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Lars H. Williams¹, Mette K. Christensen¹, Carsten Rytter²,
and Peter Musaeus¹

Abstract

In this article, we present a case study of residents' clinical experiences and communication in outpatient oncology consultations. We apply positioning theory, a dynamic alternative to role theory, to investigate how oncology residents and patients situate themselves as persons with rights and duties. Drawing from seven qualitative interviews and six days of observation, we investigate the residents' social positioning and their conversations with patients or supervisors. Our focus is on how (a) relational shifts in authority depend on each situation and its participants; (b) storylines establish acts and positions and narratively frame what participants can expect from a medical consultation viewed as a social episode; and (c) the positioning of rights and duties can lead to misunderstandings and frustrations. We conclude that residents and patients locate themselves in outpatient conversations as participants who jointly produce and are produced by patients' and nurses' storylines about who should take responsibility for treatment.

Keywords

cancer; communication; education, professional; interviews; nursing; relationships, health care; research, qualitative

The nature of each doctor–patient encounter in the clinical setting is of the utmost importance to that patient's treatment. Studies have shown that the quality of the developing doctor–patient relationship in the field of oncology has a significant impact on patient satisfaction (Ishikawa et al., 2002; Meryn, 1998; Ong, de Haes, Hoos, & Lammes, 1995), and that in other types of medical practices it has a significant impact on the treatment process (Brédart, Boulenc, & Dolbeault, 2005). Social health researchers have begun to conceptualize this social encounter in a manner that does not reduce the complexity of the situation or neglect the particular challenges that both the doctor and patient face. Over the past decade, the nature of the doctor–patient relationship has shifted from a focus on the biomedical expertise automatically associated with the doctor's role toward a conception of the doctor and the patient as persons with specific rights and duties (Balint & Shelton, 1996; van Dulmen, 2002).

To investigate the doctor–patient relationship, social health researchers are increasingly focusing less on static roles perceived as expectations and societal norms concerning how doctors and patients behave or ought to behave (which entails an essentialist notion of roles and expertise in which the doctor occupies a clear societal position and possesses a level of expertise that he or she transmits to his or her patients). Instead, researchers are

now focusing more on the dynamics of the doctor and patient roles to illuminate the unpredictable nature of medical care and how doctors and patients perform relative to one another. This shift in focus might, in part, have been brought about by technological changes: notably, the increasing amount of information available through online resources and the fast pace of medical research, which can either empower the patient and doctor or lead to information overload.

Evidence suggests that the well-informed patient perceives his or her rights differently than the uninformed patient. It also suggests that the contemporary patient has higher expectations and is more critical of his or her doctors than previously (Balint & Shelton, 1996; Emanuel & Emanuel, 1992; Szasz & Hollande, 1965; van Dulmen, 2002). In short, the doctor–patient relationship has shifted toward a more dynamic—if not egalitarian—condition, in which both doctor and patient have the duty to contribute to the patient's treatment plan (van Dulmen).

¹Aarhus University, Aarhus, Denmark

²Aarhus University Hospital, Aarhus, Denmark

Corresponding Author:

Peter Musaeus, Aarhus University, Centre for Medical Education, Brendstrupgaardsvej 102, DK-8200 Aarhus N, Denmark.
Email: peter@medu.au.dk

Nevertheless, social encounters between doctor and patient are still characterized by intricate negotiations around difficult biomedical issues, which necessitates further research into the performances of doctors and patients in clinical social encounters. Social health researchers require theoretical notions and empirical cases to grasp the dynamics of the relational space between doctor and patient to progress beyond traditional, stereotypical notions of social behavior, and to continue to expand our understanding of the complexity of the doctor–patient relationship.

The purpose of this study was to consider the positioning space between the doctor and patient roles as a large and expanding space filled with different positions, perspectives, and expectations. This space also contains the potential for new types of doctor–patient relationships to develop and for others to break down. We argue that doctors and patients are increasingly faced with the challenge of leaving their static roles and dealing with the dynamics of these shifting positions.

In this article, we present a case study that employs positioning theory as an analytical framework in the analysis of episodes of doctor–patient interaction. First, we explain positioning theory, which was developed by Bronwyn Davies and Rom Harré (1990) and revolves around three key concepts: (a) position (the rights and duties of social actors), (b) act (meaningful performance), and (c) storyline (conventions of how to make sense of narrative events). We utilize positioning theory to address the rapidly changing dynamics of clinical situations—in which behavior can change from moment to moment—to provide a suitable analytic framework for the understanding of the specific dynamics of the doctor–patient relationship in the oncology context.

Second, we present three case examples of oncology residents to support our argument that to fully understand the outpatient consultation we must view it as a collection of embodied positions dynamically enacted by the resident, patient, supervisor, and nurse. These positions are continually negotiated in the oncology clinic, which can be interpreted as a moral space by virtue of its associated rights and duties. Such rights and duties are defined by the participants as their entitlements and obligations (for example, which costly medications the patient is entitled to receive, how many hours of supervision the resident is entitled to receive, or the resident’s clinical obligations to the patient). Finally, we conclude by discussing the limitations of our approach and outlining the potential ramifications of this analysis for oncology care and resident education.

Positioning Theory

Positioning theory was originally developed to address the need for a more dynamic paradigm in social

psychology (Davies & Harré, 1990; Harré & Moghaddam, 2003; Harré & Slocum, 2003). It emerged out of a growing dissatisfaction with theories of social behavior that modeled rules and roles as static and failed to account for participants’ creation and management of meaning in the unfolding situations known as social episodes. A social episode is characterized by “the rapidity with which patterns of dominance and influence among participants [change]” (Harré & Slocum, 2003, p. 101). Thus, positioning theory offers discursive tools for the detailed analysis of positions, connecting them with the larger cultural context. To the best of our knowledge, positioning theory has not been applied specifically to the social encounter between doctor and patient in oncology, although it has successfully been employed in many other fields of study; for example, in midwifery (McKenzie, 2004), gerontology (Allen & Wiles, 2013; Jones, 2006), international politics (Moghaddam, Harré, & Lee, 2008), health information seeking (Genius, 2013), and media analysis (Brinkmann, 2010).

Position

Position is used to refer to momentary clusters of rights and duties to act and speak in certain ways over the course of an episode (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009). Rights are “expressed as anticipatory or retrospective justifications for the propriety of demands or requests for action by someone else;” duties are “expressed as anticipatory or retrospective expressions of demands for action by oneself” (Harré & Slocum, 2003, p. 105).

Act

An act is defined as “a socially meaningful and significant performance” (Harré & Moghaddam, 2003, p. 6). What counts as a meaningful performance or utterance must be judged within the specific moral context of each patient consultation. Being positioned affects the repertoire of acts one has access to; in other words, acts are what actions become when they are interpreted as socially meaningful. One example is the handshake, which is not an act until it is interpreted. It becomes an act when it is understood as congratulation, a greeting, or an agreement. For instance, two tennis players shaking hands after a match has a different meaning, is a different act, than two politicians shaking hands in front of the press or a doctor and patient shaking hands after a clinical consultation. The meaning of the handshake depends on the local moral order in which it takes place. Certain acts can cement or change the expected positions of authority between participants; for example, when a doctor begins a consultation by establishing a mutual dialogue with the patient rather than taking explicit control of the

consultation. Acts and positions are negotiable because acts make it possible to reinterpret and reestablish positions.

Storyline

Storylines are defined as “what is to be expected in the episode being studied and comprise the conventions under which to make sense of the events that have been recorded and to express them in narrative” (Harré & Moghaddam, 2003, p. 9). In other words, storylines constitute the moral context of the social episode because they provide the framework for what one can, might, and ought to do. Social episodes are not chaotic; they are ordered according to cultural narratives in which storylines form important frames:

Frame is used to refer to storyline in general—for example, the medical frame, which can be realized in a wide variety of specific storylines. Frame is important because it allows one to consider the coherence or incoherence of contemporaneous storyline and the kind of challenges that can emerge. For example, one might challenge a storyline in the medical frame by shifting to a legal frame, that is, breaking frame; or one may shift from one medical storyline to another, without breaking frame. (Harré & Moghaddam, 2003, p. 13)

When analyzing a storyline in the medical setting, we must remain aware of which frame is delimiting the storyline. The medical frame encompasses conversations about treatment and patient emotional well-being in which the patients’ feelings about treatment influence how they interpret the doctors’ communications. These issues should be kept in mind because, in oncology, doctor–patient communication is known to impact on the patients’ quality of life and satisfaction with treatment (Ong, Visser, Lammes, & de Haes, 2000; Zandbelt, Smets, Oort, Godfried, & de Haes, 2004).

Methods

Data Collection

In our case study, we applied ethnographic research methods with seven semistructured qualitative interviews and 6 full days of field observation at the oncology ward of a large metropolitan hospital in Denmark. The observations were theoretically informed by the backdrop of Spradley’s (1980) and Atkinson’s (1992) ethnography, which inspired our focus on the specifics of observation and interviewing in the medical setting.

During our observations in the outpatient clinic, we utilized a short-term ethnographic strategy (Musaeus, 2012), in which the observer spends less time in the field than in traditional ethnography. Our observations (carried

out by the first author) were used to triangulate the findings of the research interview and followed a schedule created by the consultant responsible for education in the clinical department. Prior to the short-term ethnography, the first and last authors held a meeting to brief the oncology ward staff on the project, and the first author was given free access to the ward and the residents.

Four group interviews and three individual interviews of 40 to 80 minutes were conducted with 10 junior residents. The interviews were semistructured and took place in a hospital office. The interview guide that we originally adopted included four major categories of research questions: the learning experience, team cooperation and work organization, challenging clinical situations, and learning to become a decision maker; however, this guide was repeatedly restructured and refined (by the first and last authors) to incorporate the findings of the observation and to validate these findings through the interviews. The interviewer (first author) asked for additional information, summarizing and paraphrasing to encourage dialogue and clarification.

Participants and Setting

Three of the participants were men and 7 were women. They were all second-year junior residents in oncology. All recruitment was performed through the senior doctor and head of the department of oncology at a large metropolitan hospital in Denmark. All of the participants’ names have been anonymized. The participants were interviewed about their experience with outpatient consultations. In medical research literature, an outpatient is defined as a patient whose treatment does not necessitate an overnight stay at the hospital. An outpatient consultation can be interpreted as a social episode characterized by three aspects: (a) the involvement of various participants who play interrelated roles in the episode (for example, junior or senior doctors, nurses, and patients, and occasionally the patient’s family members or friends); (b) demarcated physical boundaries, with all consultations taking place in the clinic’s consultation room; and (c) temporal boundaries, with all consultations lasting between 15 and 45 minutes. The fact that this specific social episode is so well defined and delineated makes it particularly well suited to the use of positioning theory as an analytical framework.

Analysis

We conducted our analysis of the data material in the following manner. First, the interviews were listened to multiple times before being transcribed verbatim by an experienced transcriber. This resulted in 67 pages of transcription. The transcriptions were read repeatedly to form

a basis for the analysis and were reread during the analysis. Harré and Moghaddam (2003) recommended that a positioning analysis begin by identifying the storyline of a given episode. They describe this methodological procedure as follows: “As a first step, then, a storyline is proposed as a working hypothesis about principles or conventions that are being followed in the unfolding of the episode that is being studied. Such a storyline might be ‘David and Goliath’ or ‘Doctor and patient’” (p. 9). Following this recommendation, storylines were identified (by the first and last authors) for each significant interview passage and each new setting within each interview before the acts and positions were analyzed.

Storylines as Boundaries for Positioning Space and Possibilities

In this section, we present three representative cases (Julie, John, and Sarah) of different types of storylines, each of which creates a different context for positioning. In our analysis, we strove to identify storylines that were as specific as possible, even more specific than the more general storylines proposed by Harré and Moghaddam (2003) cited above. It is important to note that storylines are working hypotheses about what can be expected from the actors in each setting, not modes of interpretation carved in stone. Meanings are ascribed to specific acts from the perspective of each specific storyline. Each storyline identifies certain positions as possible and relates its actors to one another in specific ways.

The outpatient consultation can be viewed as a narrative unfolding of the positions occupied by the doctor and patient, bounded by a storyline and frame. The frame is medical and remains so even when the consultation shifts and draws on other frames, such as a psychological consideration of the patient’s emotional suffering or an economic consideration of prescribing the best-value medication. In the majority of cases, the storyline sets the analytical starting point because it allows us to understand the acts and positions within a specific context. In summary, the three elements of the positioning “triangle” (storyline, act, and position) are interrelated. This is a strength of the analysis because it sensitizes the research to the clinical complexity and the range of duties and rights that the social actors might access during their conversation.

Case 1 (Julie). The Fluidity of Clinical Positioning

Case 1 concerns Julie, a junior resident who experienced her transition from medical student to junior doctor as characterized by a wider range of possible positions that

depend on other participants’ acts. Her case demonstrates that such a transition should be conceptualized not in terms of the static notion of the doctor in relation to other fixed roles, such as the nurse or the patient, but in terms of positioning. At the time of interview, Julie was in her late 20s and in the second year of her residency. The following interview section and analysis show how, after she began her residency in the oncology ward, Julie became familiar with herself as a doctor in relation to the nurses. She perceived herself in terms of her shifting responsibilities as a decision maker, depending on the proximity of other doctors and experienced nurses. Julie discussed her experience acquiring competencies and related this process to the proximity of other participants:

Interviewer (I): What have you become better at since starting in the oncology ward?

Julie: I have become much more familiar with my role as a doctor. When I had just graduated, we [doctors] thought that we were the ones to make all the decisions and that the nurses would like to know who was in charge; however, what matters here in the ward is cooperation. The nurses are very experienced, and there is no shame in asking for advice and confessing that I’m not sure what to do. So I guess I have become more aware of my limitations and more secure in my decisions. Cooperation in the ward becomes a lot easier when you become aware of each other’s competencies. You slowly realize which competencies other professionals have and how we can supplement each other.

In Julie’s case, becoming a better doctor meant becoming more familiar with her professional position in relation to her coworkers, not solely in terms of her own competencies and knowledge. Julie explained that she had become more aware of her own limitations and more secure in her decisions; she described how these limitations and decisions were positioned by working closely with colleagues (based on her view that treatment requires a collaborative effort). In this way, her competencies were positioned as relationships that she developed from situation to situation. She thus perceived becoming a better doctor in terms of knowing which decisions a doctor could make and recognizing when she was not qualified to make such a decision. This position also established a mutual relationship of trust because Julie understood that it was acceptable to admit when she was unsure of the best course of action.

Although Julie herself referred to “my role as a doctor,” what she was actually referring to was not the context-independent and static role of a doctor but rather her context-specific position as a doctor. In discussing how she perceived the clinical situation as a matter of accommodating doctors’ and nurses’ positions based on their

professions and expertise, she eroded authoritative boundaries between the roles of doctor and nurse. Julie's role as doctor gave rise to specific possibilities and obligations, which she recognized were not readily available to nurses; however, these situation-specific possibilities and obligations are not reducible to the social fact that, as a doctor, Julie carried certain skills or expertise. Instead, it was the social ties she developed with colleagues, the conversations she held and the acts she performed with her patients that created her position as a doctor. The positions available to Julie were tentative arrangements that varied according to her proximity to other colleagues:

- I: How do you experience the team that you are a part of? How do you see yourself in it?
 Julie: It depends on the situation. In some situations, I'm pretty far down in the hierarchy when decisions are made for the patients, like which treatment to give them. In other situations on the ward rounds, when I'm the only doctor in the ward, I'm the one to make the decisions if a patient becomes ill.

Julie's authority changed from one context to another; e.g., from when she was involved in direct collaborations with senior colleagues to when she was the only doctor on the ward. The obligation to make decisions was not up for negotiation, yet it clearly varied according to the participants in each situation.

Case 2 (John). Shifting Position From Authority to Learner

In Case 2, a junior resident, John, received feedback on his performance skills in outpatient consultations. This case illustrates how John's position changed from one moment to another and demonstrates how his position eradicated his general role as a doctor and created positions of different obligations toward different persons. The following example is taken from the outpatient clinic in which John conducted the clinical consultation.

The case comprises two scenes illustrating John's shifting positions as a doctor and as a learner receiving supervision. John was first observed speaking with his patient in an outpatient consultation (Scene 1). Ten minutes later, John was observed receiving feedback on his performance from a senior colleague (Scene 2). Although it is only the first scene that enacts the doctor-patient relationship, the second scene is still connected to this relationship, because it functions as the axis of the feedback situation between John and his superior. We therefore argue that both scenes form a single social episode that illustrates a junior doctor's positioning over the course of half a day, from a medical authority in the actual consultation in the morning to a novice and learner in the clinical feedback situation at noon.

Scene 1: John as Resident and Supervisee

It was Monday morning and John, the junior oncology medical resident, was sitting in an outpatient consultation. He was reading the patient file of a woman in her mid-40s aloud to himself and the nurse who had to review the patient's medical history. The patient entered, walked past John, and sat in front of him at his desk. A moment of silence passed before the patient looked expectantly at John, who initiated the conversation:

- John: How are you doing?
 Patient (P): I have some mucus coming up.
 John: What color is it? If it's yellowish, it could be more serious.
 P: Okay.
 John: We have hit your lungs [with the radiation], and you have to live with that.
 P: Yes, yes. I know.
 John: Now let me tell you about the options for the extension of your treatments.

John proceeded to explain the details of the treatment extension. After some initial descriptions of diagnostic procedures, he continued the conversation for a further 5 minutes. In an empathetic voice, he inquired about the patient's weight and eating habits and asked for details about the mucus. He gathered information about his patient's day-to-day functioning and her own experience of her condition. Before the patient left the consultation, John advised her on her prognosis and comforted her by describing successful medical cases comparable to her condition.

Throughout the outpatient consultation, John conducted the conversation with the utmost sincerity. He managed to convey essential information to the patient in a manner she could understand, and he listened with empathy, nodding and making eye contact, then looking away to reassure her. He demonstrated that he understood her physical and psychological condition. John adopted the authority of his medical insight and accepted his duty to convey this insight in a pedagogical manner. This is not an automatic or given element of the patient-doctor relationship, which has historically been characterized by a more authoritative-doctor position, speaking to a passive and nondemanding patient (Szasz & Hollande, 1965). In this case, John opened up space for a more equal patient-doctor relationship by treating the patient as a person with the right to know and understand the conditions of her medical situation.

The patient positioned John as someone who could help her. She did this by answering his questions willingly and allowing him to take the lead in the conversation and diagnostic procedures. She frequently nodded and said "yes" and "okay" to signal that she understood and that John should continue, cementing his position as

the one expected to take the lead. Throughout the episode, John's supervisor, a female senior resident in her 40s, was present in the room as a keen but quiet observer whose presence was not acknowledged by doctor or patient.

Scene 2: John Receiving Feedback From the Senior Resident

The patient left the room. John turned to the senior doctor, who nodded as a sign that the feedback session was about to commence. The two actors immediately agreed that the supervision session would focus on John's communication skills. They both turned toward the computer screen with the patient's information. John looked expectantly at the senior doctor, waiting for her to initiate the session. She began by explaining how she normally dealt with outpatient consultations and the order and form in which she delivered information:

Senior resident (SR): This is usually how I start the conversation: Get the patient to explain her everyday rhythms. It is a good idea to conduct the general conversation about the patient's daily routine and needs while doing the physical examination. In this way, it becomes less of an interrogation, and it becomes more natural.

John: How do you tell your patient that the treatment is palliative?

SR: Say it like it is. They won't understand it if you're not completely clear. Of course you need to show some sympathy, but you must be clear. People have things they need to take care of. Be sympathetic but completely honest. It's not something you learn by doing it once or by having this conversation with me; you need to do it many times. You need to grow into it.

It was not customary to supervise such outpatient consultations, so this verbal interaction took place as a result of John's proactive request to receive feedback on his communication skills. The resulting conversation demonstrates how John's rights and duties shifted from his conversation with the patient to his conversation with his supervisor. In the supervision situation, he had the duty to listen and learn, to remember what the senior resident taught him and to take it seriously. He had the right to feedback (this was part of his institutionally secured resident education) but, within the feedback situation, it was his duty to listen and learn. The senior doctor positioned John as someone with the duty to show sympathy for the patient's condition but to be rhetorically clear when conveying his message.

We might ask whether the supervisor's choice to begin by explaining how she normally dealt with outpatient consultations was an indirect criticism of John; however, the observer did not perceive it as such. Instead, we could account for it as a normalization event, a conversational

turn in which the supervisor used a storyline about normal procedure and provided a standard for comparison for John's performance. It might appear obvious that doctors have a duty to be sympathetic and to strive for equal positioning, but doctor-patient interactions have historically been characterized by a more authoritarian-passive relationship (Szasz & Hollande, 1965). The storyline in the second scene can be described as a younger doctor learning from a senior doctor, whereas the first scene involved taking responsibility as a medical authority. John was the protagonist in both storylines, yet his position was dramatically different in each one.

During the conversation between John and his supervisor, the supervisor remarked that the art of shaping an outpatient conversation was not something one learns in one feedback session; it requires the junior doctor to practice repeatedly. Thus, the outpatient conversation is viewed as a craft to be learned rather than a discursive competence the doctor possesses by nature or acquires from reading a book on communication. This helps to place John in a learner's position, with the right to be only partly able to conduct the perfect patient consultation. Patient consultations are a craft that requires the junior resident to develop good habits, and the supervisor positioned John as someone learning the normativity of the craft. The senior used the organic metaphor of "growing" twice during the feedback session—growing into the position of a doctor. This is a powerful illustration of the way the senior viewed the flowering nature of the outpatient conversation and the cultivation of communication skills as a gradual, unfolding process that must be nurtured to fully develop; however, John and his supervisor were not the only ones framing this positioning space.

Although she was not physically present, the patient was also an actor in the supervision conversation about how doctors should act toward their patients. One premise of the feedback conversation was that the patient had the right to understand her own condition. John and his supervisor had to agree on the patient's moral positioning; outside this context, the conversation would have lost its meaning. Furthermore, the patient's moral positioning was not concerned solely with her medical treatment; it involved her life as a whole (according to the senior doctor, "people have things they need to take care of"). Positioning the patient not only as a subject of medical treatment but as a person with projects and ambitions is an important foundation for understanding the construction of the social episode that is the outpatient consultation. It is also important for understanding the supervisor-resident interaction in a feedback situation and the way the modern doctor-patient relationship is conceptualized (van Dulmen, 2002).

These two scenes, which took place within the same hour, illustrate how positions can shift back and forth; John moved from a position as a medical authority (with

the power to regulate treatment) to a novice learner, and he moved from a position in which he shaped a conversation about cancer treatment to one in which he sought advice on how to deal with the life-and-death language of such situations.

Case 3 (Sarah). Storyline: Clash of Expectations

Case 3 is significant because it demonstrates how the expectations of each participant in a social episode can override the roles of doctor and patient and how various positions are possible within these roles. In this case, the participants' expectations of the rights and duties assigned to the doctor and patient were asymmetrical, creating confusion and dissatisfaction. In contrast with Cases 1 and 2, Case 3 does not take its point of departure in a specific situation but from a resident's reflection on her perceived duties to her patients. Previous research has shown that doctors' and patients' expectations of one another are of vital importance to their levels of satisfaction with their treatment (Brédart et al., 2005).

In this case, Sarah, a young resident with only a few months of experience in the oncology department, considered the conflict that mistaken expectations between patient and doctor can cause. Despite Sarah's relatively short tenure on the ward, she had extensive experience conducting consultations in the outpatient clinic. In her interview, Sarah expressed her concern about the potential for clashing interests or different expectations between patient and doctor in the clinic:

I: What are some of the barriers you experience in your outpatient work?

Sarah: They [the patients] want the doctor to be very well prepared, to know a lot about their condition and a lot about their background—their medical history and what they have already gone through. Many of the patients also expect that we have an overview of where they have been treated and enrolled before, in other hospitals. It is also my experience that they appreciate that we set clear boundaries for what will happen during the outpatient consultation and maybe that we start out with “today we are going to talk about so-and-so in such-and-such a way.”

This excerpt shows that the doctor–patient interaction does not begin with a clean slate. It involves expectations of what will happen and who is in charge. However, in the following excerpt, it is the doctor who positioned the patient's expectations. The patient was positioned as having the right to be treated in a certain way, and the doctor had a duty to treat the patient as such. From Sarah's perspective, the patient expected her, as the doctor, to take control of the situation as the medical authority that she

was, whereas the doctor perceived the patient as someone who expected her to assume greater control of the situation:

I have often experienced, in [outpatient consultation] conversations with patients, that patients get either angry or frustrated when I try some of the techniques I have learned in our communication courses. At the beginning [of the conversation], for example, if I ask a very open question, it is often interpreted as if I haven't read their patient journal or that I don't have a specific plan for the treatment or for what's going to happen today. In my experience, if I don't ask very specific questions in the outpatient conversation, this is interpreted as if I'm not being sufficiently prepared or that I'm leaving what is going to happen up to the patients. It should be the doctor who knows best and is well prepared. This can be very confusing for us as well, because we would like to be well prepared, and we try to. The patients often totally misunderstand our questions.

Sarah remarked that, in a clinical communication course, she had learned to first collect information on the patient's physical condition before making a treatment decision. In Sarah's experience, this advice clashed with the expectations of the patient, who wanted the doctor to know how to proceed from the beginning and to assume a position of authority. It appears as though, when the doctor fails to live up to this expectation, the patient perceives it as verging on irresponsibility, unpreparedness, and unprofessionalism on the part of the doctor. Conflicts might arise from these asymmetrical expectations between resident and patient.

It is important to ask whether the storylines of the social episode were asymmetrical in a manner that caused conflict and confusion. Sarah viewed it as her duty to be dialogical and to adopt the role of the listener, signaling the patient's right to be heard before she offered her opinion. However, the patient believed it was Sarah's duty as a doctor to know the facts of his or her condition and to develop an appropriate treatment plan. The question of which position Sarah should establish for herself is also a question about the medical treatment itself. Sarah explained that the patient's input affects the chosen procedures; in her opinion, the doctor should not decide on a treatment plan before she questions the patient about how he or she experiences his or her condition. Sarah explained this later in the interview:

I: Regarding decision making in the outpatient clinic, how do you experience the patients as part of this decision-making process?

Sarah: The patients' ways of telling their stories and their understandings of their situations has a great impact. It has a strong influence on what's going to happen, because if they say they aren't feeling well, that they have a weakened general condition and their everyday life is highly

affected, it has a great influence on what we do. So I believe that what the patients say is of crucial significance to what we choose to do.

Sarah emphasized her belief that, because of her position as a trustworthy medical practitioner, she was keen for the patient to explain how she experienced her condition before Sarah made any decisions. She considered this an important part of the treatment process. However, from the patient's perspective, Sarah was simply reluctant to fulfill her duties as a doctor and take control of the situation, whereas Sarah felt she was doing her duty by acting the way she did. From Sarah's perspective, she accepted responsibility for the situation by initiating a dialogue with the patient; however, because of her different expectations of how a doctor should act in an outpatient consultation, the patient did not perceive it in this way. She therefore positioned Sarah as someone who failed to fulfill her obligations.

In summary, the outpatient clinic is characterized by complicated social dynamics in which expectations are crucial to the outcome of the patient–doctor relationship. Applying the concepts of positions, acts, and storylines can render these dynamics less opaque and help us understand the events of these social episodes and identify their associated problems and dilemmas.

Discussion

These case studies illustrate how positioning theory can be used to analyze social episodes in the clinical setting, and demonstrate that positioning theory offers a productive framework for revealing the intricate social dynamics of the oncology clinic and treating the outpatient consultation as a social episode. To analyze our findings, we revisit the three cases as follows: In Case 1, we reconceptualize the clinical social encounter in terms of positioning theory. Instead of viewing the resident as someone acquiring a set of static norms and expectations, we conceptualize encounters with his or her coworkers as relational shifts in authority that varied from one situation to the next. This reconceptualization is confirmed in Case 2, which demonstrates how a young doctor's position of authority shifted between situations depending on the identities of the participants in the given social episode. John's position shifted from that of a full medical authority to that of a learner. In Case 3, the resident's perception of the patient's expectations of the doctor's assumed authority in the consultation room illustrates the dilemmas that can arise from such misunderstandings and which supervision might place under greater scrutiny.

Positioning theory can generally be used as an approach to supervision at the oncology clinic because it focuses on the way moral rights and duties are played out

when participants describe how their mutual acts help position each other. Future research might show whether the fluid notion of position can overcome the problems associated with what is arguably the static, morally insensitive, and context-independent notion of the physician's role, as depicted in the widely used seven roles of the physician presented in the CanMEDS physician competency framework (Frank, 2005). We suggest that, in analyzing both the clinical oncology situation and physician or resident supervision, greater attention should be paid to how residents, nurses, supervisors, and patients all contribute to the conversation about what counts as meaningful acts, positions, and storylines. With these cases, we hope to have provided illustrative examples of how the events surrounding oncology clinical care and supervision can be given meaning as positioning acts.

Two Types of Conflicts: Aggression and Misinterpretation

We used positioning theory to understand the rapidly changing social dynamics in the three sample cases in this study because they revealed different aspects of positioning, specifically of successful (Case 1) and less-successful (Case 3) patient–doctor relationships and supervisor–supervisee relationships (Case 2). We now move from the analysis of specific cases to more general considerations of what conflicts are, according to positioning theory, and how this approach might contribute to resolving them.

From a positioning theory perspective, a conflict can take two forms and might be summarized as (a) an aggression conflict or (b) a misinterpretation conflict. In the former, antagonists might perform or live out a storyline; however, by adopting such a contrary position, they might use that storyline to express and nourish a conflict (Harré & Slocum, 2003). This is the case if participants' storylines are symmetrical and uphold a mutual theme of conflict or aggression (this type of storyline was analyzed by Harré [2000] in a discussion of the American government and the Taliban). This type of conflict should (it is hoped) not occur in the doctor–patient relationship because such a relationship is not one of aggression. In the latter case, the antagonists might adopt incommensurable yet parallel storylines, but if there is no intertextual weaving together of patients', residents', and/or supervisors' narratives, no discursive bridge exists between them (Harré, 2000). This type of conflict is more likely to be found in the clinical world because the resident–patient relationship is intended as a storyline about the illness, not about winning each other over. Nevertheless, the clinical situation can become a source of conflict when participants' storylines do not match, as in Case 3.

In our analysis, we aim to highlight the discursive aspects that contribute to and uphold conflict. When Sarah acted according to the “good doctor who listens to her patients” storyline and the patient interpreted Sarah’s acts within the “unprepared doctor who does not take her patients seriously” storyline, it created conflict and mutual frustration. Transforming these storylines and positions could provide a viable resolution to this type of conflict because it is a misinterpretation conflict and not an aggression conflict.

If the transformation of storylines were possible and durable, the speech acts themselves would be transformed into entirely different acts with different meanings for the participants; however, transformation is no easy task. There is no simple recipe for conflict resolution, so any attempt to describe a solution here would be misplaced. However, we are convinced that the first step toward resolving a conflict is to understand it. Before we can resolve a misunderstanding like that in Case 3, we must dissect it and see what it comprises.

The first step toward solving such a conflict is to diagnose the roots of conflict in a social domain. The framework of positioning theory is a powerful analytical tool that relies on identifying storylines, which comprises the second analytic step (described below). In a social episode of patient consultation, this means that normative understandings exist between the doctor and patient regarding who has the right to lead the consultation, who has the obligation to introduce certain topics, and who has the duty to answer which questions. Misunderstandings and frustrations (such as those in Case 3) develop directly out of misinterpretations of who possesses which rights and duties and what these obligations comprise; in other words, how positions are distributed. Using these discursive tools to analyze this type of social episode helps to elucidate how doctors and patients locate themselves in outpatient conversations as participants who jointly produce and are subjected to storylines.

On Storyline as Analytical Concept

The second step toward resolving conflict is to identify storylines, since it is within storylines that acts make sense and positions are established. However, in trying to identify the storyline, we encounter the problem of how to delineate the storyline. Who—the resident, patient, nurse, or researcher—gets to choose which episode is worth interpreting, which episode is worth recalling, and to whom it should be recalled? We defined a storyline as that which is expected in a social episode, formulated in a narrative. This definition says little about the level at which the storylines must be identified and how different levels of storylines relate to each other. Each micro storyline, such as those we have identified in our cases, is

descriptive of a very specific part of a specific social episode. These micro storylines only make sense within a larger cultural–historical storyline. For example, the concepts identified as constituting the storylines in the three cases in our study only make sense in cultures in which “patient consultations” and “doctor–patient relationships” are similar concepts.

The cultural–historical context or bias of storylines could also be an issue for doctors dealing with minority groups with different ethnic backgrounds (Ferguson & Candib, 2002; Perloff, Bonder, Ray, Ray, & Siminoff, 2006). An important aspect of positioning theory argues that concepts are actually rooted in the specific contexts in which they occur, and that the concepts used to identify storylines must be taken from these contexts and the local cultures in which they take place. The concept of storyline, from which an analysis according to positioning theory frequently begins, is occasionally vague and must be received as such. In our view, the interpretive nature of storylines does not disqualify positioning theory as an analytical point of departure. Instead, we believe that storylines reveal meaning in the process of understanding a given situation or conflict.

Perspectives on Validating and Positioning

We have presented a case for the productive aspects of positioning theory; however, no theoretical framework can offer all the answers, and all applications of theory have their limitations. Our approach to applying positioning theory has been in alignment with positioning theory as described by Harré et al. (2009), Harré and Van Langenhove (1999), and Harré and Moghaddam (2003); it has been further informed by specific applications of the framework in the fields of other similar areas of health care research (Allen & Wiles, 2013; Bishop & Yardley, 2004; Genius, 2013). However, certain limitations and problems are also associated with this approach.

The first such problem is the choice of empirical method. It could be argued that analyzing interview data according to positioning theory is problematic because interview data can risk situating its participants as abstract or decontextualized from the milieu in which their daily routines are carried out, and from the stakes and interests they typically possess. Interviews can encourage the informants to reflect too strongly on their setting rather than existing as actors within a setting. This could create a situation far from the actual day-to-day positioning space, resulting in data that misrepresents the traditional, everyday outpatient consultation. However, even if we accept this concern, the interview data still represent a discourse and, if we approach the data analysis in an appropriate way, we are still able to make a series of valid points. Let us expand further on this.

First, although interviews are not naturalistic materials, they still represent local discourses. In narratives of positioning, the obligations and expectations understood by the residents still reveal storylines from specific contexts; for example, the storylines displayed in the discursive contexts of the outpatient clinical settings in the cases of John (Case 2) and Sarah (Case 3). Although the residents' obligations and expectations were reflexively brought out in the interviews, the question of how the residents experienced these obligations and expectations remains, such as John's duty to speak in certain ways to his patient and Sarah's duty to allow her patient to explain her experiences as a starting point for the outpatient consultation. The ways in which the participants believed that they were acting in moral ways and, thus, establishing their positions, was still brought out in the interview materials.

Second, the interviews were conducted in the context of the hospital and as part of the residents' workdays, so they were not physically removed from their professional contexts. Third, the interviews were strongly supplemented by the naturalistic materials of observation. These observational data were also used in the interviews to validate the content of the observations; for instance, when the interviewer asked, "What I saw earlier today, I understood in this way; does that make sense to you?" In this way, the interview still expressed the discourse of the doctor's clinical social encounter.

To supplement our analysis of the interview data, it would have been relevant to determine the extent to which the participants negotiated symmetrical positions. For example, in Case 3 it would have been interesting to observe and discuss how symmetrical positioning between Sarah and her patient would have looked from the patient's point of view. As Harré et al. (2009) claimed, "In a perfect case there would be symmetry between the stories told by the protagonists of each side, as they define and allocate positions for their rivals" (p. 9). The patients could symmetrically support the residents' positioning, or they could present an entirely different perspective on each participant's obligations in the social episode of the outpatient consultation. Although interesting, the question of the patients' and doctors' potentially symmetrical storylines unfortunately lies outside the scope of this inquiry.

In this article, we have applied the concepts of positioning theory to the realm of the outpatient consultation. The clinical consultation is a clearly delineated social episode, and positioning theory is a powerful tool for the analysis of doctor-patient relationships in these specific social episodes. We put forward this argument by describing its theoretical basis and presenting three case examples from an oncology practice. The cases presented in

this article were selected to provide illustrative examples of the way residents position themselves and are positioned in the clinical setting. It is evident from these cases that residents actively position themselves and others over the course of their clinical encounters and that their positions can change dramatically according to the situation and the participants present. We hope that this argument and these examples serve to demonstrate the utility of positioning theory as a beneficial framework for conceptualizing the intricate social dynamics of patient consultations in oncology.

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Author Biographies

Lars H. Williams, BS, is a research assistant at the Centre for Medical Education, Aarhus University, Aarhus, Denmark.

Mette K. Christensen, PhD, is an associate professor at the Centre for Medical Education, Aarhus University, Aarhus, Denmark.

Carsten Rytter, MD, is a consultant medical oncologist and senior lecturer in medical oncology at the Department of Oncology, Aarhus University Hospital, Aarhus, Denmark.

Peter Musaeus, PhD, is an associate professor at the Centre for Medical Education, Aarhus University, Aarhus, Denmark.