

Healthcare providers' narratives about interactionally troubling patient exchanges: Accounting for and against an active patient role

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ABSTRACT

The current trend in healthcare is to actively involve patients in their own treatment; however, in practice, healthcare providers may adhere to paternalistic views, which may not align with ideals related to patient involvement. This tension may become visible when providers talk about service encounters that they experienced as being interactionally troubling. In this empirical qualitative study, we utilize Bamberg's narrative positioning analysis to explore how healthcare providers construct patients' roles in narratives about such troubling exchanges. Data consist of 20 audio-recorded interviews with healthcare providers. We found two types of narratives in which healthcare providers' perceptions of interactionally troubling patient exchanges were consistently related to their implicit evaluations of patients along a continuum of activeness versus passiveness. In the first, an active patient was considered ideal, and the problematic patient was one who is passive. In the second, a patient's over-activeness was thought to interfere with the healthcare delivery. While providers' complaints about patient passiveness were unproblematically presented from the perspective of the patient participation ideal, complaints about patient over-activeness were difficult to account for due to their inherent connotations with paternalism. Thus, we conclude that there is a need for training and interventions aiming to develop healthcare providers' critical awareness of shifting cultural models, including patient involvement ideals and providers' capacity to reflect paternalistic tendencies.

Introduction

A current trend in healthcare is to involve patients in their own care and in the development, evaluation, and production of healthcare services (e.g., Crawford et al., 2002; Kwame & Petruca, 2021). Whereas in a more paternalistic care philosophy, patients have traditionally been handled as objects of treatment and their responsibilities in service encounters has been largely restricted to agreeing with professionals' decisions, today, it is becoming common to give patients the obligation to actively participate and express their views regarding their own care (Charles et al., 1997; Roter, 2000; Thompson, 2006). Indeed, giving patients such an active role is the central idea in patient-centered care (Crawford et al., 2002; Epstein et al., 2005; Rodriguez-Bailon et al., 2022; Sanerma et al., 2020).

The central components of patient involvement are information participation and decision-making participation. Patients are recognized as having practical, experiential information and expertise about their own service processes and needs (Charles et al., 1997). Sharing such information with providers is considered valuable. Additionally, patients may be given responsibility to seek information from different sources and to actively con-

tribute to the joint understanding of the situation (McCull-Kennedy et al., 2012). In decision-making participation, the ultimate ideal is shared decision-making relying on reciprocal dialogue and mutual respect between parties (Thompson, 2006). According to Thompson (2006), involvement can be determined by patients, providers, or both.

The degree of involvement varies in patient-determined involvement. Patients often wish to be involved in their services, but they also might want this involvement to vary according to their unique situations and needs (Thompson, 2017). Indeed, some patients do not want to be responsible for producing information at all, but instead, hope that their providers give relevant and requisite information about their treatment (McCull-Kennedy et al., 2012; Weiste et al., 2020).

From the viewpoint of the healthcare service system, patient involvement can support the correct targeting of services and, consequently, the efficiency of the system. Active involvement can also be empowering and thereby improve the patient's commitment to implementing their treatment plan. It has also been linked to improved quality of life (McCull-Kennedy et al., 2012; Sweeney et al., 2015).

Changing cultural views about the patient-provider relationship are reflected in narratives about clinical encounters (e.g., Brookes et al., 2022; Kalitzkus & Matthiessen, 2009). For instance, in Denniston and Rees's (2018) study, patients in positively evaluated service narratives described themselves as actively communicating with healthcare providers and experiencing trust and appreciation from providers; however, in negatively evaluated client narratives, patients depicted themselves being passive in the patient-provider relationship and experienced this relationship as lacking trust and sufficient safety (Denniston & Rees, 2018). In another study (Weiste et al., 2022) about negative healthcare service experiences, patients recognized that providers expect them to be active, but objected to this expectation by, for example, claiming that they are not to blame for the loss of their activeness due to illnesses.

In addition to patients' struggles related to the ideals of patient involvement, healthcare providers may also find the issue troubling. Prior research has shown that providers appreciate patient involvement; however, they may simultaneously entertain paternalistic views (Anthony & Crawford, 2000). Therefore, if providers wish to present themselves as up-to-date experts who adhere to the ideals of patient involvement, they need to shape their narratives so that they align with those ideals and mitigate against paternalistic elements in their views (Lord & Gale, 2014; Vrangbaek, 2015; Weiste et al., 2020). These tensions may become visible in the subtle ways in which healthcare providers narrate and account for interactional events that they have experienced as troubling.

In this study, we investigate healthcare providers' narratives about their troubling interactional experiences with patients. By "the troubling interactional experience," we mean providers' experiences of interactional encounters which have had unsatisfactory or unsettling outcomes for the narrator, thus, having the power to disturb the healthcare provider after the incident (Cui, 2014). Using Bamberg's (1997; 2004) narrative positioning analysis as a method, we consider the narratives not only to be expressions of providers' experiences and reflections on what went wrong in a troubling service encounter, but also as providers' ways of constructing, adopting, and contesting the division of obligations and responsibilities between themselves and their patients. Our research question is, "How do healthcare

providers position themselves in relation to their patients when recounting their experiences during a troubling clinical encounter within the wider discourse of paternal vs. patient-driven models?" Our empirical results describe the dynamic interplay for and against an active patient role, making visible the participants' meaning making and ultimately providing nuanced reflection of participants' perceptions about the role of patients in contemporary healthcare services.

Materials and Methods

Materials

Our data consist of 20 individual interviews of municipal healthcare providers in Finland. The interviews were conducted as part of the Social and Healthcare Professionals as Experts on Client Involvement project, which aimed to promote work practices that enhance patients' involvement in their own care and in the planning and developing of social and healthcare services.

The interviews were conducted face-to-face in 2019 and in early 2020. The length of the interviews varied from 22 to 90 minutes (22 hours of interaction in total), and they were audio-recorded. The interviews were semi-structured and used narrative interview style (Jovchelovitch & Bauer, 2000) where participants were first briefly introduced to the topic. Next, participants were asked to describe a typical encounter and a troubling encounter where "it doesn't go as it should." Participants were given time to uninterruptedly talk about their experiences and then asked questions to clarify and explore other areas of their experiences.

Participants

Participants represented varied occupational groups: physiotherapist (N=1), occupational therapist (N=1), psychologist (N=1), registered/community health nurses (N=10), mental health nurses (N=2), and service advisors (N=5). Participants worked in five organizations across Finland: a healthcare center, a first-contact service center for elderly people, a rehabilitation ward for people recovering from surgery, an outpatient ward for people undergoing long-term treatment for a chronic condition, and a psychiatric outpatient ward.

Each participant was interviewed once by project researchers. The interviews were conducted as part of an organizational development project at the outset, preceding any development initiatives. The interviewees were selected to take part in the patient involvement development workshops organized by the project. Participants were chosen by organization managers based on their expressed interest in service development, thus selected without specific inclusion or exclusion criteria. We have no specific information regarding their age, work experience, or other background characteristics, apart from the information that they spontaneously gave us in their interviews.

Ethics

The Ethics Committee of the Finnish Institute of Occupational Health granted approval (decision: November 23, 2018). All participants provided informed, written consent and were informed of their right to withdraw from the study. To protect the identity of the participants, we used pseudonyms and minimized any identifiable data in the article.

Method

We used narrative positioning analysis (Bamberg, 1997; 2004) to examine how participants positioned themselves and their patients in their narratives about interactionally troubling exchanges. Bamberg's model presents positioning on three levels: (1) The analysis at *the story world level* concerns how the people involved in the story are positioned in relation to each other and, in particular, how narrators position themselves in relation to other characters in the story. The analysis focuses on how the characters of the story are rhetorically constructed. (2) *The level of telling* is analyzed through narrators' positioning in relation to their audience and listeners. In our study, this means analyzing the interaction between the narrator and the interviewer—a negotiation in which the interviewer's questions and the interviewee's interpretations of an appropriate and desirable narrative are intertwined. The analysis attempts to identify specific social actions of the narrator such as whether they attempt to justify and account for certain elements in their narratives. (3) The third level of analysis concerns narrators' positioning in relation to *cultural model stories*, i.e., dominant discourses in a society that are made relevant for the narrative. Consequently, the third-level of analysis attempts to link the micro- and macro-level social categories drawn upon in the narratives.

In the analysis process, we first transcribed the interviews verbatim. Qualitative, inductive analysis was initiated by listening to the audiotapes and reading the transcriptions. Then, we identified all the narratives in which participants talked about troubling encounters with their patients (N=18 segments). In identifying these narratives, we looked at the segments in which participants complained, i.e., expressed negative feelings about a past experience with their client (Drew & Holt, 1988; Ruusuvoori et al., 2019). Out of 20 interviews, narratives that described a troubling encounter with a patient were found in 18, reducing the final sample to those 18 participants. Narratives varied in length and how much the interviewer participated in the conversation.

After selecting the sample of 18 narratives, we worked in a data-driven way, comparing the characters identified in each narrative against those in every subsequent narrative in our data. Narratives were analyzed separately by two researchers (NR and EW) and then discussed with the entire research group to deepen the analysis. When analyzing the level of telling, i.e., the interaction between the narrator and the interviewer (Level 2 in Bamberg's three-level analysis presented above), we utilized conversation analysis (Clift, 2016) to investigate how narratives were designed to invite a particular type of response, such as agreement or affiliation, from the interviewer. Data extracts presented below are representative of our findings across our dataset and were selected due to their utility in demonstrating findings in a clear, accessible way. The narratives were translated from Finnish to English by the authors.

Findings

We found that healthcare providers' experiences of interactionally troubling patient exchanges were consistently related to their evaluations of their patients along a continuum of perceived patient activeness versus passiveness during service encounters. Below, we provide examples of two types of narratives that emerged in the data. In the first, on the level of story-world, participants consider an active patient as the ideal,

and thus, the problem stems from patient passiveness. Perceived passivity entails a lack of motivation and the patient's reluctant attitude towards the service; this being the case, participants cast themselves as "inactive" due to their reduced possibilities to help the passive patient. In the second type of narrative, the patients' activeness is appreciated in principle, but too much activeness is seen as stressful for the participants' work; participants thus present themselves as independent, active actors whose interactional competence is essential for solving the problem. On the level of telling, these two types of narratives were responded to differently by the interviewer. The first type of narrative, which portrays patient passivity, was met with understanding and empathy. The second type of narrative, depicting patient over-activeness, was somewhat minimized. This differential treatment of narrative types underscores, on the level of cultural model stories, the significance of patient activeness within the cultural ideals of the patient-provider relationship.

Patient's passiveness restricts service providers' actorship

In the first type of narrative, patient activeness is considered the ideal against which patient passiveness is seen as causing problems. In the case of a passive patient, the healthcare professional, for example, might be unable to obtain the information required for good service delivery. Without this information, participants see themselves as being unable to modify and improve their own behavior and work processes. On the other hand, patient passiveness is also explained as lack of motivation and reluctant attitude towards service. When this is the case, participants describe themselves as "inactive" due to their limited possibilities in helping the passive patient. As demonstrated by verbal feedback, these narratives are empathized with by the interviewer.

We first present two short examples and then analyze one longer narrative in detail. The first extract is taken from the interview of a registered nurse who works in a somatic outpatient ward. Prior to the extract, the nurse and interviewer had talked about practices related to patient involvement:

Extract 1. Outpatient ward (NI=nurse, IN=interviewer)

01 NI: I don't think that patient involvement would cause any harm. Passiveness
02 is the worst, the patient being passive. We need both [the patient and
03 provider] for good service delivery and if the patients are passive, how
04 can we know what they want?
05 IN: Right, so you can't tailor it right.
06 NI: Yeah, you can't. It's very concrete in our work.
07 Bea and I were just saying that we never get feedback from the patients.
08 Are the plaster casts durable? Are they intact? Yes, it'd be nice to hear,
09 so that we could change our procedures. Otherwise, we continue to act
10 in the same way if we don't know.

On the *story world level*, the characters are the "passive" patient, the nurse, and the nurse's colleague (pseudonymized as "Bea", line 7). In general, the nurse highlights the ideal of an active patient who is involved in their own care (line 1), contrasting it to patient passiveness (line 2), which hinders good service delivery (lines 3, 4). Referring to a conversation with a colleague, the nurse empathizes with their coworker, voicing concern about lack of feedback from their patients (lines 7–8). Absence of knowledge about patients' wants is then cast as a something that constrains providers' ability to do a good job (lines 9–10).

On the *storytelling level*, the nurse invites the interviewer to identify with their complaint, while noting how providers cannot know how to act when a patient is passive (line 4). In line 5, the interviewer shows understanding of the nurse's complaint by formulating its outcome, "colluding" with the professional to blame the passive patient for a poorer outcome. In this way, the nurse and the interviewer build a joint affective stance toward the matter being complained about (Ruusuvaori et al., 2019).

On the level of *cultural model stories*, the nurse's story highlights the importance of patient involvement. Patients could provide the required information by, for instance, giving feedback, as this enables providers to adapt their behavior accordingly and provide tailored services. If the patients are passive and do not provide this information, providers' options are restricted.

Sometimes, passiveness is presented as a relatively permanent patient characteristic—a circumstance that is beyond participants' control. The second extract comes from an interview of a registered nurse who works at a rehabilitation ward. Preceding the extract, the nurse has been talking about what they consider to be difficult in their work.

Extract 2. Rehabilitation ward (N3=nurse)

01 N3: If the starting point is that a person has been in an accident and they've
02 already been passive before, not exercised much and have psychiatric problems,
03 well, obviously, we can't do magic in that situation. We just have to accept
04 that we treat the fracture and when they're discharged, they're still the same
05 passive person, lying around the house. So we can't heal everyone no matter
06 how hard we want. It's just something to be accepted in the moment.

On the *story world level*, the nurse uses figurative speech to describe the character of a passive patient (lines 2, 4–5) and providers' inability to influence the patient's situation (lines 3, 6). In describing providers' powerlessness in the situation, the nurse refers to their inability to "do magic," which highlights the unreasonableness of any demand for providers to change the situation.

On the *storytelling level*, the nurse engages in much interactional work to present herself as a person who accepts the reality only reluctantly. With the expression "no matter how hard we want" (line 5–6), she implies willingness to do everything that is in her power to motivate the patient to become active. In so doing, she emphasizes the central role of the patient as active agent for ideal patient involvement to be realized in practice.

Thus, on the level of *cultural model stories*, the nurse orients towards the activeness of the patient being an obligation in the patient/provider relationship: A person who only "lies around" is beyond the help of providers. The patient's activeness is thus required for the treatment to be successful. Providers can cast the fractured leg, but to be able to walk again, the patient needs to engage in active self-care.

The third extract is a longer narrative that further exemplifies participant views of active vs. passive patients. It is taken from an interview of a different registered nurse who also works in rehabilitation. Prior to the extract, the interviewer asked the nurse about their typical encounters with patients. The nurse then explained that their ward offers an intensive rehabilitation program for selected patients and starts to tell the interviewer about a specific situation in which they proposed the program to a patient named "Leo";

Extract 3. Rehabilitation ward (N2=nurse; IN=interviewer)

01 N2: Leo happened to be my patient that morning, so when I looked at his story and
02 listened to it when talking to him, I realized that this person is perfect for that
03 [the rehabilitation program].
04 IN: That's brilliant.
05 N2: Leo was terribly excited and happy that I proposed this opportunity and
06 considered it a good thing, but somehow, maybe, how can I put it? I mean,
07 patients haven't reacted negatively towards this program, not anyone to whom
08 we've proposed it. The reception has been extremely positive. That someone
09 wants to help and offer something like this. This program offers all...
[five lines omitted during which the nurse lists the services available]
15 that probably very few people don't like it. Um, well, but of course, it's just
16 that if the patients themselves aren't motivated. There was one case in which
17 the patient said straight out that they had been forced into it. This was when
18 this system hadn't yet properly started, and someone had put their oar in,
19 not quite knowing what type of patient would be suitable for this program and
20 had then recommended them, and we took them. And we should have done
21 the first call ourselves which we normally do, or the first contact, but we
22 didn't. A person from outside the ward did it, and that's where it all went
23 wrong. It was completely pointless, the whole episode.
24 IN: No one benefited.
25 N2: The patient said, "At least I don't have to come back."
26 IN: So, "At least I know now that this wasn't my thing."
27 N2: Yeah, if it isn't their thing to get up in the morning and start doing things.
28 That wasn't their thing. Yeah, a person has to be quite open when they come
29 because there will be a lot of new things, and their roommate can be anyone.
30 And there are many things when you come to hospital. So, if your attitude is
31 basically a bit wrong, then it just won't work.

On the *story world level*, the main characters are the narrator (the nurse), two different patients, and two providers from outside the ward. The story involves two incidents with two different patients with opposite characteristics and outcomes. The first incident is successful, involving the nurse herself as the active actor, recommending a specific patient to a rehabilitation program (lines 1–3). The patient is described as "really excited and happy" about the proposal, considering the program a "good thing" (lines 5–6)—a response that the nurse casts as a typical way for patients to react to such news (lines 7–9). After listing the services available for patients on the program (not shown in the extract), the nurse reports the second, more troubling incident, in which an unsuitable patient was referred to the program by a professional who—in contrast to the nurse telling the story—"didn't know what kind of patients are suitable for the program" (lines 16–20). The unsuitable patient is described as someone who is unmotivated (lines 15–16), has been forced to come (line 17), has the wrong attitude (lines 30–31), and doesn't consider "waking up in the morning and starting to do things" their choice (lines 27–28). In this case, the rehabilitation was unsuccessful: "it just won't work" (line 31).

On the *storytelling level*, the nurse hesitantly describes the negative side of the rehabilitation service. She uses multiple epistemic disclaimers ("somehow," "maybe," and "how can I put it," [line 6]), which are typical in interactions with socially problematic elements (Lindström & Karlsson, 2016). She also uses an extreme-case formulation "completely pointless" (line 23), which has been shown to be a way of legitimizing claims in interaction (Pomerantz, 1986). As in Extract 1, the nurse takes an affective stance towards the troubling event that they are complaining about and invites the interviewer to empathize with this stance (Ruusuvaori et al., 2019). In lines 24 and 26, the interviewer formulates the outcome of their complaint, legitimizing it and participating in its joint construction. In this way, patient passiveness becomes constructed as a problem that both the interviewer and interviewee share knowledge about.

On the level of *cultural model stories*, the nurse orients towards the ideal of an active patient who positively, even enthu-

siastically, participates in services. This orientation becomes clearly visible when the nurse describes a patient who fails to meet the criteria for participating in the rehabilitation program. The patient's ability to "wake up in the morning and start doing things" is presented as obligatory to the rehabilitation process. In this sense, activeness becomes an obligation that the patient is expected to fulfill when being offered the full range of services (lines 27–31). The nurse also orients towards an ideal in which the healthcare providers are also active, autonomous actors. This is shown when the nurse describes a successful case in which they realized that a patient would benefit from the program, based on their professional judgement. However, the way in which the nurse describes the troubling case shows that their own options regarding what to do are limited. The problem is the "system," which is new (lines 18) and a provider from outside the ward who acts incorrectly (lines 19–23). The nurse uses idiomatic expressions to describe their own "inactiveness" due to restricted possibilities to act in the troubling situation. As other people "put their oar in" and "that's where it all went wrong" (lines 18, 22–23), the nurse had no control over the outcome. Providers are also described as similarly helpless when the patient has what is considered to be the wrong attitude towards the service. This is considered something that the participant believes they cannot influence (line 31).

To conclude, in these examples, participants considered patient passiveness to be the cause of the problem in two ways. First, the passive patient restricted the information participants needed to provide quality service. Second, the patient restricted participants' options to act in ways that would have helped the patient. Patients' passiveness was not described as understandable to service providers, regardless of the patients' difficult life situations (cf. Weiste et al., 2022). Rather, activeness became an obligation, something that patients could, and should, choose in their lives. This view was also empathized with by the interviewer.

Strain caused by active patients requires providers' interaction skills

Although patient participation was highly appreciated in principle, too much activeness was seen as a strain on providers' work. In these narratives, participants evoked what they considered the right kind of patient activeness. In contrast to the previous cases, participants presented themselves as independent, active agents whose interactional competence resolved the problem described in the narrative. In addition, the reception of these narratives differed from previous cases; rather than empathizing with the participant, the interviewer downplayed and even partially minimized the narrative. We present two examples below. In the first extract, the nurse, who works in a somatic outpatient ward, has been talking about the intake of patients into the ward. In this context, the nurse refers to patient activeness as the possible source of the problem.

Extract 4 Outpatient ward (N2=nurse; IN=interviewer)

01 N2: There are sometimes, also, those [patients] that could have come a bit earlier
02 or call, as they've engaged in self-care for so long. So that's certainly the thing
03 here, but if they themselves would just have a bit more information about it.
04 IN: Yeah, so that is also one type of knowledge when one should contact
05 a service provider.
06 N2: Yes.

On the *story world level*, the characters are the independent, active patients and providers, both of whom are described in

general terms. The patients are portrayed as active, trying to treat themselves extensively without contacting a service provider in time (lines 1–2). According to the nurse, the patients would need more information to be able to avoid such problematic behavior (line 3).

On the *storytelling level*, the nurse starts her narrative by initiating a complaint about the patients, but instead of explicating the precise nature of the trouble, they cut off their story, and refer to the trouble as something that is commonly known to exist ("So that's certainly the thing here"), but which would be easily resolved if the patients would be better informed. This is something that the interviewer also concurs with in response to the nurse's talk.

On the level of *cultural model stories*, the nurse highlights the importance of patient involvement, but simultaneously problematizes patients' independent actions that may not sufficiently defer to participants' expertise. The ideal of patient involvement is nuanced: It is considered valuable, but necessarily when coordinated with service providers' expertise.

In the next extract, a physiotherapist (PT) who works in a somatic outpatient ward tells the interviewer about a similar experience. Before the extract, the PT has noted that patients adhere to treatment recommendations when they are involved in their own care. The interviewer then asks if patient involvement has any other possible benefits.

Extract 5 Outpatient ward (PT=physiotherapist; IN=interviewer)

01 PT: Yeah, we do get a lot of information from patients if they want to give it to us.
02 I do see this as active participation, depending on how much the patient is
03 ready to give of themselves and their personal issues to the treatment process.
04 IN: Right, yeah.
05 PT: In the case of physiotherapy, a precise description of the preliminary
06 information makes it easier to make the diagnosis already during the interview
07 stage and perhaps reduces the need for examinations, but it can be stressful
08 if they.... How can I say it nicely?
09 IN: Just be frank.
10 PT: In a way, interfere too much and start telling you what's wrong with them and
11 what causes this. They kind of make the diagnosis themselves. It's maybe, it
12 doesn't matter. You can deal with it and continue working. It's just a bit
13 stressful.
14 IN: Well, could it somehow be a lack of trust in service provider expertise if a
15 person interferes too much or....
16 PT: Personally, I don't perceive it as a professional insult if a patient does that.
17 Maybe it just makes guiding and teaching the patient harder work when the
18 patient already has a certain opinion and I have to very carefully explain why
19 it might not be as they think. This makes it....
20 IN: Yeah, right.
21 PT: You can see by the amount of talk when you try to change their opinions and
22 sell them something new [laughs].
23 IN: Out with the old and in with the new [smiley voice].
24 PT: Yeah, yeah. Well, definitely, if I think in the situation that their problem is not
25 at all what they think it is, and if they have the wrong idea about the symptom,
26 it can even hinder the rehabilitation process, and you really have to give a
27 reason why it'd be good for them to do some exercise despite them thinking
28 the opposites about what would be helpful for them.

On the *story world level*, the characters of the PT's story are providers and patients in general terms. The patient seems to have a great deal of information about what is needed in the treatment process. Their active involvement is seen to entail willingness to share this information with providers and to contribute to the treatment process with personal commitment (lines 1–3). For instance, in physiotherapy, such information can turn out to be very useful (lines 5–7). However, if the patient intervenes too much in the provider's work and makes the diagnosis themselves, their knowledge may become a stressful factor and may hinder the rehabilitation process (lines 12–13,

17–19, 26). In contrast to Extracts 1, 2, and 3, in this case, participants present themselves as capable of solving the problem with their interactional skills. They need to guide and teach the patient and provide enough explanations to change the patient's opinions (lines 18–19, 21–22, 26–28). This is strategically achieved by justifying and accounting for their professional opinions and decisions to the patient. Such persuasion, however, is perceived as a stressful factor that generates the need for “too much talk” (lines 12–13, 21–22).

On the *storytelling level*, the PT invites the interviewer's participation when formulating challenges related to patient involvement. In line 8, when describing the strain caused by the patient's involvement, the PT searches for the appropriate wording to tell the interviewer about their troubling experience (“How can I say it nicely?”). In doing this, they are also expressing orientation towards the ideals of patient involvement; complaining about patient activeness is considered a problematic issue. In line 9, the interviewer encourages the PT to speak frankly about their experience, and the PT continues explaining how they are able to deal with difficult patient behavior (lines 10–13). Next, the interviewer provides a possible formulation of the PT's experience, proposing that a patient presenting themselves as overly knowledgeable could be interpreted as a lack of trust in the service provider's competence (lines 14–15). The PT disagrees: They engage in extra interactional work to convince the interviewer that they can solve the problem (the patient activeness causing more work and time) with their professional skills; the patient's inference is not a personal insult to the PT (lines 16–19).

On the level of *cultural model stories*, the PT presents patient involvement in their own care as an ideal. The patient needs to be active and share information about themselves and their personal situation, but not to give too much information, such as presenting their thoughts on possible symptoms and diagnoses. Thus, the desired patient activeness is determined as well as constrained by the service providers.

In sum, patients are expected to share knowledge, but only to the extent that the participants feel useful in their work. The participants present the wrong kind of activeness as a stressful factor in their work. In these cases, in contrast to the problem caused by passive patients, which are difficult to deal with, participants maintain their expertise, and the problem with active patients is solved by participants' interaction skills. By persuading, guiding, and directing the patient, participants believe that they can overcome such troubling situations. Contrary to narratives about passive patients, these narratives were downplayed by the interviewer.

Discussion

In this article, we have presented healthcare providers' narratives about interactionally troubling patient situations, focusing on how participants interpret patient activity in their own treatment. In their narratives, participants considered patient activeness as an ideal—something that is essential for successful healthcare service delivery. Their orientation towards patient involvement was, however, quite narrow. They focused mainly on information participation and solely from a provider determined perspective (see, e.g., Thompson, 2006), i.e., considering activeness in terms of patients being cooperative and acknowledging providers' knowledge and expertise. This was manifested in narratives in which the source of the troubling

situation was the *patient's passiveness* and also in narratives where the patients were perceived as *overly active*.

Our findings on patient passiveness narratives can be clarified with reference to the dynamic reciprocal relationship between healthcare providers and their patients. On a surface level, patients' passiveness was a practical matter of information (McCull-Kennedy et al., 2012) in which a lack of sufficient information about the patient limited participants' possibilities of providing quality service. However, the problem cannot be reduced to a sheer matter of limited information exchange, as demonstrated in the participants' complaints about the patients' inappropriate attitude towards the service. In these complaints, the providers focused on the ideals of the patient to be active. Patients' failure to be so was considered a burden to the participants, who desired to motivate a passive patient and, at the same time, acknowledged and accounted for their failure of not being able to do so. In both cases, patient passiveness was associated with extra demands of activeness and subsequent work by participants. Such a finding is consistent with the generic patterns that have been observed in many different types of asymmetric social-interactional relations, such as aphasia (Goodwin, 1995), hearing deficits (Barnes & Ferguson, 2012; Egbert & Deppermann, 2012; Ekberg et al., 2017; Lind et al., 2004; Pajo, 2013), mental health problems (Stevanovic et al., 2020), and second-language learning (Kurahila, 2006). The main idea here involves the type of “zero-sum game.” From the provider's point of view, a patient's failure to perform their part in the situation leads to the provider compensating for that failure (Goodwin, 1995, 2013; Laakso, 2012; Linell, 1998). In addition, it is crucial to observe participants' inclination to align themselves against patients whose behavior they deem inadequate. This phenomenon further reinforces the asymmetry between providers and patients and may potentially harm the treatment relationship.

In *over-activeness* narratives, the troubling situation was perceived as arising from the patients providing *too much* information and independent action. Patients were also described as presenting themselves as too knowledgeable about what might be causing their symptoms. Participants considered this a stressful factor in their work. Working with such patients took more time and necessitated interactional skill, as participants needed to persuade and justify their professional opinions. Paradoxically, however, in the interview situation, providers also engaged in extra interactional work to show the interviewer that they did not disapprove of (overly) active patients as they did with the passive patients. This demonstrated an orientation to the normative primacy of patient activeness over passiveness, even in the face of troubling situations caused by the former. As patient over-activeness may also be interpreted as constituting a threat to participants' competence, expertise, and power (Anthony & Crawford, 2000), it is even more understandably difficult for the professionals to openly complain about it, as bringing up such experiences of awkwardness in a conversation may be delicate and cast the complainer in a negative light (Stevanovic, 2018; Stevanovic et al., 2024). Participants thus seem to lack a socially acceptable narrative framework to acknowledge the difficulties presented by patients they perceive as overly active.

It is important to note that in our study, the categorizations of active and passive patients, as well as the determinations regarding the proper amount of activeness, were solely based on the perceptions of the providers who were interviewed. Patients themselves may have very different perceptions of their

position on this continuum, and this warrants further investigation. Weiste and colleagues (2022), for example, found that healthcare patients with chronic conditions orient towards cultural expectations of patient activeness. In this study, when healthcare providers complained about passive patients, patient passiveness as being understandable; instead, patient activeness was seen as an expectation that everyone should adhere to. Thus, patient involvement ideals may give providers allowance to judge passive patients, holding no space for the patients' diverging reasons for passivity.

The participants' views on patient involvement reflect the wider cultural change in healthcare providers' perceptions of the patient's role in healthcare services (Charles et al., 1997; Roter, 2000; Thompson, 2006). As in any cultural evolution, changing values are accompanied by contradicting opinions and the need to negotiate (McCalman & Potter, 2015). In our data, participants appreciated patient involvement, but simultaneously entertained paternalistic views, which emphasized the authority of providers, such as making decisions on behalf of the patient or presuming to know better what the patient needs. This required participants to engage in interactional work when recounting their narratives during interviews to mitigate paternalistic elements in their talk and to better align their narratives with the ideals of patient involvement (see, e.g., Lord & Gale, 2014; Vrangbaek, 2015; Weiste et al., 2020).

The strength of our study was the detailed three-level analysis of participants' experiences of interactionally troubling patient exchanges. Naturally, the study also had certain limitations. The data was collected for the purposes of organizational development, and the sample consists of participants who were available for research. Additionally, we lack demographic information for our interviewees.

Furthermore, interviews were conducted among providers who represented only a small portion of service sectors and healthcare professions. This factor may have influenced participants' perceptions of patient passivity or activity. Because our data did not cover information from a wider range of provider groups, such as physicians, possible differences between provider groups could not be identified and thus remain a topic for future research.

Finally, research from various cultural contexts is necessary to gain a deeper understanding of how expectations regarding the patient's roles are shaped by diverse cultural backgrounds. This is crucial for adequately addressing the expectations and needs of multicultural/diverse patient groups in service encounters.

Conclusions

Our qualitative study, using Bamberg's narrative positioning analysis as a framework, illustrated difficulties that changing cultural expectations regarding the role of patient cause for healthcare providers. From the perspective of the participants, in their primary encounters with patients (in the *story world*), healthcare providers faced challenges when patients were either too passive or overly active. In their view, both situations resulted in suboptimal service delivery. However, in the interview situation (*storytelling world*), these two sources of trouble were treated differently both by the interviewer and interviewee. Narratives of patient passivity were empathized with by the interviewer, whereas the narratives of patient over-activeness were not, which led to them being downplayed and par-

tially retracted by the participants. These different types of responses demonstrate the overriding importance of patient activeness in the current cultural ideals of patient-provider relationship.

The same hierarchy was also reflected more widely (*cultural model stories*), as participants considered problematic paternalistic views that emphasized the authority of providers. Nonetheless, paternalism may still have shaped the participants' experiences of trouble at work, as evidence in their narratives on the level of the *story world*. Participants appeared to lack reflective awareness regarding their patients' potentially divergent perspectives on their own "passiveness" and "over-activeness." Developing this level of self-awareness beyond mere conformity to the shifting cultural model of care would be an essential aspect of providing good quality patient care.

Given the shifting normative expectations and ideals regarding patients' activeness, it is not surprising that patient's activeness vs. passiveness recurred in participants' narratives of experiences of interactionally troubling situations in their work. However, while complaints about patient passiveness are unproblematic from the perspective of these ideals, complaints about patient over-activeness are much more difficult to account for, due to their inherent connotations with paternalism. There is thus a need to address the discrepancy between the ways in which participants perceive and interpret trouble at work on an experiential level and the ways in which they can account for these experiences in interaction—a topic that has lately been generally addressed in various contexts and with various participants (see, e.g., Olakivi et al., 2024; Stevanovic et al., 2024; Weiste et al., 2022).

Healthcare providers need to develop a critical awareness of shifting cultural models, including the patient involvement ideals, their capacity to reflect paternalistic tendencies, and the enduring appeal of vertical power over others. This requires the ability to critically interrogate their narrative relational positioning, both toward colleagues and, most importantly, toward patients, to ensure the most respectful and collaborative care possible.

References

- Anthony, P., & Crawford, P. (2000). Service user involvement in care planning: The mental health nurse's perspective. *Journal of Psychiatric and Mental Health Nursing*, 7, 425–434.
- Bamberg, M. (1997). Positioning between structure and performance. *Journal of Narrative and Life History*, 7(1–4), 335–342.
- Bamberg, M. (2004). Positioning with Davie Hogan. Stories, tellings, and identities. In Daiute, C., & Lightfoot, C. (Eds.), *Narrative Analysis: Studying the Development of Individuals in Society* (pp. 135–157). Sage.
- Barnes, S. E., & Ferguson, A. (2012). Speakership asymmetry during topic talk involving a person with aphasia. *Journal of Interactional Research in Communication Disorders*, 3(1), 27–46.
- Brookes, G., McEnery, T., McGlashan, M., Smith, G. M., & Wilkinson, M. (2022). Narrative evaluation in patient feedback: A study of online comments about UK healthcare services. *Narrative Inquiry*, 32, 9–35.
- Charles, C., Gafni, A., & Whelan, T. (1997). Shared decision-

- making in the medical encounter: What does it mean? (Or, it takes at least two to tango). *Social Science in Medicine*, 44, 681–692.
- Clift, R. (2016). *Conversation Analysis*. Cambridge University Press.
- Crawford, M. J., Rutter, D., Manley, C., Weaver, T., Bhui, K., Fulop, N., & Tyrer, P. (2002). Systematic review of involving patients in the planning and development of health care. *British Medical Journal*, 325(7375), 1263.
- Cui, X. (2014). Getting to the source: Dynamics of problematic interactions. *RELC Journal*, 45, 197–210.
- Denniston, M. E., & Rees, C. E. (2018). “I will never ever go back”: Patients’ written narratives of health care communication. *Medical Education*, 52, 757–771.
- Drew, P., & Holt, E. (1988). Complainable matters: The use of idiomatic expressions in making complaints. *Social problems*, 35(4), 398–417.
- Egbert, M., & Deppermann, A. (2012). *Hearing aids communication: Integrating social interaction, audiology and user centered design to improve communication with hearing loss and hearing technologies*. Verlag für Gesprächsforschung.
- Ekberg, K., Hickson, L., & Grenness, C. (2017). Conversation breakdown in the audiology clinic: The importance of mutual gaze. *International Journal of Communication and Language Disorders*, 52(3), 346–355.
- Epstein, R. M., Franks, P., Fiscella, K., Cleveland, G. S., Meldrum, S. C., Kravitz, R. L., & Duberstein, P. R. (2005). Measuring patient-centred communication in patient-physician consultations: Theoretical and practical issues. *Social Science & Medicine*, 61, 1516–1528.
- Goodwin, C. (1995). Co-constructing meaning in conversation with an aphasic man. *Research on Language and Social Interaction*, 28(3), 233–260.
- Goodwin, C. (2013). The co-operative, transformative organization of human action and knowledge. *Journal of Pragmatics*, 46(1), 8–23.
- Jovchelovitch, S., & Bauer, M. W. (2000). Narrative interviewing. In M. W. Bauer, & G. Gaskell (Eds.), *Qualitative researching with text, image and sound: A practical handbook for social research* (pp. 57–74). Sage.
- Kalitzkus, V., & Matthiessen, P. F. (2009). Narrative-based medicine: potential, pitfalls, and practice. *The Permanent Journal*, 13(1), 80.
- Kurhila, S. (2006). *Second language interaction*. John Benjamins.
- Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: Barriers, facilitators, and the way forward. *BMC nursing*, 20(1), 158.
- Laakso, M. (2012). Aphasia as an example of how a communication disorder affects interaction. In M. Egbert, & A. Deppermann (Eds.), *Hearing aids communication* (pp. 138–145). Verlag für Gesprächsforschung.
- Linell, P. (1998). *Approaching dialogue: Talk, interaction and contexts in dialogical perspectives*. Amsterdam: John Benjamins Publishing.
- Lind, C., Hickson, L., & Erber, N. P. (2004). Conversation repair and acquired hearing impairment: A preliminary quantitative clinical study. *Australian and New Zealand Journal of Audiology*, 26(1), 40–52.
- Lindström, J., & Karlsson, S. (2016). Tensions in the epistemic domain and claims of no-knowledge: A study of Swedish medical interaction. *Journal of Pragmatics*, 106, 129–147.
- Lord, L., & Gale, N. (2014). Subjective experience or objective process: Understanding the gap between values and practice for involving patients in designing patient-centred care. *Journal of Health Organization and Management*, 28(6), 714–730.
- McCalman, J., & Potter, D. (2015). *Leading cultural change: The theory and practice of successful organizational transformation*. Kogan Page.
- McColl-Kennedy, J. R., Vargo, S. L., Dagger, T. S., Sweeney, J. C., & Kasteren, Y. V. (2012). Health care customer value cocreation practice styles. *Journal of Service Research*, 15(4), 370–389.
- Olakivi, A., Stevanovic, M., Nevalainen, H., Henttonen, P., & Ravaja, N. (2024). Voicing experiences of ageist nonrecognition in performance appraisal interaction: Complexities in constructing stories that counteract organisational ignorance. *Culture and Organization*, 1–21.
- Pajo, K. (2013). The occurrence of ‘what’, ‘where’, ‘what house’ and other repair initiations in the home environment of hearing-impaired individuals. *International Journal of Language and Communication Disorders*, 48(1), 66–77.
- Pomerantz, A. (1986). Extreme case formulations: A way of legitimizing claims. *Human Studies*, 9(2–3), 219–229.
- Rodriguez-Bailon, M., López-González, L., & Merchán-Baeza, J. A. (2022). Client-centred practice in occupational therapy after stroke: A systematic review. *Scandinavian Journal of Occupational Therapy*, 29(2), 89–103.
- Roter, D. (2000). The enduring and evolving nature of the patient-physician relationship. *Patient Education and Counseling*, 39, 5–15.
- Ruusuvuori, J., Asmuß, B., Henttonen, P., & Ravaja, N. (2019). Complaining about others at work. *Research on Language and Social Interaction*, 52(1), 41–62.
- Sanerma, P., Miettinen, S., Paavilainen, E., & Åstedt-Kurki, P. (2020). A client-centered approach in home care for older persons – An integrative review. *Scandinavian Journal of Primary Health Care*, 38(4), 369–380.
- Stevanovic, M. (2018). Social deontics: A nano level approach to human power play. *Journal for the Theory of Social Behaviour*, 48(3), 369–389.
- Stevanovic, M., Valkeapää, T., Weiste, E., & Lindholm, C. (2020). Promoting client participation and constructing decisions in mental health rehabilitation meetings. In C. Lindholm, M. Stevanovic & E. Weiste (Eds.), *Joint decision making in mental health: An interactional approach* (pp. 43–68). Palgrave Macmillan.
- Stevanovic, M., Olakivi, A., Nevalainen, H., Henttonen, P., & Ravaja, N. (2024). Telling a supervisor about experiences of gendered dismissal: Problems of documentation, tellability, and failed authority. *Gender, Work & Organization*, 31(2), 554–575.
- Sweeney, J. C., Danaher, T. S., & McColl-Kennedy, J. R. (2015). Customer effort in value cocreation activities: Improving quality of life and behavioral intentions of health care customers. *Journal of Service Research*, 18(3), 318–335.
- Thompson, A. G. H. (2006). The meaning of patient involvement and participation in health care consultations: A taxonomy. *Social Science & Medicine*, 64, 1297–1310.
- Vrangbaek, K. (2015). Patient involvement in Danish health care. *Journal of Health Organization and Management*, 29(5), 611–624.
- Weiste, E., Käpykangas, S., Uusitalo, L.L., & Stevanovic, M.

(2020). Being heard, exerting influence, or knowing how to play the game? Expectations of client involvement among social and health care professionals and clients. *International Journal of Environmental Research and Public Health*, 17(16), 5653.

Weiste, E., Ranta, N., Stevanovic, M., Nevalainen, H., Valtonen, A., & Leinonen, M. (2022). Narratives about negative healthcare service experiences: Reported events, positioning and normative discourse of an active client. *Healthcare*, 10(12), 2511.

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