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Communication Study

Shame, honor and responsibility in clinical dialog about lifestyle issues: A qualitative study about patients' presentations of self

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ABSTRACT

Objective: To explore how patients enact presentations of self in consultations dealing with lifestyle in general practice.
Methods: We conducted a qualitative observational study with thematic, cross-case analysis of video-recorded consultations inspired by discourse analysis.
Results: Patients presented themselves with an orientation toward responsibility in dialog about lifestyle. They described how they were taking care of themselves and doing their best. In this respect, they demonstrated their achievements as matters of honor. If one lifestyle issue was considered problematic, in some cases patients shifted attention to another, of which they were more proud. In areas where they were not doing well, some patients revealed shame for not acting responsibly. In such cases, patients spoke of themselves in terms of self-deprecation or admitted not living up to expected standards.
Conclusion: Negotiations of shame and honor, revolving around personal responsibility, are embedded in clinical discourse about lifestyle. Patients take a proactive role in presenting and defending the self against shame.
Practice implications: GPs should pay more attention to the tacit role of shame in consultations. Failure to do so could lead to distance and hostility while a strategy to acknowledge the impact of shame could help develop and strengthen the doctor–patient relationship.

1. Introduction

Doctor–patient dialog is an essential aspect of treatment and prevention in general practice [1,2], and the patient's story has more influence on diagnosis than do findings from clinical examination and lab results [3]. The consultation involves not only medical problem-solving or disease prevention, but is also a social encounter that includes negotiations about identity, authority, and knowledge. Verbal and nonverbal cues have strategic and emotional purposes for those involved. The rules of the dialog are regulated by the roles of doctor and patient [4]. Discourse includes speech acts (utterances with performative action) and turn-taking (who speaks next), and these serve more or less conscious and legitimate ends [5,6]. The goals of doctor and patient may not be symmetric and are sometimes not even compatible.

Foucault described how disciplinary attitudes are mediated to people, often by experts, but also by public authorities. His term 'governmentality' denotes the impact of ideas and technologies on populations and individuals, and the ways in which these constitute the subjectivity of those affected [7]. Power is exercised through discursive practices by expert professions whose social authority legitimizes their messages. Symbolic power exercised in this way is more subtle than social power coerced through oppression. An obese person, for example, will be unable to escape the subtle disciplinary practices mediated by cultural discourse, and this also permeates the medical consultation [7,8].

Clinical dialog about lifestyle evokes responses related to identity and values, most noticeably on the patient's behalf. Doctors engage in health promotion, yet patients are not always ready to internalize lifestyle advice [9,10]. While it is usually the

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patient who introduces a symptom or health problem to the doctor, the roles may shift when it comes to lifestyle consultations [11]. Complying with preventive guidelines, the general practitioner (GP) looks for opportunities to address sensitive questions which are not initiated by the patient [12]. Too often such discourse is perceived as degrading or humiliating [13,14]. Some doctors may be reluctant to address lifestyle issues, thinking that they might disgrace the patient or create a moral distance [15,16]. Others admit that they use rhetoric to manipulate patients, or discourse that relies on scare tactics to deliberately evoke feelings of guilt and shame [17].

Smoking and alcohol use are sensitive matters in medical consultations [18]. Discussion of these topics is potentially face-threatening. 'Face' is the image of one's self in terms of approved social attributes that others may share [19]. In describing any state of affairs, a person is simultaneously engaged in a 'presentation of self' [20]. A person conveys an impression of himself or herself by what Goffman terms 'performance' [21]. This does not indicate that the presentation is false or rehearsed, but rather it is a mode of situating oneself as favorably as possible in the eyes of the other. A presentation of self will usually incorporate and exemplify values that are socially appreciated and it tends to be idealized to some extent to fit such perceptions [21]. It is also fitted to the situation at hand and to the expectations connected to it. Embarrassment emerges in a person whose representation of self is discredited and practices intended to protect the presentation of self are constantly enacted.

In a consultation, the patient performs a presentation of self in order to achieve a working consensus with the doctor. The empirical evidence described above indicates that the patient might be especially at risk of threats to face and embarrassment in consultations dealing with lifestyle issues. In our study, we explore how patients enact presentations of self in general practice consultations addressing lifestyle.

2. Methods

2.1. Design

We conducted a qualitative observational study with analysis of video-recorded consultations interpreted with theories of social interaction.

2.2. Material – Participants

We conducted our study in Danish general practice. We drew empirical data from video-recorded consultations which included discussions about physical activity, diet, smoking, and weight. We used 'specific preventive consultations', which are common in Danish general practice. Most of them are annual checkups of chronic disease. According to the Danish GP contract, these consultations are designed to assess patients' health risks and discussions of lifestyle are encouraged. Specific preventive consultations are also identified by GPs as the type of consultation where lifestyle discussions often take place. We established a purposive sample of GPs selected by age, gender, urban or rural practice, and practice experience. To ensure data rich in lifestyle discussions, the GPs were found among those doing the highest number of preventive consultations during 2010 according to national statistics. Six GPs (aged 42–64) were included, three male and three female. The GPs recorded two-to-four consultations each during a two-to-four week period. Fifteen consultations lasting 10–31 min were recorded. All patients attending for preventive consultations were eligible. The patients were 10 women and five men, aged 43–80.

2.3. Analysis

We reviewed all consultations and read all transcripts repeatedly to identify patterns of interaction in lifestyle discussions. We noticed that some patients' descriptions of their activities expressed emotions beyond those expressed in other parts of the lifestyle discussion. These more emotional statements often pictured patients' lifestyles in favorable ways. A closer look revealed that patients provided presentations of themselves as responsible people in matters of lifestyle. Following our initial review of the data, we conducted a thematic, cross-case analysis of the transcripts, emphasizing variations in the patients' presentations of self [21] in this specific context. We searched all consultations systematically for patients' talk that gave presentations of self in aspects of lifestyle. Having identified this discourse, we categorized and summarized according to the position of responsibility performed by the patient. We also had a specific look for expressed emotions, particularly with regard to honor or shame. We were inspired by discourse analysis, noticing how things are said as much as what is said [22]. Then we elaborated the meaning and impact of our findings further in a theoretical, second order analysis supported by theories on shame and honor [23]. ADG reviewed all consultations and made the first analysis of all transcripts. KM and SR analyzed selected parts of the transcripts to challenge and elaborate on the initial analysis.

3. Results

Patients demonstrated responsibility for lifestyle issues by presenting themselves with an orientation toward responsibility. They described how they were taking care and doing their best. If one lifestyle issue was considered problematic, some patients shifted attention to another one, of which they were more proud. In areas where they were not doing well, some patients revealed shame for not acting responsibly. In such cases, patients spoke of themselves in terms of self-deprecation or admitted to not living up to standards. In most cases patients gave these presentations of self with no obvious trigger from the GPs. We noticed that shame is intimately connected to self-monitoring and to how the patients imagined their presentations of self would be judged by the other person.

3.1. Empirical findings – Presentation of self in discussions of lifestyle

In studying patients' presentations of self in lifestyle discussions, we found that most presented themselves as 'responsible agents' in matters relating to their health. Lifestyle discussions were not only about habits, changes, and motivation, but also implied patients' own evaluation of their accountability as 'health agents'. We found that this evaluation was usually expressed as a matter of either honor or shame. Quotations are assigned patients' ID numbers also indicating the GP (A–F).

3.1.1. Demonstrating honorable responsibility for lifestyle

Patients' performed their presentations of self as being responsible for lifestyle in different ways. Some were integrated with aspects of talking about their usual habits, adding their knowledge of right and wrong with no particular emphasis; while others showed more emotion. One example of a presentation of self as a responsible patient came from a discussion about diet with a woman with diabetes (F3):

Patient (P): I believe that we really take care of what we eat in our family.

Doctor (D): Yes.