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# Discourses of Diabetes Management in Patient-Physician Interactions

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# Discourses of Diabetes Management in Patient-Physician Interactions

**Abstract**

Discussions of diabetes management are challenging for patients and physicians during treatment plan appointments—in large part because "diabetes management" has multiple, competing meanings. Our goal in this study was to examine talk between patients and physicians over multiple visits to: (1) determine the multiple meanings of diabetes management, and (2) determine the specific ways these meanings compete with each other. To accomplish this goal, we gathered data at a family medicine residency clinic in the Midwestern United States, video-recording the interactions of six different patient-physician dyads over multiple visits. Next, we performed in-depth analyses of these interactions using Baxter's (2011) Relational Dialectics Theory 2.0, which focuses on discourses occurring within interpersonal interactions, rather than on the individuals within interpersonal interactions. Our results reveal meanings associated with two dominant oppositional discourses comprising the meaning of diabetes management: high self-efficacy and low self-efficacy. Additionally, we found that—during conversations between patients and physicians—the central discourse of high self-efficacy competed with the less-central discourse of low self-efficacy. Our results also reveal that both patients and physicians used both discourses. Finally, our results revealed that at times, both patients and physicians mixed these discourses, creating a new "hybrid" meaning for diabetes management: Moderation. Understanding these discourses and how they compete can help physicians focus on the cultural discourses that shape their own and patients' views of diabetes management and realize the transformational possibilities that can occur in treatment plan discussions through a more moderate discourse.

**Keywords**

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# Discourses of Diabetes Management in Patient-Physician Interactions

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*Discussions of diabetes management are challenging for patients and physicians during treatment plan appointments—in large part because "diabetes management" has multiple, competing meanings. Our goal in this study was to examine talk between patients and physicians over multiple visits to: (1) determine the multiple meanings of diabetes management, and (2) determine the specific ways these meanings compete with each other. To accomplish this goal, we gathered data at a family medicine residency clinic in the Midwestern United States, video-recording the interactions of six different patient-physician dyads over multiple visits. Next, we performed in-depth analyses of these interactions using Baxter's (2011) Relational Dialectics Theory 2.0, which focuses on discourses occurring within interpersonal interactions, rather than on the individuals within interpersonal interactions. Our results reveal meanings associated with two dominant oppositional discourses comprising the meaning of diabetes management: high self-efficacy and low self-efficacy. Additionally, we found that—during conversations between patients and physicians—the central discourse of high self-efficacy competed with the less-central discourse of low self-efficacy. Our results also reveal that both patients and physicians used both discourses. Finally, our results revealed that at times, both patients and physicians mixed these discourses, creating a new "hybrid" meaning for diabetes management: Moderation. Understanding these discourses and how they compete can help physicians focus on the cultural discourses that shape their own and patients' views of diabetes management and realize the transformational possibilities that can occur in treatment plan discussions through a more moderate discourse. Keywords: Patient-Physician Interaction, Diabetes, Video-Recorded Interaction, Discourse Analysis, Relational Dialectics Theory 2.0, High Self-Efficacy, Low Self-Efficacy*

One of the most wide-spread chronic illnesses in the U.S. is diabetes. In 2012 the American Diabetes Association (2016a) estimated that 29.1 million Americans—nearly 10% of the population—had diabetes, with 1.4 million new cases of diabetes diagnosed each year. Considerable research has focused on the challenges of diabetes management, including patients' reluctance to discuss self-care behaviors with physicians (Ritholz, Beverly, Brooks, Abrahamson, & Weinger, 2014), lack of dietary knowledge (Nagelkerk, Reick, & Meengs, 2006), difficulty obtaining testing supplies and affordable medication (Handelsman & Jellinger, 2011), frustration with diabetes management requirements that conflict with patients' lifestyles (Horton, 2008), and trouble managing complex treatment regimens (Rubin, 2005).

To address these challenges, patient-centered medicine focuses on understanding the patient's view of their illness – what it means and what managing it means to the patient (McWhinney, 1989). This understanding enables patients and physicians to collaborate when making healthcare decisions. For example, the Patient-Centered Outcomes Research Institute (PCORI), established as part of the Affordable Care Act, advances rigorous research that includes the voice of patients in the evaluation of health research and outcomes (Frank, Basch,

& Shelby, 2014). To date, PCORI has funded over 70 diabetes-related research projects ([www.pcori.org/research-results](www.pcori.org/research-results)). Patients who actively participate in medical care decisions are more likely to adhere to treatment plans, report greater patient satisfaction, and experience improved clinical outcomes (Zachariae, Pedersen, Jensen, Ehrnrooth, Rossen, & von der Maase, 2003). For example, Bailey et al. (2016) evaluated the usefulness of a patient decisional aid to promote patients' knowledge of diabetes, self-efficacy, and certainty related to making health decisions. Those patients who used the decisional aid reported higher levels of knowledge, self-efficacy, and health decision certainty than those who did not use the aid. Bolen et al. (2014) provide further evidence of the utility of patient engagement in their meta-analysis of 138 randomized-controlled trials of patient engagement interventions. Compared to control groups or usual care, individuals with type 2 diabetes who participated in patient engagement interventions had improved hemoglobin A1c levels.

Scholars have also explored barriers to patient engagement and shared decision-making in the clinical context, such as different languages, low-health literacy, lack of appropriate clinical training, patient apprehension, and time (Blackstone, Garrett, & Hasselkus, 2011; Nekhlyudov & Braddock, 2008). We argue that understanding the meanings that shape patients' and physicians' views of a medical condition such as diabetes, are also essential factors in patient-centered care as well as in the successful development and implementation of any patient engagement intervention. Therefore, this study focuses on patient-physician interactions related to diabetes management to understand what discourses inform the meanings of diabetes management. We also examine how the meanings of diabetes management are shaped in the interplay between competing discourses.

## The Role of Talk in Disease Management

Mishler (1984) observed that the talk that forms the relationships between patients and physicians "has real consequences for diagnosis and treatment and for the course and outcome of patients' illnesses" (p. 12). Heritage and Maynard (2006) provide a detailed discussion of the two primary strands that have guided patient-physician interaction research. The first of these is *process analysis*, in which researchers systematically classify role and task behaviors within the patient-physician interview. Although there are a number of classification systems (e.g., Inui, Carter, Kukull, & Haigh, 1982), the best known of these is the *Roter Interaction Analysis System* (RIAS) (Roter & Larson, 2002), which has been used extensively to investigate broad types of patient-physician interaction, such as rapport-building talk, psychosocial/lifestyle talk, or biomedical talk in a myriad of contexts (Roter et al., 2014; Washington Cole & Roter, 2016). As successful as process analyses have been in terms of providing "exhaustive and quantified" overviews of medical encounters (Heritage & Maynard, 2006, p. 357), such schemas do not account for the content and contextual nuances inherent in patient-physician interactions.

As a redress, scholars have incorporated *discourse analyses* into their investigations of patient-physician interactions. Perhaps the best-known examples of studies in this second tradition are the works of Mishler (1984) and Waitzkin (1991). First, Mishler observed that physicians' and patients' talk reveals often contradictory "underlying frameworks of meaning" (p. 14). For example, physicians' talk tends to privilege[1] "the voice of medicine," such as biomedical evaluation and treatment. On the other hand, patients' talk tends to privilege "the voice of the lifeworld," such as everyday constraints and anxieties (p. 14). Waitzkin (1991) extended Mishler's insights, demonstrating how the fundamental, but unseen biomedical focus

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[1] Like Baxter (2011), we employ the term *privilege* as a verb meaning to show partiality toward particular discourses in one's talk.

built into medical discourse often works to marginalize the discourse most pertinent to patients' lives. We argue that Baxter's (2011) Relational Dialectics Theory 2.0 (RDT 2.0) permits extension of previous research on medical discourse in patient-physician interactions by providing an insightful communication-centered conceptual framework for understanding how discourses may influence patient-physician talk about diabetes management and how these discourses compete within the interactions taking place between patients and physicians.

## Theoretical Framework: Relational Dialectics 2.0

RDT 2.0 focuses on interpersonal interactions, attending to the *discourses* occurring within interactions, rather than to the *individuals* within interactions. Thus, scholars using the RDT 2.0 redirect attention from "an isolated sequence of words uttered by a speaker. . . to an utterance chain in which multiple discourses. . . can be identified" (Baxter, 2011, p. 18). The role of culture factors prominently in RDT 2.0, for as Baxter notes, "there is no such thing as culture-free interpersonal communication" (p. 53). Like many contemporary theorists (e.g., Bakhtin, 1981; Swidler, 2001), Baxter (2011) views cultures as constantly in flux, containing ideological fissures and constant incongruities, rather than as monolithic, fixed systems. According to Baxter, this view of culture allows the "interanimation of multi-ideologies [and] often competing, verbal ideological languages" (p. 54) within interpersonal interactions. As Baxter asserts, "[these] verbal ideologies are given life in the social standpoints at play in a given conversation; that is, interaction between individuals who are gendered, raced, and classed cultural members" (p. 54).

According to Baxter (2011), there are four links (or sites) in the utterance chain. Baxter (2011) visually represents these links as four flower petals that meet in the center, which represent any given utterance (see p. 51, figure 3.1). As Baxter notes, any utterance has the potential to simultaneously provide insight into each of the following four links. The first link includes *distal already-spokens (DAS)*, which include cultural resonances that have occurred previous to the current encounter and that inform the current encounter. The second link includes *proximal already-spokens (PAS),* which focus on how the combined history of conversational partners permeates their present conversation. The third link includes *proximal not-yet-spokens (PNYS),* which are the anticipated utterances of the other speaker within the encounter. There is a clear evaluative element to this link (e.g., "how will my utterance change what my partner thinks of me?"). Thus, the "meanings at stake at this link . . . are the social identities of the relating parties" (p. 98). The final link includes *distal not-yet-spokens (DNYS).* There is an evaluative component at this link too. However, anticipated responses/imagined judgments are from "a distal imagined listener" (p. 114) not present within the encounter. Because these anticipated judgments are from a generalized other, speakers often evaluate their own utterances according to the "conventional" and the "ideal," which are "embedded in a culture's discourses" (p. 114).

Baxter (2011) argues that "[m]eaning making emerges from the struggle of competing discourses, but those discourses are often not on an equal playing field" (p. 123). Thus, a primary goal for scholars employing the RDT 2.0 framework is to examine how meaning is constructed from the articulation of these often unequal discourses, as well as to examine why "some discourses are centered while others are marginalized" (p. 124). In an effort to reach these goals, scholars must map out both centripetal discourses—those moving toward the center, and which are often categorized as "normative, typical, and natural" (p. 123), and centrifugal discourses—those moving toward the margins, which are often categorized as "nonnormative, off-center, unnatural, and somehow deviant" (p. 123).

To our knowledge, no scholars have used RDT 2.0 as a framework to examine how discursive meaning systems compete as patients who manage chronic health conditions interact

with their physicians. Our work carries the potential to sensitize health care workers to the meanings guiding their *own* and their *patients'* understanding of diabetes management. By understanding the varied meanings of diabetes management, health care workers can gain clearer insight into the lived realities of patients and are thus better positioned to provide patients with the types of support they may need but may not express explicitly. To this end, we pose the following research questions:

RQ 1: What discourses inform the meanings of diabetes management?
RQ 2: How is the meaning of diabetes management shaped in the interplay between competing discourses during the medical appointment?

### Authors' Roles and Relationship to the Present Inquiry

Both authors are scholars in the field of Communication Studies. The first author is trained primarily as an interpretivist scholar. The second author is trained primarily as a post-positivist scholar who has recently employed more interpretivist methodologies. The second author has professional experience in the area of medical education and assessment. For the past decade, both authors have employed their respective epistemological perspectives in a number of research collaborations in the field of health communication. The current research stems from a mediated health education intervention for patients with diabetes who also experience low health literacy. The object of the intervention was to improve the quality of communication occurring during the patient-physician encounter. Patients participating in the intervention project viewed a short video in the medical examination room while awaiting their physician appointment. The video presented patients with information about their disease and strategies for communicating with their physician. As part of the intervention, the co-authors video-recorded the patient-physician encounters. When the authors were introduced to Baxter's (2011) theorizing on RDT 2.0, they believed that it would provide rich insights into such clinical encounters.

### Method

#### Setting

The authors, along with a team of undergraduate and graduate students, gathered the data at a family medicine residency clinic in the Midwestern U.S., which, at the time of the study, served nearly 8,000 patients, 400 of whom had diabetes. The Institutional Review Board at the hospital overseeing the clinic approved this study, as did the Institutional Review Board at the authors' university.

#### Rationale for a Qualitative Approach and Data-gathering Technique

We approached our study through a qualitative lens because we were interested in obtaining in-depth, detailed examinations of actual patient-physician interactions. We also wanted to provide readers with contextually-based insights that would benefit both patients and physicians. We video-recorded patient-physician interactions—a practice common among qualitative researchers working within medical contexts (e.g., Eggly, Barton, Winckles, Penner, & Albrecht, 2013; Ofstad, Frich, Schei, Frankel, & Gulbrandsen, 2014). Video-recording patient-physician interactions is part of the norm at this residency clinic, which records patient-physician visits for educational purposes. In the case of our study, video-recording patient-physician interactions provided us the opportunity to attend carefully and

unobtrusively to the ways in which communication occurred in this context. In turn, this allowed for in-depth analysis of the interaction. As do many qualitative researchers employing this methodology (e.g., Latvala, Vuokila-Oikkonen, & Janhonen, 2000), we conceptualize video-recordings as a form of participant observation, likening our own role at the clinic to one of Gold's (1958) four master roles: *participant-as-observer*. In this role we were able to openly acknowledge to participants our positions as researchers, as well as communicate our purpose to participants. For example, although all patients at the clinic are routinely informed that their visits may be recorded for educational purposes, we explained to participants that the data for this study were to be collected as part of an evaluation study of a mediated diabetes education intervention. We also explained to participants that the video-recordings would be stored securely at the clinic and that we would use pseudonyms in all published research findings stemming from the project in order to protect patients' identity.

**Case Selection**

Prior to the start of the larger evaluation study, physician directors and residents received, reviewed, and signed consent forms. Prior to recording patient-physician visits each day of data collection, the authors, or a member of the research team, discussed the project with the patients, provided them a copy of the consent materials, and collected signed consent forms from those willing to participate. Overall, 73% of the patients we approached agreed to participate in the study, resulting in a data set containing 101 videotaped patient-physician cases. Twenty-eight of the patients returned for a second or third visit during the 15-month data collection period. Twenty-six of the returning patients reaffirmed their consent to participate in the study.

For the current project, we looked specifically for cases demonstrating a *shared history* between the patient and the same physician, which allowed for a more in-depth examination of the utterance chain (Baxter, 2011). We reviewed all of the 26 cases with multiple visits to ensure that all visits focused on diabetes management and that all visits were with the same primary care physician (because the research site was a residency clinic, patients often were assigned new physicians when residents graduated or saw different residents for same day appointments). Finally, some of the return visits were for acute care or emergency room follow-up. These visits did not focus on diabetes management in a meaningful way and were subsequently excluded from the data set.

The final data set for this analysis included video recordings of 14 total visits of six patient-physician dyads. All six patient participants were Caucasian. Patient participants (5 females and 1 male) ranged in age from 34-75 (mean age = 45.17; median age = 46.5). All patient participants had a diagnosis of type 2 diabetes. All physician participants were Caucasian. Physician participants (2 females and 4 males) ranged in age from 28-51 (mean age = 33.3; median age = 30). Three of the physician participants were residents and three were physician directors. The age and race demographics of the participants included in this analysis are reflective of the entire dataset. The larger dataset, however, did include more male participants (48%) than is represented in the current analysis (17%).

**Data Analysis**

**Credibility and confirmability.** Lincoln and Guba (1985) describe a number of criteria by which qualitative research can be judged credible and confirmable, as well as the associated procedures used to achieve these criteria. Before we describe our particular analytical procedures, we delineate how we established credibility and confirmability in our own study. First, we had *prolonged engagement* in the culture from which these data were gathered.

Because we spent 15 months gathering data, we came to understand more fully the culture of the clinic, including the people who worked there and the people the clinic served. Second, we performed a *negative case analysis,* during which we attended to aspects of the data that seemed contradictory to evolving patterns. This allowed us to amend and expand our explanations to account for varying occurrences in the data. Third, we *identified exemplars*, which reflected clearly the discourses and the discursive contradictions that we claimed were present in the talk. We established confirmability in two ways. First, we used *investigator triangulation*, engaging in a confirmatory coding process during which we verified and challenged any discrepant interpretations of the data until we reached consensus. Second, we maintained an extensive and detailed *audit trail* throughout the entire investigation, so that we could easily reference and explain previous work.

**Procedures.** We transcribed all visits in each of the cases verbatim, resulting in 172 pages of typed transcriptions. The visit lengths ranged from 8 minutes 30 seconds to 29 minutes 5 seconds with an average visit length of 21 minutes and 21 seconds. We focused on analyzing language instead of nonverbal expressions and gestures because, in most cases, the ceiling cameras at the clinic did not capture clear facial expressions of both the patients and the physicians (often the view was from behind the physician or a side view of the interaction). In other cases, the quality of the video allowed us to clearly hear the interaction but did not allow us to visually attend to detailed nonverbal cues.

The transcriptions did allow for a detailed contrapuntal analysis (Baxter, 2011) which emphasizes the ways in which various discourses compete within a given text(s). Specifically, we followed the method Baxter articulates in her work, much of which is "common to most qualitative/interpretive analyses and is fruitful in the identification of discourses" (p. 161). To begin, we reviewed the "completed set of transcripts from beginning to end in order to gain a holistic sense" of the entire data set (p. 162). Next, we identified all talk concerning diabetes management. We located 49 specific passages, which involved 107 of the 172 transcribed pages.

Following this initial analysis, we carefully reviewed the "diabetes management" passages to generate initial coding categories. Examples of these included *action* (Exercise is important; Patient monitors blood glucose levels closely), *strategizing* (Developing memory aids for medicine; Patient moves supplies to convenient location), *blind faith* (Patient relies on pharmacy, rather than her own monitoring of medical supplies; Doctor supports patient's blind faith), and *constraint* (Patient resources/supplies running out; Inconsistent work schedule impacts taking medicine on a consistent schedule). We sorted through the initial coding categories, refining, re-categorizing, and combining them until no new coding categories emerged, a point known as "theoretical saturation" (Strauss & Corbin, 1998). Next, we worked in an iterative, recursive manner to "identify larger patterns by clustering the lower-level codes" (Baxter, 2011, p. 162). As in the previous step, we continued this process until we reached theoretical saturation, stopping when the analysis yielded no new themes. The result of this analytic step was the identification, naming, and defining of two higher-order themes or primary discourses, as well as a number of sub-discourses. Finally, we located specific exemplars which "capture[d] the essence" of these discourses/sub-discourses (Baxter, 2011, p. 164).

Our next analytical task—identifying how these discourses competed as the patient-physician dyads co-created meaning about managing diabetes—represented a methodological point of departure from the previously described procedures. Here, we analyzed how the identified discourses competed by scrutinizing the talk of the participants carefully. We used three forms of discursive markers, each of which helped sensitize us to instances of competing discourse within the talk (Baxter, 2011; Martin & White, 2005). These included *negating* (a discourse marker that plainly rejects or dislocates another discourse, which is often evidenced

in words and phrases such as, "not," "no way," and "never"), *countering* (a discourse marker that displaces a discourse with a different discourse, which is often evidenced in words and phrases such as, "although," and "on the other hand"), and *entertaining* (a discourse marker that suggests a discursive position is just one among many possibilities, which is often evidenced in words and phrases such as "perhaps," and "it could be"). Our final analytical task was to explore the "discursive details of centripetal-centrifugal struggle" (Baxter, 2011, p. 168).

## Results

In our first research question, we ask, "*what discourses inform the meanings of diabetes management?*" Our analysis of patient-physician interactions revealed that two primary conflicting discourses inform the meaning of diabetes management: high self-efficacy and low self-efficacy.

### The Discourse of High Self-efficacy

Bandura (1986) defines self-efficacy as:

> [P]eople's judgments of their capabilities to organize and execute a course of action required to attain designated types of performances. It is concerned not with the skills one has but with judgments of what one can do with whatever skills one possesses. (p. 391)

According to Bandura (1977, 1986, 1997) high levels of self-efficacy can reduce one's perceptions of barriers and increase one's confidence that new behaviors will yield desired results. The discourse of high self-efficacy is embedded into a number of macro American discourses (Baxter, 2011; Kohls, 1994), including *rationalism* (that if one has a goal and determines that the goal is possible, one will undertake the action necessary to reach the goal), *self-discipline* (that one must control impulses that thwart the achievement of one's goals), *personal responsibility* (that one is solely accountable for one's actions), and *free will* (that one acts according to one's own choices, rather than as a result of external forces). Because behavior change is viewed as essential for reducing practices that lead to or exacerbate chronic illness, the discourse of high self-efficacy has gained wide purchase in the fields of health care—particularly in terms of managing chronic illnesses (Choo & Kang, 2015). The discourse of *high self-efficacy* was evidenced in our study by three interconnected themes: (1) controlling one's self and one's medical regimen; (2) overcoming one's habitual way of being in the world; and (3) self-surveillance and self-monitoring.

**Control of one's self and one's medical regimen.** In the following exemplar, high self-efficacy discourse is apparent in the conversation between "Adele," a Caucasian female, aged 34, and her Physician, "Dr. A," a Caucasian male, aged 28 [Visit 1, Passage C]. Specifically, Dr. A emphasizes the importance of controlling one's medical regimen as the key to managing diabetes.

> Dr. A: Your deal is you've got some medical problems and you're young. . . if you stay on top of them you are going to be the perfect picture of what the United States wants to have happen. I mean live long, deal with chronic issues. We have medicines that treat [diabetes and with] . . . diet [and] exercise, you'll live just as long as everyone else [Adele nods her head up and down in agreement]. Counterside is the gal who was [here earlier]. [She] had similar issues and she just doesn't care. . . . She smokes, and you don't smoke. She just

doesn't care, and I'm trying to think, "you're just going to die early, so good for you."

Adele: I got babies I want to see grown. . . . I got future grandbabies I want to see [laughs].

In this exemplar, Dr. A sets Adele up to be "the perfect picture" of U.S. chronic disease management—provided that she "stay[s] on top" of her "medical problems." Dr. A states that medication, diet, and exercise will allow Adele to live "as long as everyone else," to which Adele nods in agreement. Dr. A uses a countering move to contrast Adele's own health-related behaviors and bright future with those of another patient with diabetes who "just doesn't care." Here, Dr. A juxtaposes the discourse of high self-efficacy with that of low self-efficacy ("counterside"), noting that apathetic patients who do not follow treatment plans will "die early." This cautionary tale illustrates for Adele that her desire to be a part of her children's and grandchildren's lives will be realized only if she maintains tight control over her medical regime.

      **Overcoming one's habitual way of being in the world.** High self-efficacy discourse was also in evidence as physicians encouraged patients to overcome their habitual way of being in the world by adopting consistent exercise routines and by quitting smoking. Patients also identified ways of overcoming their habitual way of being in the world. For example, "Danielle," a Caucasian female, aged 36, does this by describing to her physician, "Dr. D," a Caucasian female, aged 34 [Visit 2, Passage A], the need to keep her diabetes supplies where she can see them so that she might be prompted to monitor her blood glucose more consistently.

Danielle: I carry [my glucose monitor] in my purse all the time, just so I've got it with me. . . . And, I think I need to maybe stop because if I don't see it out, I don't—

Dr. D: You don't think about it.

Danielle: I don't think about it. And I think maybe if I had it sitting out someplace where [I could see it], like either the kitchen counter or my bathroom—

As we see in this exemplar, Danielle's first PNYS communicates a discourse of high self-efficacy to Dr. D, in that she practices diligence habitually ("I carry [my glucose monitor]. . . all the time"). However, Danielle's second PNYS entertains the notion that she might adapt a better habit to help her practice diligence ("I think I need to *maybe* stop [carrying the glucose meter in her purse]").

      **Self-surveillance and self-monitoring.** The discourse of high self-efficacy was also evident in patients' and physicians' talk about the importance of self-monitoring in patients' diabetes management. For example, in a visit in which Dr. A asks Adele to report her blood glucose readings [Visit 1, Passage A], Adele replies, "Actually it's not, it wasn't too high this morning compared to usual." Here, Adele's PNYS seems aimed at reducing any potential disapproval from Dr. A for having consistently high blood glucose values. First, Adele reports a qualified success ("wasn't too high"). Next, Adele simultaneously implies that she regularly monitors her blood glucose and acknowledges that her blood glucose is usually high ("compared to usual"). Later, as Dr. A is reviewing Adele's blood glucose log, Adele mentions that she "should have brought the other book [because] I could have showed you that [her blood glucose readings have] been about the same." In addition to wishing to show Dr. A her blood glucose numbers and the potential reasons why some of her numbers are high, Adele seems anxious to show Dr. A that she has indeed, been keeping good records of her blood glucose values. High self-efficacy discourse is clearly demonstrated by Adele's emphasis on collecting

and monitoring objective scientific evidence (e.g., blood glucose values) in order to *use* that information to make positive changes in her diabetes management.

## The Discourse of Low Self-efficacy

Bandura (1977, 1986, 1993) observed that people often experience feelings of low self-efficacy when dealing with threats or difficult circumstances. Bandura (1993) notes that those with low self-efficacy tend to focus on their own failures, limitations and potential obstacles. Thus, they often experience diminished desire to achieve certain goals and often have lower commitments to goals they *do* pursue, giving up rapidly when confronted with setbacks or challenges. Rebounding from failure is often more challenging for those experiencing low self-efficacy because they often perceive their unsatisfactory performance as a measure of their low capability. Additionally, Bandura and his colleagues (1999) suggest that if one perceives low self-efficacy in a given situation, he or she can experience higher anxiety and higher "feelings of futility and despondency" (p. 259). The discourse of low self-efficacy is rooted firmly within a larger cultural discourse of "fatalism," which, as Keeley, Wright, and Condit (2009) point out, is "understood as the subset of deterministic attitudes that project pessimistic rather than optimistic futures" (p. 736). Citing extant literature, Keeley et al. articulate three, often overlapping, dimensions that comprise fatalistic attitudes: (1) a sense that one lacks control over external events; (2) a belief in fate, luck, destiny and predestination; and (3) a sense that one is powerless, hopeless, and purposeless. The discourse of *low self-efficacy* was evidenced by two interconnected themes, both of which emphasized one's inability to control one's diabetes. These included: (1) concession of personal control; and (2) succumbing to one's habitual way of being in the world.

**Concession of personal control.** In the following exemplars, we see three distinct ways that the discourse of low self-efficacy is evidenced in talk emphasizing concession of personal control in patients. First, concession of personal control is attributed to external factors. For example, In one appointment between "Conrad," a Caucasian male, aged 53 and "Dr. C," a Caucasian male, aged, 28 [Visit 2, Passage A], Conrad highlights how work-related pressures have resulted in his higher-than-normal blood glucose readings.

> I was having a hard time there. I had some business. . . . They put a deadline on me. . . . I was up until three in the morning several nights in a row doing paperwork, and just, 'Oh God!'" [shakes head].

In the second example, concession of personal control is attributed to internal factors. Specifically, Adele concedes control by stressing how pain in her body has prevented her from engaging in the kind of exercise needed to keep her weight in check. As she notes, "because [of] the lowness in my activity because of my back [pain] again, I'm slowly creeping up on my weight again. It's really pissing me off." Both Conrad's and Adele's comments suggest that even though they *desire* control, extenuating circumstances (internal and external) impede their abilities to exercise it.

In the third example, concession of self-control is actually endorsed when "Bonnie," a Caucasian female, aged 69, reviews a list of potential prescription refills with Dr. B, aged 32 [Visit 1, Passage B]. Referring to the medications, Bonnie confesses, "I don't look at the bottle. I just send 'em in." Dr. B laughs, replying, "that's totally fine." This short exchange, Bonnie's willful ignorance about the medication she takes as well as Dr. B's approval of that ignorance, is consistent with a paternalistic medical discourse (Emanuel & Emanuel, 2000), in which doctors "know it all" and patients often concede to them decisions related to their own health care.

**Succumbing to one's habitual way of being in the world.** Our findings revealed that the discourse of low self-efficacy was expressed as patients lamented the difficulty of changing habits. For example, in a conversation between Bonnie and Dr. B [Visit 2, Passage C], Dr. B asks Bonnie whether or not she is still smoking. Bonnie admits to smoking and asks about a medication she believes will help her stop smoking.

> Dr. B: Well, you know the big thing is that—
> Bonnie: You gotta do it.
> Dr. B: You gotta do it. You gotta want to do it. You know.
> Bonnie: I know.
> Dr. B: You know me saying anything, and it doesn't matter. You've got to personally   say, "this is the time."
> Bonnie: Yep.
> Dr. B: And the medicine does help, but I have seen people that it doesn't work on because they are not ready.
> Bonnie: They're not ready, right?
> Dr. B: You have to be ready so—
> Bonnie: That's me. I've tried so many times. I guess I'm just not ready.

This exemplar illustrates clearly that it takes a high level of commitment to solidify newly adopted behaviors into new habits and that old habits are hard to break. For instance, Dr. B counters Bonnie's request for smoking cessation medicine, explaining, "[w]ell, you know the big thing is that—." Bonnie completes Dr. B's sentence with the PNYS "[y]ou gotta do it," using high self-efficacy discourse to indicate that she understands the commitment needed to quit smoking. However, after hearing repeatedly from Dr. B that a high level of commitment to success is the key to quitting smoking, Bonnie uses a low self-efficacy discourse, conceding that she is not as committed as she needs to be ("I've tried so many times. I guess I'm just not ready").

## Interplay of Discourses

Baxter (2011) challenges RDT 2.0 scholars to attend to the ways in which multiple discourses occur *simultaneously*, articulating a variety of dimensions that can present synchronically at any of the discursive sites along the utterance chain. This challenge led to our second research question, in which we ask, "*How is the meaning of diabetes management shaped in the interplay between competing discourses during the medical appointment?*" Our analysis revealed that at times there was a simultaneous interplay of both high and low self-efficacy discourses, which occurred in two specific ways: (1) antagonistic and non-antagonistic struggles, and (2) transformation.

**Antagonistic and non-antagonistic struggles.** Two of Baxter's "synchronic dimensions" include *antagonistic and non-antagonistic struggles*. According to Baxter (2011) *antagonistic struggles* occur when the utterances of different speakers align with divergent discursive positions. On the other hand, *non-antagonistic struggles* occur when at least two discourses are present within the utterances of a single speaker. The following exchange between Conrad and Dr. C [Visit 1, Passage D] reveals both antagonistic and non-antagonistic struggles as the centripetal discourse of high self-efficacy and the centrifugal discourse of low self-efficacy compete simultaneously. In this exemplar, Conrad reintroduces a topic he had broached earlier in the visit: potential bariatric surgery.

Conrad: It's like I went through the emotional stress of deciding to have that surgery that summer, 'cause I'd kicked it around for several years. . . . 'Cause I'd fought with myself. "I'm not gonna give in. It's too easy." And then they. . . came out and said, "it cures diabetes." And that made it a little easier to make the decision. . . . [the surgery was] scheduled to go and . . . now I'm kinda in that torment again. Y'know, "go through it or not?" . . . . If [the cardiologist would] clear me to have it, I'd almost do it. It's just. . . . If it'd cure the—if I never had to give myself another shot. It's "aww, man [laughs]!"
Dr. C: Well, let's see how it goes with this diet thing, and. . . . Ya never know what'll happen, so. . . . Maybe you can avoid havin' to do that, 'Cause [bariatric surgery] can carry some risks.
Conrad: I know, I know. I hate—[shakes head "no" slightly].

Antagonistic and non-antagonistic struggles between the centripetal discourse of high self-efficacy and the centrifugal discourse of low self-efficacy manifest a number of times during this excerpt. To begin, Conrad reports that when he first considered bariatric surgery, he had vacillated between these two discourses ["I'd kicked it around for several years"] ["I fought with myself" about the decision to "give in" to this "easy" solution]. Conrad then engages countermove that tilts toward the discourse of low self-efficacy [And then they. . . came out and said, "it cures diabetes"]. Given the "cure," Conrad reveals that he is seriously considering this medical intervention, despite feeling "torment" over the decision ["I'd almost do it. It's just. . . . If it'd cure the—if I never had to give myself another shot"]. Dr. C's entertaining moves to interject high self-efficacy discourse into the conversation ["Well, let's see how it goes with this diet thing"] ["Maybe you can avoid havin' to do that"] suggests an antagonistic struggle, in that it suggests that Conrad should continue trying to control his diabetes through his diet, given the risks that bariatric surgery might impose. Conrad acknowledges the risk ["I know, I know"] and shakes his head to indicate that he is still somewhat caught between both discourses.

**Transformation.** Baxter also describes *transformation*—a moment in which previously oppositional discourses, although they are still different, "lose their zero-sum relation" (p. 139). During such moments new, non-oppositional, and transcendent meanings materialize. Thus far, our analysis has illustrated the polemic positions of high and low self-efficacy. However, in some of the exchanges, patients and physicians moved from these polemic positions to a "newly emergent meaning" resulting in a "discursive transformation" (Baxter, 2011, p. 139). In the following passage, in which Dr. A and Adele [Visit 1, Passage B] are discussing Adele's eating habits, they create a "discursive hybrid" in which they mix two distinct meanings to create a new meaning that eliminates the "zero-sum dynamic" of the polemic positions of high and low self-efficacy. The new, hybrid discourse is *moderation*, and is used as a means of introducing flexibility into the management of diabetes to address the complexities of social life and physical health.

Dr. A: How's your diet?
Adele: I've been cuttin' back.
Dr. A: Good.
Adele: Watchin' what I eat, which this month's horrible because we have . . . my birthday, then we have Father's Day, then we have my mom's birthday, and my dad's birthday. So there's always a little bit of cake in there, but—
Dr. A: Moderation.
Adele: Exactly.

As Adele lists the month's celebrations that have the potential to force her to succumb to her habitual way of being in the world, a discursive position of low self-efficacy, Adele offers a contradiction to that discourse [but—], which Dr. A completes with the statement, "moderation." Dr. A could have completed the counter with a high self-efficacy discursive position, such as advice for how to stick to strict diet restrictions in the face of temptation. Instead, Dr. A and Adele jointly endorse moderate enjoyment of the celebratory treats—a hybridization of high and low self-efficacy discourses. This is evident when Adele answers, "exactly."

The hybrid discourse of moderation can be empowering and liberating for some patients while for others, it may be a struggle. For example, the following passage illustrates that the discourse of tight control looms large in Bonnie's understanding of diabetes, even though Dr. B introduces the discourse of moderation to address potential negative health outcomes of such strict control.

> Bonnie: Mostly I don't eat at night.
> Dr. B: O.k. Well, the only thing is, is you're runnin' low—your lows are in the morning—sometimes that means that you actually need a little bit of something to get you through the night. And I don't mean a whole new meal. It's just something like . . . a piece of fruit.
> Bonnie: I never eat after 6:00.
> Dr. B: Which is good! I mean normally, that's kinda our deal.
> Bonnie: 'Cause I can't eat and go to bed.
> Dr. B: I know. And, so our problem is—is that sometimes with diabetes your blood sugars will kinda do this up and down thing unless we give you a little bit of food all the time. And, so sometimes [the] problem is that you're going too low.
> Bonnie: Last night I got real hungry about 10:00, but I didn't eat anything.

This exchange illustrates how absolute adoption of the discourse of control over one's self can sometimes be detrimental to one's health. Dr. B introduces the discourse of moderation when she says, "sometimes that means that you actually need a little bit of something to get you through the night. And I don't mean a whole new meal. It's just something like . . . a piece of fruit." Using the discourse of moderation, Dr. B advocates for flexibility with night-time eating, yet clarifies with the counter that she is not endorsing an entire second meal, so as not to shift Bonnie too far afield of her strict adherence. Rather, Dr. B uses the discourse of moderation to counter Bonnie's strict adherence to the "no eating at night" rule, even when she "got real hungry about 10:00," which has contributed to her blood glucose fluctuations.

In other instances, patients resisted moderation as a sign of weakness, as is the case in the following exchange between Dr. F and Fran [Visit 1, Passage B]:

> Fran: I always, when I go to the hospital or any place like that, I go the steps, I don't take the elevator, because I need the exercise.
> Dr. F: Yeah.
> Fran: But [taking the steps is] out. That kinda' bothers me up here [points to head] because it kinda hurts my pride to think I can't walk up all those steps.
> Dr. F: Yeah, sure. But you can walk on a flat surface.
> Fran: Yeah, sure. Oh I can walk without it hurting, I know it's there, but it doesn't hurt. I have a treadmill I use, and then of course I'll be getting out on the bike path now this summer.
> Dr. F: Good.

Fran: I ride the bike.
Dr. F: Yeah, that's the key. I mean we don't want the arthritis limiting your, your exercise so much that you start having troubles with your blood sugars. . . . [A]s long as you can walk, it doesn't have to be fast. It doesn't have to be up steps.
Fran: I can.
Dr. F: You know that's what we need.
Fran: I can avoid steps pretty much.
Dr. F: K.
Fran: But, I always thought it was healthy for my heart to climb the steps.
Dr. F: Well, not necessarily.
Fran: Well, anyway.
Dr. F: Not necessarily.
Fran: But anyway, uh.
Dr. F: OK.

As Dr. F and Fran discuss Fran's ability to stay active, both are moving toward a discursive position of moderation, which enables Fran to obtain the health benefits of exercise, while also attending to the constraints of her arthritis. Even though Fran can no longer climb stairs, she can bike and walk on flat surfaces. Dr. F praises Fran for her active lifestyle and does not want the arthritis to progress to the point that it impedes her ability to stay active. Dr. F introduces the moderation discourse with the counter, "but as long as you can walk, it doesn't have to be fast, it doesn't have to be up steps." Fran counters with the statement, "but, I always thought it was healthy for my heart to climb the steps." Dr. F's entertaining move ["not necessarily"] moderates Fran's strict adherence to exercise rules that may not serve her well. Fran attempts to change the topic with her "anyway" responses. Dr. F finally drops the issue with an "OK." It seems here that the discourse of moderation may be hard for Fran to accept because it is also an acknowledgement of her diminishing abilities, as is evident in her statement that not being able to be as physically active as before bothers her "up here [points to head]" along with her reluctance to join Dr. F in a conversation about why climbing steps may not be a healthy option for her.

## Discussion

Our study has identified the discourses that inform the meanings of diabetes management and how the meaning of diabetes management is shaped in the interplay between these competing discourses during the medical appointment. Our analysis reveals three main findings. First, the meaning of diabetes is tied to two prevalent, competing medical discourses surrounding diabetes management. Specifically, the discourse of high self-efficacy frames diabetes management as one's ability to exercise control, engage in careful and consistent self-monitoring of blood glucose levels, and overcome lifestyle habits that are potentially detrimental to good health outcomes. The discourse of low self-efficacy frames diabetes management quite differently, revealing difficulties controlling one's behavior, a lack of personal agency, and submission to external factors that challenge one's ability to effectively manage one's diabetes.

Second, high self-efficacy is centripetal–centered–in a number of macro cultural discourses that embrace self-discipline, personal responsibility, rational behavior, and rational science. Within this discourse, problems occurring in one's life are often attributed to one's poor choices, bad habits, or laziness (Kohls, 1994). Therefore, success in overcoming problems resides in individuals' abilities to change how they act in the world. And, the discourse of high

self-efficacy within medical contexts drives what it means to engage in self-care behaviors, which have been associated with improved health outcomes for those managing diabetes (Gao et al., 2013). Indeed, even using the term "management" with diabetes or health reinforces control-centric values. The centripetal position of high self-efficacy, however, is continually challenged synchronically by low self-efficacy, a prevalent experience for many but one that is centrifugally positioned in medical contexts because it emphasizes a lack of personal volition and fatalism that supports the perception that one is powerless to change (Keeley et al., 2009).

Our study reveals that discourses of high self-efficacy and low self-efficacy are fluid as they are enacted in patient-physician interactions. We see, for example, situations in which patients' talk reveals rapid shifts between discourses of high self-efficacy and low self-efficacy. And, as many of our examples suggest, life circumstances often interfere with one's ability to remain adherent to prescribed medical regimes and strict adherence does not automatically guarantee positive health outcomes. This is consistent with the literature (e.g., Broom & Whittaker, 2004), which acknowledges the tremendous physical and social complexities inherent in managing diabetes. Thus, diabetes management does not simply mean *high self-efficacy*. Rather, diabetes management means the continual negotiation of the interplay between high and low self-efficacy. Interestingly, *both* physicians and patients invoke discourses of low and high self-efficacy at various times during appointments. For example, physicians endorse low self-efficacy, specifically conceding personal agency, when they support patients' blind faith in the medical system. Patients' low self-efficacy discourse is also clear, as we saw in the exemplar when Conrad expressed a desire to endure bariatric surgery because of difficulty monitoring his diet. Alternatively, patients invoke the discourse of high self-efficacy to address potential PNYS admonishments from physicians for behaviors consistent with low self-efficacy, such as a lack of self-monitoring or slipping back into lifestyle habits detrimental to one's health. High self-efficacy discourse is also evident as patients propose behavioral change strategies that will help them adhere to dietary recommendations or self-monitoring expectations. Yet, consistent, strict control is not necessarily feasible or advisable. This leads to our third main finding, that a transformative discourse of moderation can inform what it means to effectively "manage diabetes" in patient-physician interactions.

The transformative discourse of moderation is a position that reconciles the two contradictory discursive poles of high and low self-efficacy. In our study, this more moderate, hybrid position offered a realistic conceptualization of management (i.e., Adele's report on how she was handling her diet during a month of family celebrations). This more moderate discourse was also introduced by physicians in response to patients' strict adherence to a high self-efficacy discourse that was actually detrimental to the patient's health. Interestingly, in these instances, patients struggled with the discourse of moderation as it seemed contrary to a health "rule" (i.e., Bonnie's imperative that she must not eat after 6:00 p.m.) and/or indicated personal weakness (i.e., Fran's confession that no longer being able to walk up stairs "kinda hurts my pride"). These findings imply that for some patients, adhering strictly to rules can actually be easier than enacting behaviors consistent with the discourse of moderation. And, for other patients, moderation may be perceived as a sign of weakness. Thus, a potential challenge of the discourse of moderation is that it requires patients to critically evaluate choices and anticipate outcomes of those choices in the moment. This task can be overwhelming for patients, making it difficult to adopt behaviors consistent with the discursive position of moderation.

Nonetheless, the use of a more moderate discourse is consistent with literature on managing patients' diabetes in constructive ways, such as "setting realistic and attainable" goals (van de Laar & van der Bijl, 2002, p. 68) and dividing up larger, more difficult diabetes-related tasks into smaller, more easily manageable tasks. Motivational interviewing (Christie

& Channon, 2013; Miller & Rollnick, 1991), which has become widely accepted in the medical community over the past three decades (and in which residents receive instruction at the site of the current study), resonates soundly with a moderation discourse. By using an exploratory interview style including open questions and active listening, health care workers employing motivational interviewing help patients express incongruities between their current health state and their desired health state. Emphasizing empathy and understanding of patients' situations, health care workers using motivational interviewing also normalize patients' circumstances, and stress patients' personal choice about the extent to which (or even if) they wish to approach their health issue through medical interventions. As Christie and Channon (2013) observe, although a health care worker using motivational interviewing contributes to the patient's treatment, the patient directs his/her own health journey. In our view, such an approach exemplifies a moderation discourse of diabetes management because it does not automatically advocate for high self-efficacy or demonize low self-efficacy. Rather, it works within the constraints and context of patients' lives.

Our study demonstrates that high and low self-efficacy discourses animate the talk of *both* patients and physicians. This work is important because it draws attention to the competing, but subtle meanings that may affect the management of chronic diseases such as diabetes. Understanding these meanings can help physicians focus on the cultural discourses that shape their *own* views of diabetes management, understand the discourses shaping their *patients'* views, and realize the transformational possibilities that can occur in such talk through hybrid positions such as moderation.

### Limitations and Opportunities for Future Research

Our findings must be interpreted in light of specific research design constraints, which offer opportunities for future research. First, our work occurred in one family medicine residency clinic. While we feel confident that the high and low-self efficacy discursive struggle extends beyond the realm of primary care, the degree of that struggle likely varies depending on the medical specialty. For example, patients may not be able to have a high degree of self-efficacy when needing surgical interventions. Future research should examine patient-physician interactions occurring across different medical conditions requiring the skills of other types of medical specialists. Second, as we have discussed above, for a case to be included in the current analysis, it had to have at least two video-recorded patient visits with the same physician. This design criterion was essential given the assumptions of RDT 2.0 that we wished to explore. This criterion did, however, limit the number of cases available for analysis. For example, our research site was a physician-training clinic. Many of the patients in the dataset with multiple recorded physicians' appointments visited two different physicians, and thus those visits did not meet the inclusion criteria. Future research could be strengthened by including more cases in the analysis. That said, we are confident that our findings illuminate a prevalent discursive struggle, given the strong evidence in our exemplars and present in extant literature.

Finally, we encourage future researchers to focus on how transformative discourses are introduced and are received by relationship partners. Baxter (2011) explains how discursive transformation can happen in relationship talk, yet limited research exists that empirically demonstrates these concepts (see Norwood, 2013 or Scharp, 2013 for exceptions). In the health care context, the idea of moderation can be introduced as an attainable means of balance between health and life needs. Yet, for some and as evidenced in our findings, living the discursive position of moderation is not as simple as the messages may suggest. Future RDT 2.0 research that embraces the conceptual complexity of meanings and synchronic interplay has the potential to reveal reasons why *simpl*e strategies for success cannot be *simply* enacted

in the face of meaning and discursive opposition. This understanding can help reduce unproductive talk, as well as reduce the repetition of ineffective patient-physician visits. It can also help identify communication strategies for activating meaning systems that work for patients managing chronic disease.

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