

Competing Discourses of Professional-patient Relationships in Type 2 Diabetes

Management

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Abstract

Type 2 diabetes is a contradictory chronic illness that needs to be managed in cooperation with health care professionals. Despite the significant role of the professional-patient relationship in diabetes management, the meaning of this relationship as part of diabetes management has not yet been studied. The aim of this qualitative study is to describe the competing discourses of professional-patient relationships in type 2 diabetes management. As a background theory, the study applied the relational dialectics theory (RDT) 2.0 by analyzing discourses in patients' interpersonal communication experiences with health care professionals. Overall, 63 experiences were analyzed using contrapuntal analysis. According to the results, both the patients' positive and negative descriptions were connected to three struggling discourses: 1) having the right to care versus deserving care, 2) guidance versus control, and 3) personalization versus standardization. These discourses offered new perspectives to clarify and strengthen the role of professional-patient relationships in type 2 diabetes management.

Introduction

Diabetes is one of the most common chronic illnesses in the world, affecting patients' physical, psychological, and social wellbeing in several ways (International Diabetes Federation, 2017). Patients are, for example, required to make considerable lifestyle changes; begin regular medication regimes; and handle multidimensional emotions, including fear, sadness, uncertainty, and shame in relation to their illness (Browne, Ventura, Mosely, & Speight, 2013; DeCoster, 2003). Moreover, diabetes has been characterized as an invisible illness, as its symptoms, seriousness, and progression are difficult to detect and take into account in daily decision-making, which has the most central role in treating the illness (Stuckey & Tisdell, 2010; Vishwanath, 2014). Thus, diabetes has been characterized as a

multidimensional illness, which requires ongoing adjustment to change health conditions and feelings (Ingadottir & Halldorsdottir, 2008).

The contradictory and changing nature of diabetes might be one of the reasons why patients reportedly give ambiguous meanings to diabetes management, which has been defined as a complex task involving meal planning, medication, exercise, self-monitoring, and cooperation with health care professionals (Barlow, Wright, Sheasby, Turner, & Hainsworth, 2002; Moser, van der Bruggen, Widdershoven, & Spreeuwenberg, 2008). While some patients have described diabetes management as “disciplining ‘the dog,’” with the control of the illness in the patients’ own hands (Ingadottir & Halldorsdottir, 2008), other patients have described diabetes management as “rolling with it” (Stuckey & Tisdell, 2010), or “being in the grip of blood glucose levels” (Rasmussen, O’Connell, Dunning, & Cox, 2007). With these findings in mind, the meanings given to diabetes management are of great importance. In fact, meaning-making may “affect how they [patients] rate their overall health, and these perceptions may influence treatment effectiveness, psychological symptoms, coping and somatic outcomes” (McFarland, Rhoades, Campbell, & Finch, 2001, p. 250). Thus, meaning-making might affect diabetes management as a whole (Ingadottir & Halldorsdottir, 2008).

Although diabetes management is based on patients’ daily lifestyle choices, the different meanings related to the illness and its management are not just the results of the patients’ own cognitive processes. The meanings in question are also constructed and discussed in interpersonal communication relationships with other people (Kleinman, 1988). In addition to family relations, friendships, and peer relationships, professional-patient relationships have a central role in diabetes management (Mulder, Lokhorst, Rutten, & van Woerkum, 2015; Rasmussen et al., 2007). The professional-patient relationship is central to successful chronic illness care; furthermore, this relationship is an operational environment in which patient care is administered and the various meanings of the illness, its management,

and the interlocutors' roles in this management are constructed through various interpersonal communication processes (e.g., Zoffman & Kirkevold, 2007). For example, these processes include the interlocutors' communication behaviors, as well as related influencing attributes, such as their communication styles, strategies, self-concepts, emotional states, health status, and perceptions of each other and their relationship (Street, 2003).

The interpersonal context is not the only relevant social context for meaning-making in professional-patient communication. According to the ecological perspective on communication (Street, 2003), professional-patient communication is situated within and affected by a variety of social contexts, such as organizational, political-legal, and media contexts. Thus, the meaning-making related to diabetes management in professional-patient communication is not limited to the discussions themselves; it is also affected by how the illness is seen and treated in different interpersonal relationships and health care cultures and how the etiology of diabetes and its treatment are emphasized in the different discussion platforms of the society.

Type 2 diabetes is an especially interesting chronic illness from the perspectives of different social contexts, as the number of the people with this form of diabetes is increasing explosively (International Diabetes Federation, 2017). In addition, special tensions have been associated with type 2 diabetes care, since, at the societal level, it tends to be framed as a self-caused, stigmatized illness (e.g., Browne et al., 2013; Viswanath, 2014) despite the connection of its etiology to a combination of biological, environmental, cultural, and social factors. Thus, type 2 diabetes has been described as a discursive battlefield where different actors advocate for their own perspectives and discourses concerning diabetes treatments, causes, and diagnostics in different societal forums (Nahon-Serfaty, 2012). Although this kind of discourse fragmentation has also contributed to the expansion of polyphonic discourses, where the managerial discourses in the health sphere, such as efficacy and efficiency (e.g., Iedema,

Degeling, Braithwaite, & White, 2004; Iriart, Merhy, & Waitzkin, 2001), have been confronted with the emergence of plural voices representing the patient perspective (e.g., Hivon, Lehoux, Denis, & Rock, 2010), the views of type 2 diabetes patients have stayed in the margins of the public discussions. Thus, more study is needed on how these patients recall the meaning-making processes related to type 2 diabetes management in different social contexts to strengthen their marginal voices. Moreover, this kind of research could support diabetic patients' participation in professional-patient relationships, which might be one of the most important ways for them to obtain reliable diabetes-related information and social support and update their views on diabetes management (e.g., Burke, Earley, Dixon, Wilke, & Puczynski, 2006).

Despite the significant role of the professional-patient relationship—not just as a social context but also as an important part of diabetes management (e.g., Barlow et al., 2002; Moser et al., 2008)—the meaning of this relationship from the patients' perspective has not yet been studied. Much of the previous research has focused on clarifying what kinds of communication behaviors gear meaning-making toward the widely recommended patient-centered orientation which encourages cooperative relationships that empower patients to choose the best care for themselves (e.g., Koenig, Wingard, Sabee, Olsher, & Vandergriff, 2014). However, these studies have also shown that, despite gaining more knowledge on the patient-centered approach, this practice has been relatively challenging to implement into practical diabetes care. For example, when giving advice on diabetes care, professionals used a very narrow selection of communication strategies, granting themselves control of the care situations; this is quite contrary to the widely recommended patient-centered approach (Kiuru, Poskiparta, Kettunen, Saltevo, & Liimatainen, 2004; Mulder et al., 2015). Since patients have the comprehensive responsibility for their own diabetes management and their views on the meanings of different aspects of diabetes management are the most important ones for

successful illness management (e.g., Burke et al., 2006), more study is needed on patients' perspectives of the types of meanings and meaning-making processes used in single care situations. Research of this kind can be executed utilizing the relational dialectics theory (RDT) 2.0, which is based on the communication sciences (Baxter, 2011).

Relational dialectics theory 2.0 as a theoretical background

Relational dialectics theory (RDT) describes the meanings surrounding individual and relationship identities and how these meanings are constructed through language use (Baxter, 2011). According to RDT, every relationship is a dynamic social entity in nature, which means that there is an unceasing interplay between several, usually contradictory discourses. According to this theory, discourses are systems of meanings or viewpoints that guide social constructions of understanding in relationships (Baxter, 2011; Pederson, 2014). The discourses are seldom equally strong; usually, some discourses are privileged and others are marginalized (Norwood, 2010). This kind of inequality causes struggle between the discourses, which can, consequently, strengthen the central discourses or form new meanings.

According to Baxter (2011), different discourses are actualized in utterances, which are not merely isolated communicative acts but are part of a wider utterance chain that extends to the past (already-spoken utterances) and to the future (not-yet-spoken utterances). The already-spoken and not-yet-spoken utterances are seen in the utterances of the present in two ways; on the one hand, the utterances reflect culture- and community-related privileged discourses, illustrating, for instance, the type of relationships that have been seen and evaluated as ideal and acceptable in the culture or community in question (distal utterances). On the other hand, the utterances also reflect the communication history of relationships and expectations related to future communication situations (proximal utterances).

Discourses are struggles in the communication processes between the interlocutors, as they are not only communicating content but also sending relational messages in which they

create and balance the meanings of selves and the nature of the relationship (Baxter & Montgomery, 1996; Watzlawick, Bavelas, & Jackson, 1967). For example, these meanings can imply whether the relationship is equal or formal and whether the interlocutors are independent or interdependent in the relationship. Thus, meaning-making is not examined as a product of the individuals but as a product of the communication processes between the interlocutors, which simultaneously connect and differentiate the participants through competing discourses (Baxter, 2011). The interplay between the competing discourses is not defined as a conflict or a problem to be resolved, but as an unavoidable and essential element of the relationships, connecting the discourses to each other in knots (*multivocal contradictions*) and affecting the nature, development, and outcomes of the relationships (Baxter, 2011; Baxter & Montgomery, 1996).

In more recent communication studies, the use of RDT to examine professional relationships has gained more interest among health communication scholars. The theory—especially version 1.0, which focuses on tensions—has been used when clarifying the dialectical nature of the cooperative processes between health care professionals (Apker, Ptacek, Beach, & Wears, 2016; Martin, O'Brien, Heyworth, & Meyer, 2008). In addition, RDT has been applied when studying the nature of professional-patient relationships in general (Gerlander, 2003) and in specific communication situations, such as end of life discussions (Amati & Hannawa, 2014; Considine & Miller, 2010) and when examining the relationships from the point of view of specific professional positions (Dean & Oetzel, 2014; Olufowote, 2011). However, meaning-making in the context of specific illnesses has been rarely studied.

To our knowledge, only two studies have utilized RDT 2.0 in the context of diabetes management. O'Hara's (2017) case study examined how the meanings of diabetes management were constructed through the interplay of competing discourses in the same physician-patient dyad during three different visits. In the second study O'Hara and Shue

(2018) examined six physician-patient dyads over multiple visits to determine the multiple meanings of diabetes management and the specific ways these meanings were shaped in the interplay between the competing discourses. However, the competing meanings that professional-patient relationships are given during discussions on diabetes management have rarely been examined. This kind of research frame might provide useful information when clarifying the challenges and the significance of professional-patient relationships in supporting the patients' comprehensive responsibility for diabetes management.

Study design

In this study, we concentrated on examining the competing discourses of professional-patient relationships as a part of type 2 diabetes management. These discourses were examined from the point of view of the patients through critical incidents with their doctors and nurses, which is a rarely applied approach within the frame of diabetes care. Depending on the research objectives and methods used, studies have also referred to critical incidents as meaningful encounters. Both concepts have been defined as affecting social situations in which a person has been personally involved and in which he/she was thought to have a positive or a negative effect on changing his/her own behavior, attitudes, or ideas (Flanagan, 1954; Gustafsson, Snellma, & Gustafsson, 2013; Norman, Redfern, Tomalin, & Oliver, 1992; Schluter, Seaton, & Chaboyer, 2008). In the present study, critical incidents were defined as professional-patient discussions that patients described as being positively or negatively connected to their diabetes management. In addition, to emphasize that patients' ability to manage their diabetes is always associated with professional-patient relationships, we have regarded critical incidents as significant interpersonal communication experiences.

While competing discourses were examined in both positive and negative experiences related to diabetes management, the aim was not to value the competing discourses in positive or negative ways. According to RDT, communication, relationships, and life itself are not

finalizable and have no ideal goals or endings (Baxter & Montgomery, 1996). Thus, the main purpose of the present study was to recognize what sort of struggling discourses related to professional-patient relationships can be found in different kinds of experiences. Moreover, our interest was to examine, whether some competing discourses were so central that they were emphasized in both positive and negative experiences. Therefore, the first research question (RQ) was posed as follows:

RQ1: *What competing discourses related to the professional-patient relationship in type 2 diabetes management can be found in the patients' descriptions of their experiences?*

According to Baxter (2011), studies should place more attention on how discourses struggle in the interlocutors' utterances in order to understand the various processes of meaning-making in relationships. The discourses can, for example, be emphasized differently depending on the context or time or they might interplay with each other within the same utterance. In addition, they may be presented as equal, or they may mix as the struggle between discourses ceases, making it possible for new meanings to be created. This approach may prove useful when clarifying how different meanings are constructed in professional-patient relationships, with meaning-making considered as a very complex process by both patients and professionals (e.g., Zoffman & Kirkevold, 2007). Thus, the second RQ was posed as follows:

RQ2: *How do the competing discourses interplay with one another in the patients' descriptions of their experiences?*

Methods

In order to enable patients to describe the nature of the communication situation and the significance of their experiences—the importance of which has been emphasized in the development of more patient-centered diabetes care practices (e.g., Burke et al., 2006; Thorne,

Harris, Mahoney, Con, & McGuinness, 2004)—we used an open e-survey and semi-structured interviews. In both methods, the critical incident technique was utilized to help the patients focus on describing genuine situations instead of creating generalizations and to help them be as specific as possible when describing their significant interpersonal communication experiences (Flanagan, 1954; Kemppainen, 2000). Consequently, the patients were instructed to choose and share, from memory, experiences of one or several professional-patient discussions that facilitated or impeded their self-management. Thus, in this study, the participants' descriptions of their professional-patient discussions were not seen as objective. Instead, the patients' descriptions were used to understand how meanings were constructed through professional-patient conversations from the patients' points of views.

Participants and data collection

The study participants were adult patients with type 2 diabetes diagnoses, who were residents of the province of Finland where the study was conducted; they agreed to participate voluntarily and had experiences of diabetes care discussions with doctors or nurses, who are the main professionals in the field of diabetes care. Since, in Finland, diabetes care practices vary significantly (e.g., Tuomola, Idänpään-Heikkilä, Halkoaho, & Virkamäki, 2011), there were no requirements related to whether the patients engaged services in the public, private, or occupational health care sectors.

The data collection was performed by the first author of this study after obtaining ethical approval from the Regional Ethics Committee of Tampere University Hospital. Information on the e-survey and the semi-structured interviews was transmitted to social media, to every diabetes association in the Finnish province in question, as well as to the discussion forum of the Finnish Diabetes Association. Altogether, 41 people participated in the study. The e-survey had 13 female and 3 male respondents; however, 3 of the female respondents were excluded from the study because their response forms were nearly empty. In addition, 18

women and 7 men participated in semi-structured interviews. The participants were 30–93 years old, and the time lapse since their diagnosis ranged from 3 to 28 years. All the participants used insulin or oral medication in addition to applying dietary measures to maintain glycemic control.

Following the principles of the critical incident technique (e.g., Anderson & Wilson, 1997), the participants in both the open e-survey and the semi-structured interviews were asked to describe the communication situation and the progression of the positive or negative professional-patient discussion of their choice. The questions concerned the communication situation, the atmosphere of the discussion, the communication behaviors of both interlocutors, and the significance of the discussion in relation to the patients' self-management. The same questions were used for the open e-survey and the interviews, but during the interviews, it was also possible to ask specific questions to the participants. The length of the open e-survey answers varied from five lines to a whole page. The interviews lasted from 30 to 90 minutes, and they were conducted in settings chosen by the interviewees, mostly at their homes. All interviews were audio-taped and transcribed verbatim.

The 13 participants of the open e-survey produced 23 stories, and the 25 participants of the semi-structured interviews provided 40 stories for possible use in this study. In total, there were 63 accounts of several sentences relating for each professional–patient discussion. The patients' experiences were classified as positive and negative according to whether the patients themselves regarded the experiences as helping or hindering their diabetes management. In total, 42 were positive—with 32 concerning communication between a patient and a doctor and 10 between a patient and a nurse. The number of negative experiences was 21—with 14 concerning communication between a patient and a doctor and 7 between a patient and a nurse.

Data analysis

The research data were analyzed by the first author using contrapuntal analysis, as recommended by Baxter (2011). Contrapuntal analysis is an RDT-related method of discourse analysis that can be utilized to identify competing discourses and examine, through different methodological practices, how meanings are created in the interaction between the discourses (Baxter, 2011; Baxter & Braithwaite, 2010). Discourse analysis is a theoretical and methodological frame that has been defined in several ways and used within various disciplines in qualitative research. In the present study, adapting the views of Baxter (2011), the definition is based on Taylor's (2001) article, in which discourse analysis is widely understood as a field of research that focuses on the thorough study of the use of language as a constructional factor of reality—not as a certain and strict manner of analysis.

The contrapuntal analysis consisted of three phases, as recommended by Baxter (2011): 1) searching the discourses, 2) identifying possible competing discourses, and 3) examining how the competing discourses were set against each other in the utterance chains. In these phases, several methodological practices were applied. In the first phase, the discourses were searched using theme analysis, as defined by Braun and Clarke (2006). The patients' significant interpersonal communication experiences were read several times to establish a general overview of the whole dataset. In addition, all of the research data were read several times so that no information of importance would be missed. After that, all expressions related to the professional-patient relationship and type 2 diabetes management were coded as brief statements with preliminary themes alongside each experience. The coded expressions were either short statements or longer parts of the e-survey answers or the interview responses. Special attention was given to the aspects of their professional-patient relationships and diabetes management that the patients praised, criticized, judged, or supported (e.g., Baxter, 2011; Martin & White, 2005). Within this approach, we found it reasonable to analyze the discourses inductively, not deductively, while realizing that the

discourses named in previous studies unavoidably affected our thinking when examining the utterance chains of the patients' experiences.

In the second phase, we examined whether the competing discourses found in the first phase fell under the three discourse markers: *negating*, *countering*, and *entertaining* (Baxter, 2011; Martin & White, 2005). The main focus was to determine which discourses were rejected or described as unessential (*negating*) and identify any unexpected discourses presented in connection with a more privileged discourse (*countering*). In addition to the mentioned discourse markers, the data were examined from the perspective of whether the patients considered other possible ways of communicating in relation to type 2 diabetes care (*entertaining*). One-on-one discussions between the authors and consultations with other researchers of the communication and nursing sciences revealed that there were three central discourse pairs that were struggling with each other in the positive and the negative experiences of the professional-patient communication relationships. These discourse pairs were: 1) having the right to care versus deserving care, 2) guidance versus control, and 3) personalization versus standardization.

In the last phase, the discourses were examined in terms of their positionings in relation to one another (Baxter, 2011) to show how struggling discourses construct different kinds of meanings in relation to type 2 diabetes management. Specifically, we examined which discourses were marginalized, which discourses co-existed in the patients' utterances, and which discourses were set in the foreground. According to the data, in terms of the interplay of the competing discourses, it seemed to make no difference whether the other interlocutor was a doctor or a nurse. What seemed to make a difference was whether the experience of the patient was positive and negative. For this reason, in the results, the interplay is described in terms of the patients' positive and negative experiences.

Results

Having the right to care versus deserving care

The discourses of having the right to care and deserving care in relation to the professional-patient relationship in diabetes management were seen as either every patient's right, irrespective of what one has or has not done, or as something to be deserved individually by taking good care of oneself. The discourses in question were implemented in the descriptions where the patients described their feelings of guilt for having the illness and the professionals' reactions toward patients with type 2 diabetes, which has been connected to unhealthy lifestyle habits. In the positive experiences, the patients typically saw type 2 diabetes as a self-caused illness because of their unhealthy lifestyle habits and their earlier indifference toward the care instructions given by the professionals. Also, the influence of the public discussions related to the causes and treatment expenses of type 2 diabetes was mentioned when analyzing the feelings of guilt about having diabetes:

Of course, my thoughts have been affected by the public discussions where it has been questioned, do the patients with this kind of self-caused illness have the right to use the public health care services. It has surely been affecting my feelings of guilt. (...) I am horribly good to get these thoughts of the public discussions.

In the positive descriptions, patients typically brought up their feelings of guilt in the professional-patient discussions. However, during the care situations, the discourse of having the right to care was more emphasized as a result of the supportive communication behaviors of the professionals. Thus, the discourses of having right to care and deserving care seemed to interplay as a spiraling inversion, which was "characterized by a back and forth pattern over time in the dominance of first one discourse and then another for a given topical or activity domain" (Baxter, 2011, p. 127). One of the patients described her experience as follows:

I was disappointed for not achieving, in my opinion, a sufficient care balance and for not keeping track of my blood sugar levels. I was disappointed with myself, with my

powerlessness. I felt that I should be in control of my illness. It is my own fault that I have become ill. But, this professional knew how to turn my thoughts to the positive matters and to what was well concerning my health. He did not blame me for having a standard illness.

In the negative experiences, it was more common for the care relationship to be seen as something to be deserved individually. In these experiences, the professionals awakened the patients' feelings of guilt when they blamed the patients for unhealthy lifestyle choices or stated that it was the patients' own fault that they had become ill with type 2 diabetes. In addition, according to some of the descriptions, the professionals directly refused to care for the patients. The blaming behaviors of the professionals were mainly seen as caused by their own negative personalities and attitudes, as well as difficult circumstances, such as the hurriedness of the professionals or their having a bad day. However, the professionals' behaviors were also seen as well-meaning efforts to help the patients, but the patients interpreted these behaviors as blaming because of their own life circumstances:

The professional, after my descriptions of flu-related symptoms, said that I should take better care of myself and that I should drop weight. She explained that when blood sugar is high, it will increase the infection risk. (...) I think that she surely thought that it was important to say these things to me because perhaps nobody had told me these facts before. However, it only made me feel guilt and led me to question my right to the care, because I was really tired, and I am not often sick. Moreover, I do not often need the professional's help.

In the negative experiences, the discourses were struggling through the spiraling inversion and segmentation; at the beginning of the care situations, the patients seemed to have the right to express their illness-related concerns, but later, the professionals seemed to shift their focus to mainly evaluating what the patients should have done or whether the patients

deserved the care. One of the patients described this kind of communication situation as follows:

I asked the professional to measure my blood pressure, because elsewhere it had been said to be very high. But my request only seemed to be rather amusing to her. She did not care about my blood pressure in any way, and pretty much threw me out of the room. (...) She thought that my symptoms were caused by obesity and the use of alcohol. In her opinion, I should merely stop drinking. (...) It felt as if I was complaining over nothing and that there were people even more ill than me.

Guidance versus control

The discourses of guidance and control were manifested in descriptions of whether professional-patient relationships were seen as communication arenas to control or guide the diabetes management that is implemented by patients in their daily lives. In the positive experiences, the patients described their professional-patient relationships as guiding processes, in which the control was differently divided between the interlocutors. Meanwhile, in the descriptions, the patients were seen as capable of taking control of their illness and flexibly controlling discussion subjects and decision-making in care situations. They also seemed to allow the professionals to control the guidance of the diabetes management in the care situations and to lead their illness-related thoughts in more functional directions. Thus, in the positive experiences, the discourses of guidance and control seemed to interplay through integration: the discourses were both equally present and did not compete with one another. One example of this integration can be seen in the following quotation:

It felt like that he was interested in which way I was treating my illness and how he would be able to help in that process. (...) It was like he was giving me his own professional knowledge to be used by me.

In the patients' negative descriptions, the discourses of guidance and control seemed to interact in synchronic interplay, as both discourses were present but set at contradictory poles. The patients usually described guiding as an ideal communication orientation but added that it was unreasonable with the professionals in question, because the controlling communication behaviors of the professionals restricted the patients' participation and control sharing in the care discussions. The professionals were described as giving too strict, unclear, or obvious care guidance, which made the patients feel as though the professionals were trying to control the diabetes management, but they did not provide any instructions that would have been useful to the patients. In addition, the patients remarked that the professionals did not seem to listen to them, which complicated the patients' abilities and willingness to try to control and move the nature of the professional-patient communication in a reciprocal direction. Thus, the patients had to figure out for themselves how to control and manage their diabetes. One example of the synchronic interplay can be seen in the following quotation:

In the future, I'll try to make an appointment with another professional. I have been thinking that I do not want to go to this professional anymore, because I was not able to give information about myself in a way that I felt it would be necessary. Talking to him was futile as it felt as if he was not listening to me.

Personalization versus standardization

The discourses of personalization and standardization concerned whether the professional-patient relationship was seen as a unique, episodic care situation between two individuals or a general process not to be differentiated from patient to patient and professional to professional. In the positive experiences, the patients described accommodated interpersonal communication, where the professional-patient communication and diabetes care were tailored to fit the patients' individual situations. At the same time, the patients stated that their care situations followed the standardized principles of diabetes care, which should be the same for

all diabetes patients. This meant, in practice, that the professionals and the patients discussed diabetes-related information and conducted diabetes-related tests. They also discussed health goals, the possibilities to change the patients' lifestyle habits, and the roles of the interlocutors in the professional-patient relationships and the diabetes management. Thus, the discourses seemed to interplay through integration, where the discourses were equally present and did not compete with one another. An example of this integration can be seen in one patient's description as follows:

I was worried about my ability to live according to the medicines; to be able to dose them correctly, to eat healthily, and simply to follow the professional's instructions in general. (...) The professional said that that is what the professionals are for—it is their job to create a medication plan that fits the life of the person, so the patient doesn't have to try to live one's life being controlled by the medication.

In the negative experiences, the discourses of personalization and standardization struggled through synchronic interplay, as both discourses were equally present but also pitted against one another. The patients reported having been treated according to the standards of diabetes care, not as individual patients. In practice, this meant that the professionals covered the matters that should be discussed with all diabetic patients as part of the basic appointment procedures, but the professionals did not employ communication strategies that would take notice of the individual patient in the discussion. One of the patients described this kind of situation as follows:

I just sat there, and she looked at my papers, looked at those results, asked for something, and wrote the new prescriptions. And said thanks, goodbye. Then I was outside the door. (...) I was one patient in that program of that day. (...) And, however, it the purpose of the visit was a question about quite a big matter, in my opinion, because my individual medication was changed.

Interestingly, these discourses also seemed to interplay through integration, with the discourses being equally present in the patients' negative experiences. This was seen in the patients' descriptions in which they linked a singular care situation to the standardized care relationships of diabetes management. Recently diagnosed patients with negative experiences, especially, seemed to wonder whether all professional-patient relationships related to diabetes care were similar or whether it was specific to a single experience. Both the synchronic interplay and the integration of personalization and standardization can be seen in the following quotation:

I think that she [the professional] did not actually think of me in that situation. She thought of what she had to do. (...) And I was thinking that here I am, in my first visit as diabetic patient, and the treatment is like this. Such a thought came, of course, to my mind that I must see if this continues.

Discussion

The aim of this study was to examine the competing meanings of the professional-patient relationship in professional-patient discussions held as part of type 2 diabetes management. This was accomplished by analyzing the patients' descriptions of significant interpersonal communication experiences with their health care professionals. The main findings on the competing discourses can be crystallized into four main points.

First, in addition to the meanings related to living with diabetes (Ingadottir & Halldorsdottir, 2008; Stuckey & Tisdell, 2010) and the meanings related to diabetes management (O'Hara, 2017; O'Hara & Shue, 2018), the professional-patient relationship also seems to give struggling meanings as part of diabetes management. So far, professional-patient relationships have been described quite consistently in the context of diabetes management through their objectives as cooperative processes supporting the patients' comprehensive responsibility for diabetes care. This study, however, shows that the relationships in question

have many struggling meanings in single care situations—at least from the perspectives of the patients. Thus, these meanings are important to include when analyzing chronically ill patients' multidimensional meaning-making processes as a whole related to diabetes management and its effects for living with the illness.

Second, the most interesting struggling discourse pair in this study was having the right to care versus deserving care, which has not yet been emphasized as a central struggling discourse pair of the professional-patient relationship in international health communication research, unlike other pairs, such as personalization versus standardization (Amati & Hannawa, 2014). The new discourse pair was related to how patients' feelings of guilt for having the illness were handled in care situations and how the professionals regarded patients with type 2 diabetes, which has been connected to unhealthy lifestyle habits. The handling of patients' guilt for causing their illness themselves and blaming behaviors of professionals in care situations have been examined in earlier studies (e.g., Browne et al., 2013). However, the new finding in the present study is that, at the same time that interlocutors construct meanings related to the causes of an illness and its management, there is also a more fundamental consideration: is the functional care relationship—which has usually been seen as a human right in patient care (e.g., Cohen & Ezer, 2013)—a service that patients with “self-caused” illnesses should earn through their own health-related actions? This multidimensional nature of the struggling discourses and their connections to fundamental rights justifies the importance of examining the struggling discourses of professional-patient relationships in order to recognize them and prevent the emphasis of detrimental discourses concerning suitable diabetes management.

When comparing the discourse pair right to care versus deserving care with the studies related to type 1 diabetes—which has also identified as a stigmatized illness (Viswanath, 2014)—in professional-patient relationships, patients have been blamed mainly for not following care instructions, not for causing the illness themselves (e.g., Browne et al., 2013;

Rasmussen et al., 2007). Thus, to our knowledge, there has not been same kind of struggling in the context of type 1 diabetes between the discourses of right to care and deserving care. Although the patients in the present study did not compare their professional-patient relationships with those of type 1 diabetics, the results, compared to previous studies, give grounds for supposing that the two types of diabetes might have different professional-patient communication challenges concerning diabetes management, at least with regard to meaning-making. Thus, more research needs to be done on professional-patient communication to distinguish between the management of different chronic illnesses and increase the understanding that different kinds of meanings are attached to different chronic illnesses and made visible and constructed in professional-patient communication in different ways (e.g., Thorne et al., 2004).

Third, when examining the discourse struggles in the patients' positive and negative descriptions (Baxter, 2011), the meaning-making process related to the professional-patient relationship as part of type 2 diabetes management seemed to be controlled by the professionals. The significance of the professionals' role was especially illustrated in the patients' negative experiences, in which the struggling discourses were set at opposite poles and the patients' impressions of the constructed meanings were based on the views offered by the professionals. These results are in line with studies that have presented professionals as controlling type 2 diabetes management, even when given the current knowledge on the benefits of patient-centered care (e.g., Kiuru et al., 2004; Mulder et al., 2015).

The professionals also played a central role in the positive experiences, especially in changing patient discourses that might have been harmful in terms of overall type 2 diabetes management. However, the most considerable difference between the patients' positive and negative descriptions was that, in the positive experiences, the patients were able to bring their own discursive struggles into the communication situation, and different discourses were

allowed to be present in the communication situations through negotiation. This was seen, for example, in the description by the patient who questioned her skills to live on the medication's terms. Although it has been asserted that the main responsibility in establishing a well-functioning relationship falls on the professional rather than the patient, due to the asymmetrical nature of professional-patient communication (e.g., Bennett & Irwin, 1997; Roter & Hall, 2006), examining the mechanisms of the discursive struggle afforded a new approach to study and implement the patient-centered orientation in practical care situations. In addition to focusing on what sort of communication behaviors result in a successful communication relationship, an essential question might also be what sort of meanings the interlocutors give to the professional-patient relationship as part of illness management and what kind of perception of the care relationship should be considered as the basis for the cooperation process. Considering these questions within care conversations could help the interlocutors place more responsibility on the care relationship instead of on single individuals, which might clarify the appropriate roles of both parties within chronic illness management (e.g., Zoffman & Kirkevold, 2007). Moreover, these perspectives on the care relationship might strengthen the understanding that patient-centeredness is already a process from the level of meaning-making in which both interlocutors' communication behaviors are of significance for the success of the care relationship and the patients' care (e.g., Street, 2017).

Finally, according to the results, the struggle between the discourses appeared, not only at the level of specific professional-patient relationships but also at the level of general professional-patient relationships, which were reflected in the patients' descriptions. On the one hand, the relationship was seen as a series of separate interaction situations in which the two interlocutors negotiated the meanings of, for instance, their responsibilities and rights in relation to care planning. On the other hand, the relationship was also seen as a shared care relationship, in which an illness suffered by a great number of people and treated by many

professionals. These findings support RDT's idea of the utterance chain (Baxter, 2011), which extends to the past and the future. The different discourses are not perceived as isolated communicative acts, but reflect how professional-patient relationships have been defined as part of diabetes management in the culture and in communities and the appreciations and expectations of the reflections and definitions in the present and the future. Thus, each communication situation with health care professionals could be seen as an opportunity, not only to support patients' current diabetes care and build current relationships but also to develop a wider understanding, in cooperation with professionals, of professional-patient relationships as part of type 2 diabetes management.

The results also support Street's (2003) ecological perspective in which professional-patient communication it is seen as part of the different social contexts. In the present study, other contexts mainly emerged when considering the patients' experiences in relation to wider perspectives of type 2 diabetes care, including questioning the patients' human right to the functional care relationship and when describing patients' feelings of guilt and the sources of this guilt, such as discussions in the media (e.g., Nahon-Serfaty, 2012). What is surprising, though, is that the effect of the Internet and the digitalization of health care did not emerge in the patients' experiences, although these themes have also been represented in Finnish public discussion and research (e.g., Drake, 2009). This might be because the questions asked in the open e-survey and semi-structured interviews did not cause the participants to think about their experiences in these perspectives. In addition, most of the study participants were retired, so the themes in question might not have been current to them. According to a recent study on the use of information and communications technology by individuals in Finland (OSF, 2018), 22% of 65- to 74-year-olds and 60% of 75- to 89-year-olds have never used the Internet. However, the use of the Internet is expected to increase, especially among older people, and social media is expected to become a more central place for influencing public discussions and

care practices (Hawn, 2009; Torkkola, 2016). This kind of digitalization might be one of the central ways to not only strengthen type 2 diabetes patients' marginal voices in the public discussion but also to enrich the discussion and deepen the understanding of diabetes management from a less discussed point of view—the discursive struggle related to professional-patient relationships in diabetes management.

The limitations of the study are particularly connected to the utilization of RDT and the research methods. The first limitation was that RDT 2.0 is usually not utilized when studying patients' positive and negative care experiences to avoid evaluating the discourses. In this study, however, separating the descriptions of the positive and negative experiences demonstrated in a new way how discourses compete in different ways in these types of experiences. Thus, the struggling of the discourses might have affected how patients experienced the care situations in question. Although RDT defines relationships as not finalizable and having no ideal goals or endings (Baxter & Montgomery, 1996), clarifying the interplay between competing discourses in different kinds of communication experiences could provide important information on how the competition of discourses affects the nature, development, and outcomes of the relationships. Thus, more research needs to be done on the discourse struggle in different relationships to clarify the complex process of meaning-making (Baxter, 2011).

The second limitation was related to the use of significant interpersonal communication experiences. It is important to recognize that the research data might suffer from recall bias in the patients' retrospective self-reports of events from several years before (e.g., Burlison & MacGeorge, 2002). Moreover, patients with continuing care relationships may have confused their perceptions of a single visit with those of other visits; in other words, memories are not necessarily realistic. However, the theory was applied well to the analysis of this type of data, as the discourses exist in the descriptions of past professional-patient discussions, not only in

genuine communication situations (Baxter, 2011). Moreover, in discourse analysis, the focus is not on determining what actually happened. What is essential is how the reality is described as constructed through various discourses (Remes, 2006).

The final limitation was that the majority of participants were women, and their perceptions of different communication behaviors—such as supportive communication—may have differed from those of men (e.g., Hanasono et al., 2011). However, in this study, the same questions were asked of all participants, and we did not find any substantial differences when comparing the responses of women and men regarding their positive and negative experiences.

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References

- Amati, R., & Hannawa, A. F. (2014). Relational dialectics theory: Disentangling physician-perceived tensions of end-of-life communication. *Health Communication, 29*, 962–973. doi:10.1080/10410236.2013.815533
- Anderson, L., & Wilson, S. (1997). Critical incident technique. In D. L. Whetzel, & G. R. Wheaton (Eds.), *Applied measurement methods in industrial psychology* (pp. 89–112). Palo Alto, CA: Davies-Black Publishing.

- Apker, J., Ptacek, J., Beach, C., & Wears, R. (2016). Exploring role dialectics in inter-service admission handoffs: A qualitative analysis of physician communication. *Journal of Applied Communication Research, 44*, 399–414.
doi:10.1080/00909882.2016.1225164
- Barlow, J., Wright, C., Sheasby, J., Turner, A., & Hainsworth, J. (2002). Self-management approaches for people with chronic conditions: A review. *Patient Education and Counseling, 48*, 177–187. doi:10.1016/S0738-3991(02)00032-0
- Baxter, L. A. (2011). *Voicing relationships: A dialogic perspective*. Thousand Oaks, CA: Sage Publications, Inc.
- Baxter, L. A., & Braithwaite, D. O. (2010). Relational dialectics theory, applied. In S. W. Smith, & S. R. Wilson (Eds.), *New directions in interpersonal communication research* (pp. 48–66). Thousand Oaks, CA: Sage Publications, Inc.
- Baxter, L. A., & Montgomery, B. M. (1996). *Relating: Dialogues & dialectics*. New York, NY: The Guilford Press.
- Bennett, K. C., & Irwin, H. (1997). Shifting the emphasis to “patient as central”: Sea change or ripple on the pond? *Health Communication, 9*, 83–93.
doi:10.1207/s15327027hc0901_7
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77–101. doi:10.1191/1478088706qp063oa
- Browne, J. L., Ventura, A., Mosely, K., & Speight J. (2013). I call it the blame and the shame disease: A qualitative study about perceptions of social stigma surrounding type 2 diabetes. *BMJ Open, 3*, 1–10. doi:10.1136/bmjopen-2013-003384
- Burke, J. A., Earley, M., Dixon, L. D., Wilke, A., & Puczynski, S. (2006). Patients with diabetes speak: Exploring the implications of patients’ perspectives for their diabetes

- appointments. *Health Communication*, 19, 103–114.
doi:10.1207/s15327027hc1902_2
- Burleson, B. R., & MacGeorge, E. L. (2002). Supportive communication. In M. L. Knapp, & J. A. Daly (Eds.), *Handbook of interpersonal communication* (pp. 374–424). Thousand Oaks, CA: Sage.
- Cohen, J., & Ezer, T. (2013). Human rights in patients' care: A theoretical and practical framework. *Health and Human Rights*, 15(2), E7–E19.
- Considine, J., & Miller, K. (2010). The dialectics of care: Communicative choices at the end of life. *Health Communication*, 25, 165–174. doi:10.1080/10410230903544951
- Dean, M., & Oetzel, J. G. (2014). Physicians' perspectives of managing tensions around dimensions of effective communication in the emergency department. *Health Communication*, 29, 257–266. doi:10.1080/10410236.2012.743869
- DeCoster, V. A. (2003). The emotions of adults with diabetes: A comparison across race. *Social Work in Health Care*, 36, 79–99. doi:10.1300/J010v36n04_05
- Drake, M. (2009). *Terveysviestinnän kipupisteitä. Terveystiedon tuottajat ja hankkijat Internetissä. [At the interstices of health communication. Producers and seekers of health information on the Internet]*. Doctoral dissertation. *Jyväskylä Studies in Humanities*, 127, Jyväskylä: University of Jyväskylä.
- Flanagan, J. C. (1954). The critical incident technique. *Psychological Bulletin*, 51, 327–358. doi:10.1037/h0061470
- Gerlander, M. (2003). *Jännitteet lääkärin ja potilaan välisessä viestintäsuhteessa [Dialectical tensions in the doctor-patient communication and relationship]*. Doctoral dissertation. *Jyväskylä Studies in Humanities*, 3, Jyväskylä: University of Jyväskylä.

- Gustafsson, L.-K., Snellma, I., & Gustafsson, C. (2013). The meaningful encounter: Patient and next-of-kin stories about their experience of meaningful encounters in health-care. *Nursing Inquiry*, 20, 363–371. doi:10.1111/nin.12013
- Hanasono, L. K., Burlison, B. R., Bodie, G. D., Holmstrom, A. J., Rack, J., MacCullough, J. D., & Rosier, J. G. (2011). Explaining gender differences in the perception of support availability: The mediating effects of construct availability and accessibility. *Communication Research Reports*, 28, 254–265. doi:10.1080/08824096.2011.588580
- Hawn, C., (2009). “Take two aspirin and tweet me in the morning; How Twitter, Facebook, and other social media are reshaping health care. *Health Affairs*, 28, 361–368.
- Hivon, M., Lehoux, P., Denis, J.-L., & Rock, M. (2010). Marginal voices in the media coverage of controversial health interventions: How do they contribute to the public understanding of science? *Public Understanding of Science*, 19, 34–51.
- Iedema, R., Degeling, P., Braithwaite, J., & White, L. (2004). ‘It’s an interesting conversation I’m hearing’: The doctor as manager. *Organization Studies*, 25, 15–33. doi:10.1177/0170840604038174
- Ingadottir, B., & Halldorsdottir, S. (2008). To discipline a “dog”: The essential structure of mastering diabetes. *Qualitative Health Research*, 18, 606–619. doi:10.1177/1049732308316346
- International Diabetes Federation (2017). *Diabetes atlas* (8th ed.). Retrieved from <http://www.idf.org/diabetesatlas>
- Iriart, C., Merhy, E. E., & Waitzkin, H. (2001). Managed care in Latin America: The new common sense in health policy reform. *Social Science & Medicine*, 52, 1243–1253. doi: 10.1016/S0277-9536(00)00243-4
- Kemppainen, J. K. (2000). The critical incident technique and nursing care quality research. *Journal of Advanced Nursing*, 32, 1264–1271. doi:10.1046/j.1365-2648.2000.01597.x

- Kiuru, P., Poskiparta, M., Kettunen, T., Saltevo, J., & Liimatainen, L. (2004). Advice-giving styles by Finnish nurses in dietary counseling concerning type 2 diabetes care. *Journal of Health Communication, 9*, 337–354. doi:10.1080/10810730490468586
- Kleinman, A. (1988). *The illness narratives: Suffering, healing and the human condition*. New York, NY: Basic Books.
- Koenig, C. J., Wingard, L. M., Sabee, C., Olsher, D., & Vandegriff, I. (2014). Managing patient-centered communication across the type 2 diabetes illness trajectory: A grounded practical theory of interactional sensitivity. *Journal of Applied Communication Research, 42*, 244–267. doi:10.1080/00909882.2014.911943
- Martin, D. R., O'Brien, J. L., Heyworth, J. A., & Meyer, N. R. (2008). Point counterpoint: The function of contradictions on an interdisciplinary health care team. *Qualitative Health Research, 18*, 369–379. doi:10.1177/1049732307311119
- Martin, J. R., & White, P. R. R. (2005). *The language of evaluation: Appraisal in English*. New York, NY: Palgrave Macmillan.
- McFarland, K. F., Rhoades, D. R., Campbell, J., & Finch, W. H. (2001). Meaning of illness and health outcomes in type I diabetes. *Endocrine Practice, 7*, 250–255. doi:10.4158/EP.7.4.250
- Moser, A., van der Bruggen, H., Widdershoven, G., & Spreeuwenberg, C. (2008). Self-management of type 2 diabetes mellitus: A qualitative investigation from the perspective of participants in a nurse-led, shared-care programme in the Netherlands. *BMC Public Health, 8*, 91–99. doi:10.1186/1471-2458-8-91
- Mulder, B. C., Lokhorst, A. M., Rutten, G. E. H. M., & van Woerkum, C. M. J. (2015). Effective nurse communication with type 2 diabetes patients: A review. *Western Journal of Nursing Research, 37*, 1100–1131. doi:10.1177/0193945914531077

- Nahon-Serfaty, I. (2012). The disruptive consequences of discourse fragmentation in the organization and delivery of health care: A look into diabetes. *Health Communication, 27*, 506–516. doi:10.1080/10410236.2011.618426
- Norman, I. J., Redfern, S. J., Tomalin, D. A., & Oliver, S. (1992). Developing Flanagan's critical incident technique to elicit indicators of high and low quality nursing care from patients and their nurses. *Journal of Advanced Nursing, 17*, 590–600. doi:10.1111/j.1365-2648.1992.tb02837.x
- Norwood, K. M. (2010). *Here and gone: Competing discourses in the communication of families with a transgender member* (Doctoral dissertation, University of Iowa, Department of Communication Studies). Retrieved from <https://ir.uiowa.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1749&context=etd>
- O'Hara, L. L. S. (2017). Discursive struggles in “diabetes management”: A case study using Baxter's relational dialectics 2.0. *Western Journal of Communication, 81*, 320–340. doi:10.1080/10570314.2016.1241425
- O'Hara, L. L. S., & Shue, C. K. (2018). Discourses of diabetes management in patient-physician interactions. *The Qualitative Report, 23*, 1282–1300.
- Official Statistics of Finland (OSF). (2018) *Use of information and communications technology by individuals* [e-publication]. Helsinki: Statistics Finland. Retrieved from http://www.stat.fi/til/sutivi/meta_en.html
- Olufowote, J. O. (2011). A dialectical perspective on informed consent to treatment: An examination of radiologists' dilemmas and negotiations. *Qualitative Health Research, 21*, 839–852. doi:10.1177/1049732311402097
- Pederson, J. R. (2014). Competing discourses of forgiveness: A dialogic perspective. *Communication Studies, 65*, 353–369. doi:10.1080/10510974.2013.833526

- Rasmussen, B., O'Connell, B., Dunning, P., & Cox, H. (2007). Young women with type 1 diabetes management of turning points and transitions. *Qualitative Health Research, 17*, 300–310. doi:10.1177/1049732306298631
- Remes, L. (2006). Diskurssianalyysin perusteet [The principles of the discourse analysis]. In J. Metsämuuronen (Eds.), *Laadullisen tutkimuksen käsikirja* [The guide of the qualitative research] (pp. 288–374). Helsinki: International Methelp.
- Roter, D. L., & Hall, J. A. (2006). *Doctors talking with patients/patients talking with doctors* (2nd ed.). Westport, CT: Praeger.
- Schluter, J., Seaton, P., & Chaboyer, W. (2008). Critical incident technique: A user's guide for nurse researchers. *Journal of Advanced Nursing, 61*, 107–114. doi:10.1111/j.1365-2648.2007.04490.x
- Street, R. L. (2003). Communication in medical encounters: An ecological perspective. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of Health Communication* (pp. 63–89). Mahwah, NJ: Lawrence Erlbaum Associates, Inc.
- Street, R. L., Jr. (2017). The many “disguises” of patient-centered communication: Problems of conceptualization and measurement. *Patient Education and Counseling, 100*, 2131–2134. doi:10.1016/j.pec.2017.05.008
- Stuckey, H. L., & Tisdell, E. J. (2010). The role of creative expression in diabetes: An exploration into the meaning-making process. *Qualitative Health Research, 20*, 42–56. doi:10.1177/1049732309355286
- Taylor, S. (2001). Locating and conducting discourse analytic research. In M. Wetherell, S. Taylor, & S. J. Yates (Eds.), *Discourse as data: A guide for analysis* (pp. 5–48). Thousand Oaks: Sage.

- Thorne, S. E., Harris, S. R., Mahoney, K., Con, A., & McGuinness, L. (2004). The context of health care communication in chronic illness. *Patient Education and Counseling*, *54*, 299–306. doi:10.1016/j.pec.2003.11.009
- Torkkola, S. (2016). Multifaceted health communication. In V. Marinescu, & B. Mitu, (Eds.), *Health and the media: Essays on the effects of mass communication*. Jefferson, NC: McFarland, 17–36.
- Tuomola, S., Idänpään-Heikkilä, U., Halkoaho, A., & Virkamäki, A. (2011). *Diabeteksen ehkäisyn ja hoidon kehittämisohjelma (DEHKO 2010). Loppuraportti—osa 2* [The Development Programme of the Prevention and Care of the Diabetes. Final report, Part 2]. Retrieved from https://www.diabetes.fi/files/1373/Dehkon_loppuraportti.pdf
- Viswanath A. (2014). Negative public perceptions of juvenile diabetics: Applying attribution theory to understand the public's stigmatizing views. *Health Communication*, *29*, 516–526. doi:10.1080/10410236.2013.777685
- Watzlawick, P., Bavelas, J. B., & Jackson, D. (1967). *Pragmatics of human communication*. New York, NY: W.W. Norton.
- Zoffman, V., & Kirkevold, M. (2007). Relationships and their potential for change developed in difficult type 1 diabetes. *Qualitative Health Research*, *17*, 625–638. doi:10.1177/1049732307301230