judgements, it provides a key to understanding patients' experiences concerning their doctors beyond abstract categorizations and standardized evaluations.

## Methods

### Data

We conducted in-depth interviews with patients with chronic pain and diabetes type 2,<sup>13</sup> focussing on patients' experiences with the illness, with its diagnostic and treatment procedures and with its impact on daily life. Purposive sampling strategies sought a maximum variation of experiences.<sup>14</sup> Significant parts of the interviews presented patients' experiences with health care institutions and with their doctors. From the interviews, we extracted all the narrated events which contained quotations of doctors in direct speech.

### Analysis

In a first step, doctors' voices were analyzed according to their linguistic form.<sup>15</sup> To characterize the epistemic status the doctors' utterances were given, we examined the origin of the reported speech (a specified doctor or group of doctors versus doctors in general), distinguished between direct and indirect quotations and analyzed whether the quotes were narrated as singular events or as repetitive utterances (what doctors usually say). Doctors' voices were analyzed in a word-by-word procedure based on conversation and narrative analysis by means of the transcripts and the prosodic and emotional characteristics from audiotape. Our main analytic focus was on the positioning aspects of the quotations based

on positioning analysis in stories,<sup>16,17</sup> which draws from narrative as well as conversation and discourse analysis. In this analytic approach, a 'position' is characterized as the social space a person claims for himself and assigns to the addressee through utterances. Within the story, these positionings as part of the reported speech convey a characterization of the doctor and his actions. After close linguistic and positioning analysis focussing on content and function of doctors' voices, the clips were grouped according to an established method (18) in a bottom-up procedure into themes of positionings and their evaluative function within the story. This technique ensures that each item is represented in the final summary. Analysis and coding were discussed and elaborated within the research group.

Further analyses and extracts from the interviews are published on the website [www.krankheitserfahrungen.de](http://www.krankheitserfahrungen.de).

## Results

### Story characteristics

Table 1 shows some characteristics of the sample and the texts.

Due to the open interview style, many anecdotes and re-enacted stories of encounters with their doctors were given spontaneously, enfolded in longer story lines. Sometimes they were rendered in little dramas with the whole array of narrative structure,<sup>16</sup> sometimes in the form of 'small stories'<sup>17</sup> with just a few narrative clauses. Some of the speech acts were assigned to a 'generalized' voice of doctors, displaying a typicality of 'what all doctors usually say' (Example 5). Other stories were presented as iterative, pointing out that 'this is what the doctor always says' (Example 6).

Our analysis showed that voicings were able to render precise characterizations of doctors' actions and attitudes and of the tellers' feelings towards them.

**Table 1.** Sample characteristics

	Diabetes 2 sample	Chronic pain sample
Sample size patients total	26	30
Average age	60.2	57.8
Age range	35–75	29–74
Male/female	14/12	11/19
Constructed speech clips	202	192
Categories		
Doctors performing typical activities	53	24
Rather negative characterizations of doctors	65	67
Rather positive characterizations of doctors	63	62
Contradicting doctors	6	13
Others	15	26

As results, we will discuss the prevalent themes illustrated by original extracts.

### *Doctors' typical activities and their testimony of the impact of the illness*

In both samples, part of the quotes (Table 1) can be summarized as stereotypical acts, category-bound activities (p. 241)<sup>18</sup> of doctors which occur in medical consultations: telling a diagnosis, prescribing, referring to a hospital, etc.

Characteristically, these speech acts were performed in a neutral manner with matter-of-fact voicings and without emotional content. They highlighted important moments of the medical history and its turning points. However, there was a smooth transition to quotes which served yet another function: to highlight dramatic events and significant moments in the course of the illness. In the following example, the representation of the way the doctor intensifies the diagnostic procedures conveys that a serious condition must be managed. She becomes an expert witness to the dramatic state the patient was in, thus endorsing the patient's view of his illness as an outstanding experience.

### *Example 1*

- 01 then – I was lying on a stretcher in the corridor  
 02 the door opened and then the doctor came out oh Mrs B  
 03 → what is going on with you  
 04 then I told her about it  
 05 → and she said if that's the case  
 06 → we certainly won't (-) no normal x-ray  
 07 → we'll go right over for a CT

### *Negative positionings: interpretative authority, dominance and insensitivity*

In about one-third of both samples, doctors' utterances bear rather negative emotional characteristics. This impression is conveyed by the content and manner of the utterance, the negative tone is often underscored by the making the enacted voice sound demeaning, rude or aggressive or by the use of contextualization. We found consistent differences in the main topics of dispute between our two samples.

In the sample of patients with diabetes, they report doctors' voices as uttering

recurring reproaches and exhortations: they are critical of their patients' body weight, demand weight loss, and push patients authoritatively to do more exercise. More often than not, the doctors' voices are presented as rude and patronizing, if not openly humiliating.

### Example 2

01 the craziest thing that ever happened  
to me  
02 it was at the orthopedist's  
03 this guy didn't – he didn't know me  
at all  
04 and he comes in no how are ya says  
nothing at all  
05 just turns around and says over his  
shoulder  
06 → have you always been so fat  
07 just that word fat  
08 I shot up from the examination bed  
09 to this day I don't know how I  
did it (laughs),  
10 but I spoiled it for him,  
11 they must've heard it three rooms  
down.

Mrs M complains that doctors order her to lose weight without acknowledging her as a person. In direct speech, which is already categorized at the start as inappropriate by its lack of politeness (line 7), Mrs M portrays the doctor as attacking her with a humiliating question and referring to her weight condition by the demeaning word 'fat'. Her experience is supported by many other patients' stories in which anger is expressed that doctors emphasize their patients' weight problems while ignoring their personal situations and problems with shedding the extra pounds. The voices constructed to characterize the doctors are uniform: they state the condition (being overweight) and

proclaim weight loss and exercise in lackadaisical tones of voice. The orders are presented as exasperating for the patients, and their (reported) retorts mirror their frustration.

### Example 3

01 it's the easiest thing to come in  
02 and then they say  
03 → first of all lose like 10 15 kilos  
04 → then ah you'll be much better off  
05 of course that's it very well right  
06 just tell me how to do it  
07 and I'll do it

None of the diabetes patients in our sample suggested that they doubted the appropriateness of their doctors' order to reduce their weight. In contrast to Example 3, some of them re-stage their doctor's reproaches of overweight, without any indication of whether they felt affronted or even took it as sign that their doctor was appropriately concerned. The doctors' self-positionings in the voice reconstructions show a smooth transition from anger to acceptance, ranging from impertinence or provocation to plain speech, genuine concern and interest in their patients' health. In the following example, the doctor makes the condition a shared problem:

### Example 4

01 and, as I said, if the blood sugar  
tests are worse,  
02 → then he shakes me a little Mrs M,  
we've got to do something  
03 and ya then I'll try to be more  
careful  
04 or keep my fingers away from sweet  
stuff it was really bad before

Whereas the diabetes patients struggle with what some perceive as their doctors' insensitive violations and authoritative attempts to override their problems with control and healthy behavior, the main concern of the chronic pain patients is the acknowledgment of their medical condition by the doctors. In the patients' accounts, doctors' voices often declare that they are at their wit's end or that they doubt the physical origin of the complaint.

#### Example 5

- 01 → everything possible has been tried  
with the result  
02 → we didn't find anything you can go  
home  
03 → why don't you go to see a psychiatrist

The re-staged recommendations to see a psychiatrist (Example 5) or to consider a psychological explanation are sometimes presented as offensive, as in another example when a doctor's voice maintains that a patient sticks to her pain because she needs something to hide behind.

In several stories the doctors' voices openly proclaim their helplessness. They are punctuated by aggressive and derogatory attacks against their patients or culminate in simplistic recommendations, as in Example 6.

#### Example 6

- 01 either he was having a bad day  
02 or it was a purely personal viewpoint,  
03 but his advice was that I should  
just (-)  
04 → in my position he would get on  
his bike  
05 → and take a 30-kilometer ride through  
the forest

- 06 → that would make the problem  
manageable  
07 that's exactly what he said because  
he was just frustrated  
08 and I don't blame the guy who  
treated me  
09 that his therapy isn't a success.

So, the negative evaluations both of the patients with diabetes and the pain patients have one point in common: the feeling of not being recognized as persons of moral integrity and thus being considered as incapable of disciplining their body or their psyche. Some of the utterances attributed to the doctors' convey the impression that they see their patients as a nuisance, as people who willingly sabotage the doctors' sphere of competence and claim undue attention with their unjustified suffering.

Several stories of trouble with doctors characterize the practitioners as unreliable and unwilling to acknowledge their patients' efforts to cope and to comply.

#### Example 7

- 01 and then one doctor told me Mr M,  
make a list for yourself  
02 and take down your blood pressure  
values,  
03 in the morning, at noon and in the  
evening, okay?  
04 and so I made a list over a whole  
month  
05 and then I went into this practice like  
I said it was a group practice  
06 the one who had recommended it  
was just busy with another patient  
07 and so I saw another one  
08 → and I showed it to him beaming with  
pleasure  
09 and I said well I wrote it down  
like this

- 10 and he took a quick glance at it and  
((laughs))
- 11 scrunched it up and like that back  
to me ((gesture of throwing away))
- 12 we sat across from one other like  
that at the table
- 13 → he said you're driving yourself crazy
- 14 → that's nonsense what you're doing  
there
- 15 → write it down twice a week but not  
like that
- 16 and then I said but you told me  
yourself
- 17 well not you as a person but it was  
here I was told
- 18 → and then he said impossible nobody  
could have said anything like that
- 19 well I did not want to say that was  
your colleague so and so only
- 20 I put an end to the discussion by  
taking the paper ball
- 21 threw it back to him and said
- 22 well then I can't make use of it either

In this story, the patient's willingness to comply with what he describes as his doctor's 'order' is undermined by another doctor at the same practice. He contrasts his own feeling of pride (line 08) of having done well with the doctor's sharp retort, voiced with an angry and slightly contemptuous affect (lines 13–15). Mr M's attempt to put things right by pointing out that he was just trying to follow medical advice falls flat as the doctor discounts his explanation (line 18). So, the doctor in this patients account positions himself not only as the one who is entitled to criticize and devalue the patient's efforts, but also to decide on which version of reality is appropriate and which is not. The angry and arrogant voice quality and his blatant negation of what the teller positions as the truth contextualize the doctor's utterings as offensive.

Similarly related events of feeling 'stabbed in the back' by doctors responses to patients efforts to contribute to the healing process create an impression that the teller was not taken seriously, or rendered incompetent, and punished for setting out to show initiative and responsibility.

### *The contradictory doctors*

Several stories suggest that doctors confuse their patients by contradicting one another, leaving them at a loss as to what might improve their condition. In most cases, these stories have an ironic mode, as in the following example where the statements are rendered indirectly and include extreme expressions of assurance (lines 7 and 10) and unquestionable expertise.

#### *Example 8*

- 01 In the end some of the doctors  
recommended
- 02 that I have an electric spinal cord  
stimulation implanted
- 03 or a pain pump
- 04 ...
- 05 but the other group of doctors  
vehemently advised me
- 06 against doing these very two things
- 07 → so the one group says I definitely need  
to do it
- 08 → since otherwise I'd have no quality  
of life anymore
- 09 and the other group says
- 10 → that I should do it under no  
circumstances
- 11 → those are good methods in and of  
themselves
- 12 → however in the case of arachnoiditis  
they're contraindicated



**Positive positionings: appreciation, sympathy and support**

Interestingly enough, in both samples there is a balance of doctors' voices between positive and negative evaluations (Table 1). While the points of issue of the negative positionings differentiate clearly between patients with diabetes and with chronic pain, the positive positionings are more similar. The doctors in these positive accounts are presented as sympathetic and interested in their patients' well-being and acknowledge their predicaments. They are willing to respect the patients' own expertise and displays of competency. Most of all, the doctors' reactions are portrayed as 'simply' human, beyond role restrictions, and claims of hierarchy.

With the diabetes patients, the positive accounts of doctors' voices reflect concerns about matters of weight, but they also suggest that they understand how difficult it is to shed the extra pounds. So they are willing to allow exceptions to be made on extraordinary occasions or even mention their own struggles with cravings.

**Example 9**

01 I tell him I even tell him when I sinned  
 02 and I say oh doctor you want to  
 take a (blood sugar) test today  
 03 I say yesterday I did things  
 04 or I ate this and that we were  
 at a party  
 05→then speak it out well tell me your  
 sins he would say  
 06→better conscience afterwards  
 07 I say well then we both know  
 ((laughs))  
 08 and then he measures my blood sugar  
 and then we see it  
 09→then he says well it's okay, all went  
 well  
 10→did you dance a lot

11 I say yes that too  
 12→well you see then you balanced  
 it out a bit

In the following examples, both from patients with chronic pain, the doctors' voices are presented as kind and empathic.

**Example 10**

01 I recall this one doctor, for instance  
 02 I was at her office for the first time  
 03 and then after the anamnesis  
 she says  
 04 → yes, you've been through – a lot and  
 05 → where do you derive the strength to  
 endure that  
 06 and the question felt good in a way  
 07 because all of a sudden the  
 focus was away from all of the  
 deficits  
 08 what I'm not capable of and so  
 the question well  
 09 all of our attention was focused all at  
 once on some kind of sources  
 of strength

**Example 11**

01 one time he gave me a hug  
 02 → and he said now just let yourself  
 go and  
 03 → don't fight it just let it let it all out  
 he said  
 04 → go somewhere in the forest and just  
 scream  
 05 → if you don't want to do it at home  
 06 where I have to say (–) yeh you grin,  
 but it's true –  
 07 you need it you just need it in order  
 to deal with it

### *Differentiating evaluations by change of perspective*

Beyond clear-cut negative or positive evaluations, there are also stories in which the same direct reported speech from a doctor is presented as initially objectionable or shocking but re-evaluated as possibly helpful.

In the following example, the patient tells how he was diagnosed with an encephalitis, and goes on:

#### *Example 12*

- 01 the worst was, at the follow up  
examination in the clinic,  
02 about one year later,  
03 a young doctor said how are you  
04 and I say well I still suffer from  
headaches  
05 then he yelled at me like mad and said  
06→ ninety percent die immediately  
from this disease  
07→ and the others keep a nervous tick  
08→ if you only have a headache you  
should be content  
09 this was fierce for an eighteen year  
old of course  
10 ....  
11 but on the other hand this  
sentence has helped me a lot in  
my life

A few minutes later in the interview, he comes back to the scene:

- 12 I noticed early I have to live with that  
13 perhaps it was this sentence of  
the young doctor who said  
14→ count yourself happy if you only  
suffer from headaches  
15 he was callous but I recalled that  
many times  
16 ...

- 17 perhaps I thought at that moment  
18 yes that is it I have to live with that

Whereas in both versions of the twice-told story the doctor is positioned as unkind and confronting, the patient adds a reflexive stance in retrospection and concludes that after all the doctors words may have helped him to cope. In the re-staging he acts out the disgruntled feelings of his 18-year-old self. The re-evaluation in hindsight, however, puts the unkind remarks into the wider biographical horizon of its facilitation of acceptance.

In our next example, the patient also tells an incident twice at different times of the interview. In both versions, the doctor is ascribed the very same words (first version: line 4, second version: lines 6 to 7).

#### *Example 13, first version*

- 01 finally I found a good doctor  
02 and this guy he looked at the  
paperwork  
03 folded it together  
04 → he said I cannot help you anymore  
05 you're at the wrong place here  
06 and he, I must say I was lucky  
07 he referred me to the university  
hospital in city X, a pain clinic.  
08 and only after six months he'd  
written down his hunch  
09 chronic pain patient because he said  
10 pain memory is activated after that  
kind of a history

#### *Example 13, second version*

- 01 the doctor who'd referred me  
to X-town  
02 I was actually angry at him  
03 he just flew over the paperwork

04 I didn't even have to take off my  
t-shirt  
05 he didn't even look at my lower back  
06 → just said hm you're at the wrong  
place here  
07 → I cannot help you anymore  
08 wham closed the file boom  
09 So I said hey you I still have to work  
10 → He goes what do you do  
11 then I'm like I'm in sales  
12 → Ahh so you're on your feet the  
whole day,  
13 → well, you may as well throw that  
job in the trash can  
14 and then you're standing there  
and you know  
15 you're forty years old. . .  
16 and you know that you have to  
keep going for a long time you know  
17 earning your daily bread my god  
18 we've got to earn money just like  
everyone else  
19 and then you're just you know  
with that kind of statement  
20 go here referral go to the X -clinic  
21 I can't help you anymore anyway  
22 and then you leave stunned

Whereas in the first version the doctor is introduced as a 'good doctor' (line 1) who recognizes his own limitations, refers the patient to a special clinic and offers a correct prognosis, in the second version he is portrayed as being inept and disinterested; he even skips the examination and stupefies the patient by announcing that she will not be able to continue with her sales job. In the first version, the doctor's actions are considered appropriate when he 'looked at the paperwork and folded it together' (line 2 and 3), while in the second version he 'flew over the paperwork. . . wham closes the file boom', thus acting out his disinterest and gruffness. So, the very same quotations get

different meanings by different contextualizations. In the first example they play a positive ('I was lucky') role in the context of the course of the illness. His referral to the appropriate institution provides the turning point in her illness career. In the second version however, when the doctor affronts her with his unkindly prognosis of her future life, the words convey negligence and offence. Even the act of referring her to the clinic is no longer positive, but it rather shows that he just wants to get rid of the patient (line 21). So, different storylines can present incidents and persons differently depending on the contexts and emotional perspectives at stake in the narrative.

### *Narrative retaliation and reconciliation*

Reconstructing conflicts can also offer the opportunity for the teller to compensate for negative emotions and share them socially with the listener. This can serve to restore the patients' sense of dignity (REF), either through legitimating the patient's position or by discrediting the doctor's voice. Positioning the doctors by voicing them can alleviate the burden of health instructions that cannot be accomplished or of the frustration of living with a condition which is denied acceptance by the medical profession.

#### *Example 14*

01 then I said to the cardiologist for  
instance ((laughs))  
02 well, with the smoking I've got a  
pretty good hold on that  
03 but then he yells at me he says  
04 → you've got absolutely nothing under  
control  
05 well now I didn't think that was a  
good tactic  
06 so I don't go to that boy anymore  
then I was deeply insulted

- 07 instead of saying wow great Mrs. Y  
keep up the good work  
08 maybe you will get through it after all  
09 but – to scream at you – nope

Here, the offence attributed to the doctor's yelling is overcome by the teller's sarcastic remarks. By degrading him as a 'boy' and indicating his lack of interpersonal skills, the patient gains autonomy and emancipates herself from his authority. Similar compensatory activities can be shown in Examples 2, 6 to 8, and 12 or, by using the doctor in a reinforcing way, in Example 10.

## Discussion

### *Main findings: narratives as a device to cope with doctors*

As our data show, doctors' voices in told stories are autobiographically contextualized to special events and key scenes. Reported speech acts display the complex emotions that patients feel towards the professionals and the illness. Our data suggest several conclusions about the doctors' impact on the patients' experience of their illness:

- (a) Although the wish to be recognized and respected for one's efforts to cope is the same in both groups of patients with diabetes 2 or with chronic pain, the specific problems of their medical conditions entail their own risks and may put different aspects of the respective relationship. With the diabetes patients, doctors' may question the patients self-discipline, whereas the narratives of chronic pain patients suggest that they feel their pain is not adequately acknowledged (or even believed).
- (b) Doctors can play a pivotal role in the meaning making process of coming to

terms with the illness. Beyond their related actions, they are symbolic key figures in the context of feeling either understood and respected<sup>19</sup> or contested and disparaged. They may unsettle or validate their patients' grip on reality and identity constructions. Although at first sight their positionings in patients accounts seem to easily divide them into 'good' and 'bad' doctors,<sup>4</sup> close analysis shows that their evaluation can show many facets within a narrative according to different local stakes and interests. The very same behavior may be judged differently by different patients and for different reasons; the 'bad' or a doctor presented as abusive, for instance, can also indirectly help a patient by initiating an act of emancipation or insight, as in Examples 12 and 14. This is not to say that the same doctor did not find (or might not have found) a more effective way of communicating.

- (c) From our social interactionist and constructionist point of view, the narrations of encounters are themselves coping efforts to come to terms with the emotional impact of doctors on self-understanding and moral status of their patients (especially in Examples 2, 6 to 8 and 10 to 13), thus confirming the need to listen and to take patients' stories seriously in the medical consultation.<sup>5,20</sup> By means of their narrative strategies and stylistic devices, patients endow the narrated doctors and their own narrated selves with attributes and actions according to the moral of the story. Through narrative elaboration, creating distance and interactively acting out feelings they can cope with the emotional impact of the encounters and their illness experience. The constructed stories (which often bore the traces of having been told many times) can help patients maintain self-respect,

agency and self-esteem. Tensions between patients and doctors with respect to expertise and supremacy of interpretation are retrospectively negotiated. Our point is that the re-stagings of patient–doctor encounters are emotionally significant moral compensations and vindications. They create a new interactive reality and make up for the humiliations and loss of dignity which may, on occasion, underlie the experience of chronic illness or encounters with medical professionals.

### Strengths and limitations of the study

A consideration of our results has to take into account that they are not based on observations of clinical interactions, but on stories about patients' subjective experiences of them. As such they represent patients' efforts of meaning making and they shed light on the underlying moral problems which the illness itself introduces into the doctor–patient relationship. They also point out how the patients handle the emotional problems of their encounters with doctors in an unrestricted, biographically significant and non-responsive way. Compared to results from standardized scales, they draw on different psychological processes rooted in biographical meaning-making procedures and show situational goals of identity negotiation. So they deepen the predominantly cognitive approach of questionnaires. The impact of the here-and-now of storytelling, on the other hand, makes the data vulnerable to situational influences and offers a rather momentary and iridescent picture than the seemingly solid structure of patients' evaluations. Many of the accounts in the interviews, however, seem to be canonical as they bear the traces of having been told many times.

The limited range of medical conditions treated in this paper relativises the results and suggests further research into different diseases using the approach discussed here.

### Conclusion

We could show that the two illness conditions presented in this paper raise different challenges for the patients, which are reflected in their stagings of encounters with doctors: while diabetes patients have to vindicate their lifestyle habits, chronic pain patients have to cope with the problem of legitimizing their suffering. Their accounts provide insight into their efforts to defend their moral identity. Our data not only confirm the often registered need of the patients to be recognized and respected as human beings;<sup>20,21</sup> they also show that patients actively cope with their frustrations, regardless of whether they stem from the illness itself or from unsatisfactory encounters with doctors, by re-constructing them in a compensative and meaning-making way in their storyworld. To be effective doctors' efforts to help with self management and self control need to be administered from the perspective of the patients, and not only from the standpoint of health care.<sup>22</sup> Clinicians and researchers need to be aware that patients' stories are not simple representations of underlying 'facts' which may be adequate or distorted, but psychologically significant constructions from the inner world of patients. Accordingly, health professionals can learn from these stories about their patients' experiences and needs by the ways they perceive and construct them in their narratives as helpful or as destructive.

They should take these insights into the patients' perspective into account in order to help them maintain their self respect and moral dignity and to avoid frustrations and humiliations.<sup>23,24</sup>

The authors declare that there is no conflict of interest.

Informed consent has been obtained following the guidelines of the International Committee of Medical Journal Editors.

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