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# **Working title**: Between *knowing* and *doing* person-centredness: a qualitative examination of health professionals’ perceptions of roles in self-management support

## Abstract (250/248)

Self-management has become an imperative for people living with chronic conditions. The notion of self-management requires patients and professionals to work in new ways – patients as active participants, and professionals as partners, sharing control and responsibility with patients. Utilising Bourdieu’s concepts of doxa, capital and field, we analyse roles in self-management support encounters. A total of 32 indepth interviews were conducted with 11 health professionals in Sydney, Australia. Our findings revealed an incongruence between how participants characterised and enacted their roles. While aspects of patient involvement were valued, a hierarchy of knowledge and power within self-management support, privileged health professional work over socially oriented support, influenced the legitimiacy of patients’ goals, and who was eligible for a more person-centred rather than directive approach. The discursive space around ‘the good patient’ within a medically and professionalised dominant field showed how only some subjectivities were considered legitimate, and in turn contributed to reproduction of a medicalised and neoliberal doxa, conceptualised as SM doxa. We conclude the ‘taken for granted’ assumptions of self-management need to be challenged further to avoid the negative social representations and unreleastic expectations placed on those with less capital, and which sees them marginalised within clinical interactions. Arguably though, if real change is to occur for the roles of patients and professionals, disruption is needed of the unquestionable orthodoxy that operates across the entiriety of the healthcare field – in the practices and perceptions of patients and professionals, to the practices and perceptions of institutions, the government and social groups.

## Introduction (1500 / 1328)

Self-management support is a key component of chronic condition management in many contemporary healthcare systems. This is the support that health professionals provide to people with chronic conditions to help them to develop their knowledge, skills, and confidence to manage their conditions in the context of their everyday life (Jordan et al., 2008; Lawn & Schoo, 2010). The importance of health professionals working collaboratively or in partnership with their patients is emphasised in chronic care guidelines (e.g., Australian Health Ministers' Advisory CouncilCouncil, 2017); and reflects a broader shift in the healthcare policy agenda away from the traditional ‘top-down medical model’ – where patients are often positioned as passive recipients of care from health professionals. The notion of partnerships between patients and professionals suggests that ideally, power, authority and involvement should facilitate the inclusion of what is important or value to the individual in helping them to live with their chronic condition; even when this differs from what health professionals perceive to be relevant for effective self-management. This person-centred and inclusive approach to supporting self-management, reflects the multidimensionality of health and illness; the democratisation of information and knowledge; and changing expectations regarding roles and responsibilities of patients and professionals and the relevance of connecting to capabilities and things that are of value to people in their everyday lives (Dubbin et al., 2013; Entwistle et al., 2018; Ravn et al., 2016). Yet, it also comes with new challenges for health professionals working in chronic care, and their patients, not the least of which is that they are often working within healthcare systems set up for acute, rather than chronic healthcare and are socialised into clinical ways of thinking and operate with differing logics which prioritise the importance of compliance with expert‐based knowledge and traditioanl individual lifestyle choices (Bossy et al 2019).

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Health professionals, traditionally tasked with diagnosing and treating illness, are now expected to seek and consider patients’ preferences and experiences, and provide opportunities for patients to participate in their own care (Epstein & Street, 2011; Rogers et al., 2005). Health professionals have been urged to also engage with patients’ lived experience of illness which is shaped by interrelated social aspects (e.g., norms, customs, physical environments, and resources) alongside clinical care based on evidence-based practice (Elissen et al., 2013; van Hooft et al., 2015). The patient’s role has also changed. Patients are expected to be ‘active’ participants in their own healthcare, engaging in shared decision-making, goal setting, and action planning. While there is evidence that patients do want to be included more in decisions related to their care, patients are not a monolithic group, nor are all chronic care encounters (Chang et al., 2016; Coulter et al., 2015; Dubbin et al., 2013; Scambler et al., 2014). Levels of ‘activity’ or participation in this shared agenda also vary according to perceptions of social status and social class (Portheroe et al 2012) Daker White et al (2014). Patients have varying and shifting preferences, wishes and capacities to play a more active role in their healthcare, shaped by their biographies, access to resources and individual characteristics. There is also little evidence that health professionals are able to move into these ‘new’ roles and away from ‘traditional’ roles and identities, and the appropriateness of the new role to all chronic care encounters (Franklin et al., 2017; Mudge et al., 2015; Nimmon & Stenfors-Hayes, 2016).

Self-management support remains a contested arena. Some argue that the values of neoliberalism (e.g., responsibilisation; choice; autonomy) and traditional health-professional values (e.g., clinical models, professional expertise and authority) form the background for a contradictory approach for patient involvement, creating a range of tensions and dilemmas for patients and professionals in realising the ideals of self-management support (Morgan et al., 2017; Newton et al., 2011; Ong et al., 2014; Scambler et al., 2014). Important insights into the ideological and professional contingencies of professionals’ discretionary actions are evident throughout the self management chronic care literature (Blakeman et al., 2010; Dubbin et al., 2013; Kennedy et al., 2014; Newton et al., 2011). This body of work indicates professionals’ capacity to fulfil the partnership role is often constrained by an array of interwoven factors including systems based on fee for service, episodic care, limited consultation times and rewards for treating sickness rather than health (Blakeman et al., 2010; Kennedy et al., 2013; Macdonald et al., 2008). These factors reportedly contribute to tensions “between the subjective, undifferentiated experience of the patient and the need of the doctor to objectify, code and structure this information” (Blakeman et al., 2010; Lawn & Schoo, 2010; Taylor, 2009). While this paradox is fairly well established in the literature, little is known about how professionals negotiate and prioritise between such competing frameworks in practice, and the resulting effects on patients in self-management support.

In this article we engage with the paradox outlined above, by employing a Bourdieusian perspective to examine how principles of person-centredness are enacted (or not) in self-management support. A Bourdeusian perspective can facilitate deeper consideration of the factors impacting person-centredness, adding nuance to current understandings of patient involvement. We examine how deeply embedded assumptions about professional identities, ‘good care’ and ‘patienthood’ can contribute to disparities in self-management support (Gengler & Jarrell, 2015; Ong et al., 2014; Sointu, 2017).

**Applying a Bourdieusian perspective to self-management support**

Society consists of many fields (e.g., medicine, healthcare, education and the state), each subject to a unique set of rules or unquestioned truths that constitute that field. The taken for granted values, beliefs, ideas and representations informing the field – are referred to by Bourdieu as ‘doxa’. Conceptualising self-management support as a field in the Bourdieusian sense (bounded spaces, sites of struggles), we argue medicalisation and neoliberalism have combined to establish a self-management doxa – a set of unquestioned rules for self-management – driving expectations of individual responsibility and adherence to a clinically orientated regimen of self-management. Self-management doxa operates across the healthcare field in its entirety – from the practices and perceptions of health professionals, to those of healthcare institutions and government and at times third sector organisations.(Bossy et al 2016)

From a Bourdiusian perspective, individuals ability to meet the taken for granted rules of the field, is linked to one’s capacity to accrue and moblise capital. The concept of capital elicits notions of relative advantage and power, as not all can access and utilise capital to equal extents ([Bourdieu, 1990](https://www.sciencedirect.com/science/article/pii/S0277953614001993?via%3Dihub#bib7)). In the context of self-management support, patient capital can be conceptualised as cultural resources (e.g., instrumental and proactive attitude to health, medical knowledge, flexible interactional style, educational qualifications); social resources (social networks which can be mobilised for support); and economic resources (generated wealth that can be mobilised to enact lifestyle changes – to purchase healthy foods, gym memberships). If patients do not possess the desired forms of capital legitimised by the field marginalization may occur (Shim, 2010; Sointu et al., 2017). This idea is expressed through Shim’s (2010) theoretical work on cultural health capital. Cultural health capital refers to “a set of socially transmitted and differentially distributed skills and resources” critical to effective healthcare interactions (Shim 2010:p1). When people acquire values and qualities expected and valued by health professionals (e.g., knowledge of medications and health conditions, ability to communicate that knowledge efficiently, and cues of favourable social and economic status), and leverage these in interactions with professionals, aspects of person-centred care are more likely. Shim argues the exchange of cultural health capital in clinical interactions contributes to the reproduction and exacerbation of structural inequalities over time (Shim, 2010). Others testing this idea empirally in the healthcare context report people from lower socio-economic or other marginalised groups (e.g., IV drug users) are less able to successfully navigate medical encounters in the contemporary context, as they are less able to accumulate and mobilise cultural health capital (see Chang et al., 2016; Dubbin et al., 2013). Further, people with stigmatised chronic conditions (e.g., obesity, HIV), especially those who are more socially disadvantaged, are subjected to negative evaluations, and receive less time and information from health professionals (Fix et al., 2018; Phelan et al., 2015). These studies also point to how issues of personal responsibility and moral behaviourism are sustained by principles of health professional judgement.

While some of the mechanisms contributing to the reproduction of healthcare inequalities have been examined, there is yet to be a detailed examination of how the actions of health professionals contribute to (dis)advantage through the dynamics at play in self-management support interactions. To understand these dynamics in this context, we utilise concepts of Bourdieu – particularly the notions of doxa, capital and field, to examine the roles of health professionals in action.

**Method (600 / 548)**

We designed an interpretive qualitative approach study to examine health professionals’ perceptions of self-management support and grounded this in actual interactions using matched patient-professional dyads. This forms part of a larger study examining how patient-professional interactions shape self-management goals for people living with chronic conditions which focused on self-management support using matched dyads of patients and professionals. Ethics approval was granted by a local health district human research ethics committee, university human research ethics committee, and participating healthcare sites.

Purposive sampling was used to include patient-professional dyads with diverse experiences in relation to self-management support. This included professionals from different disciplinary backgrounds, working across different settings (public/private, hospital/clinic) and a patient with one or more of three different conditions – obesity, type 2 diabetes and/or chronic obstructive pulmonary disease (COPD), who was attending a routine healthcare encounter for chronic condition management. These conditions were chosen due to their chronicity, ongoing interactions with health professionals and focus in healthcare on lifestyle risk factors.

Health professionals were recruited initially through email invitation to ensure access to patient-professional dyads. Patients were recruited through health professionals who agreed to participate. Those who expressed interest in participating in the study were provided with a participant information sheet outlining the purpose of the study and what participation involved and provided an opportunity to ask questions. After written consent was obtained by both professionals and patients, 17 patient-professional dyads (comprising 15 patients and 11 health professionals) were observed during their usual chronic care consultation and interviewed separately after the consultation, between December 2015 and April 2017 in NSW, Australia. Where possible, patients and health professionals were interviewed on another two occasions during a 12-month period. (Observational and patient data are reported elsewhere).

In order to focus on health professionals’ perceptions of their roles in self-management support, this paper reports on the data collected from 32 indepth interviews with 11 health professionals from the patient-professional dyads. An interview guide was used with questions about organisational context, professional background and experience, roles and responsibilities in the consultation observed, the therapeutic relationship, goals for self-management and self-management support in general. Interviews were audio-recorded, were 20 to 90 minutes in length, and conducted at a time and location convenient to each participant. Interviews were transcribed verbatim, with pseudonyms used to preserve anonymity.

Thematic analysis was used to explore patterns and differences in how professionals perceived and enacted their roles in self-management support. First, the transcripts were read and reread, and words and phrases coded into descriptive categories related to ‘roles of patients and professionals’, ‘individual-level factors’ and ‘system-level factors’. These categories were examined, and emergent patterns coded and grouped to explain the perceptions and enactment of roles. Second, employing a Bourdieusian lens and Shim’s (2010) concept of cultural health capital we examined how roles emerged as practices shaped by social positionings using the concept of cultural health capital. This process of analysis enabled the interactional elements of how roles are enacted to be examined as dynamic and socially situated. In the sections below, we draw upon our empirical material to demonstrate how self-management support is structured around struggles over the capitals that are at stake in the field (i.e., provision of ‘good’ care; ‘effective’ self-management; cultural health capital), the rules of the game, and practices emerging within the field.

## Findings (3500 / 3719)

Our findings showed an incongruence between how participants characterised and enacted their roles. We present two distinct yet interrelated themes demonstrating participants articulated a person-centred philosophy to self-management support, yet maintained an authoritative position in interactions with patients – with some patients more so than others. In the first theme, we examine the incongruence between how participants constructed their roles as person-centred, yet enacted traditional roles in which professional knowledge; clinical practice, routines and habits; and objectivity and measurability and normative ideas and values about health and self-management were privileged, over patient subjectivities (knowledge, values and preferences). This is supported with two sub-themes – ‘the role of therapeutic relationships’; and ‘the compartmentalisation of the ‘medical’ and ‘social’’. In the second theme, we examine the differential provision of care and support using the notions of ‘patienthood’ and cultural health capital. Here we reveal that alignment between patients and professionals on the taken for granted understandings of the self-management field (e.g., normative values of health, medical knowledge, and individual responsibility) increased participants’ tolerance for negative emotions, and care and support not available to all patients.

### **Incongruence between the construction and enactment of roles**

Participants described themselves as having a person-centred approach to self-management support. They described being responsive to patients’ literacy levels, showing empathy, being non-judgemental, building trust and rapport, facilitating informed decision-making, providing patients with options, and treating patients as persons. Health professionals described themselves as ‘supporters’, ‘coaches’, ‘advocates’, and ‘coordinators’ (rather than clinicians or doctors) to narrow patient-professional asymmetries, and distance themselves from what they perceived as more traditional roles as the ‘expert’ in how to manage a long-term condition.

Participants viewed patients’ involvement as important for patients to be able to manage their condition in their daily lives, and to establish meaningful goals – referred to as a way to get “better buy-in for the patient” and to save time and effort – as Simon stated: “that if it’s not something they want to do then we’re probably wasting our time, you know”. Participants reflected on the importance of patient autonomy in activities such as goal-setting, as Lesley and Emily illustrate:

And that’s why it’s up to them to make the goal, not me, because it’s not my life, it’s their lives (Lesley)

I don’t like to tell patients what they have to do because we know that doesn’t work so well. With the chronic illness of obesity, it’s a lifestyle issue, so you’re asking them to completely change what’s been comfortable for them their whole entire life. And that’s why it’s up to them to make the goal (Emily)

However, when discussions turned to the dyad and their interactions with a particular patient, participants narratives revealed that in practice they tended to position themselves as ‘experts’, privileged professional knowledge over patients’ knowledge, focused on managing the ‘condition’ rather than supporting the ‘person’, and enacted a more directive style of interaction. Professional expertise and authority were maintained by focusing on what they could *do to* or *for* patients (e.g., ‘teach’, ‘educate’ ‘coach’ ‘give hope’ ‘give goals’ ‘validate’, motivate) to achieve compliance (e.g., for behavioural change; medication adherence), and minimise risk (e.g., “so they can get on top of things sooner”) as illustrated in following quotes:

I think my primary role is to educate him so that he can continue losing weight or at least keep that 30 kilos off. (Emily)

Our role often is, a lot of it is like motivation. But at the same time, sometimes you think well actually my role is, “I know about diet and what foods are going to help you. (Kate)

I guess in the role we want to teach a lot of self-management, like exacerbation, infections and things so, they can get on top of things sooner. … I educate them about what they can be looking out for to avoid [hospital admissions], and then try and educate them as well about the importance of exercise and activity. (Simon)

Engaging with patients was challenging, especially when patients’ goals did not align with what health professionals considered was in patients’ best interests. Participants reported reverting to directive practices, in the guise of ‘medical nagging’, ‘guiding’, ‘nudging’, ‘telling’ and ‘forcing’ patients toward medically oriented goals and changing lifestyle behaviours. Patient involment was therefore predicated on the ‘right kind of involvement’ (e.g., the values of professionals) – as highlighted by Lesley:

And, in a way – I mean, it’s very important to set goals with a patient, but if we do 100% that way, patients probably wouldn’t do very much exercise at all. They have to be guided a little bit (Lesley)

Some participants expressed taking disciplinary measures, such as holding patients to account and scolding them when patients’ actions were not aligned with what professionals valued:

I've just seen somebody today who really hasn't got the message right and I did something I shouldn't do, but sometimes it's necessary. I kind of roused [scolded] him and said, "Why are you doing this? We've been through this before.”

These exemplars highlight how the boundaries were blurred between a patients’ pecieved right to self-manage autonomously and the imperatives of the healthcare system and professional socialisation. The blurring of these boundaries was further evident through participants’ references to evidence-based policy and practice guidelines, and institutional requirements for objectivity and measurability. Participants emphasised ‘treating’, and ‘educating’ patients on their ‘condition’ and ‘lifestyle’, as per clinical guidelines and ‘tried and tested’ evidence. They focussed on achieving predetermined medical outcomes. The normative use of guidelines and evidence is reflected in the comments by Simon and Dr White:

Just by then relating what the evidence says, that it says if you can complete the program and come twice a week for eight weeks then you would be able to stay out of hospital. (Simon)

That’s sort of the guidelines in terms of management of diabetes to ensure that they stay at target, they're all hypoglycaemics, and so that’s what basically I was doing with James… I put out what I think would be a good - you know, the goals and the target that he should try and meet. (Dr White)

The presence and interplay of the symbolic power of institutions and the goals of professonals in complying with governance monitoring and arrangements was also evident in Emily’s comment regarding overruling the patients’ preference not to be weighed:

Every consult.  Patients will say, “I don’t want to do this.”  And then you’ve just got to reassure them, “This is just a number and if it’s up all it shows me is that you’re struggling at the moment.”  Some people are like, “I don’t want to know it.”  It’s like, “Fine, you don’t have to know it but it has to happen, it’s part of coming here.”  […] … we need to see whether you’re in a state of weight loss.

When participants talked about tailoring information to the needs of their patient, this tended to relate to *how*, rather than *what*, information was delivered (e.g., avoiding medical jargon). Information exchange was used to challenge patients’ perceived illogical beliefs and to bring patients toward the clinicians way of seeing things. As Dr Ealges stated:“he’s entitled to his opinion, but I’m allowed to have a different opinion and challenge his opinions from my perspective which is kind of like the, the scientific perspective you might say”. Across participants there was a view that the underlying message (e.g., to change behaviour, reduce risk) needed to be given to all patients, as Jenny illustrates:

How you present that it’s tried and true might be slightly different. But the baseline information will be the same.

Economic rationalities also shaped the roles and identities of participants. Tensions were present for participants in maintaining identities of both the competent and caring professional. This tension is present for Lesley as she discussed meeting dual demands of institutional economies and caring for patients:

…because one of our big goals, really, is to keep people out of hospital because of the cost, the managers like money, so that’s really important to them, so it’s important that I can show that I keep people out of hospital even though, to me, it’s much more important that the patient feels better and is able to do more.

*The role of therapeutic relationships*

Participants considered therapeutic relationships as important to the enactment of their roles and for the achievement of clinical outcomes. However, at times participants experienced tensions in achieving both ‘good’ relationships and ‘good’ clinical outcomes. Some managed this tension by beginning consultations or goal-setting with a collaborative approach before then taking control of the agenda. Here, Emily articulates how developing a secure relationship enabled her to maintain her authority and control over the agenda:

You hopefully make that person feel secure about what the discussion point was and then shift it back to what you think is going to be the most helpful part of the discussion, which I still think the fruit was what we needed to focus on.

Participants tried to resolve frustrations emerging in the therapeutic relationship, by oscillating between closing (e.g., fostering a friendship) and creating distance (e.g., othering - “with people like these”) between themselves and patients:

And it’s like George, oh, for god’s sake, I can’t tell you how many times we’ve talked about the fact that he can’t keep eating what he’s eating and expect miracles to occur. But the thing is that you need to maintain a friendship with these people; not a friendship, but a - a - a therapeutic relationship with these people (Jenny)

A sense of familiarity aided the development and maintenance of therapeutic relationships. As Dr White stated: “Look, I think on a personal level, we've got a good rapport, because he's a country person and I'm a [country person] so we kind of get each other”. Length of time also helped to establish a therapeutic relationship: “It takes a while to sort of get to know someone and trust them. Like when you see someone like him for years, it is a kind of an element of friendship, but it is a professional relationship as well. (Dr Jones). However, a passing of time did not guarantee therapeutic relationships. Compliance, a proactive attitude toward health and accumulating knowledge, and trust in the medical expert were all important to establishing therapeutic relationships.

*Roles of health professionals compartmentalised the ‘medical’ and ‘social’*

The role of health professionals tended to be divided into two separate and distinct areas of self-management support – medical (e.g., condition management and lifestyle behaviours – dietary behaviours and physical activity); and non-medical work (e.g., social, cultural and emotional). Although health professionals acknowledged that supporting people to self-manage their condition involved focusing on a broader set of patient concerns encounters (e.g., social isolation, loss of identity, respecting cultural values) and wider skills for professionals than those traditionally considered in clinical settings, this did not fit neatly within the logics of healthcare encounters.

Participants tended to artificially compartmentalise clinical tasks which aligned with their discipline or expertise, and other work (e.g., addressing the social needs of patients) was perceived as fitting better with other professionals (e.g., psychologists) or patients themselves. This categorisiation highlighted the value participants attached to certain activities and codes of practice. For instance, medical work (e.g., testing glucose levels, medication management, improving condition related knowledge ) was described as both the ‘real’ and ‘easier’ work, as Dr Li stated: “if you talk to most experienced long-term GPs they'll tell you …the social part is the really difficult part”. ‘Non-medical’ work was mostly reported as being outside of health professionals’ professional scope, as it was not what they had been trained to do. Working outside one’s scope or ‘comfort zone’ threatened one’s sense of authority, and previously held assumptions around identity and what constitutes ‘good care’.

There was some reluctance to discuss patients' social situations (distinct from lifestyle behaviours – diet, physical activity) due to fear of opening a “pandora’s box” of social problems within patients’ private worlds; losing control of the interaction; or being ill-equipped to address these issues. Addressing the social and emotional aspects of managing a long-term condition were not embedded as habitualised practices in the same way that condition management was, as Kate and Dr White illustrate:

I think generally the social things – I don’t normally ask. I never would - I never ask, about how like if anything changed in your living situation or anything like that (Kate)

you know, when we talk about the diseases and what it does functionally, but you know, what it actually does emotionally, you - you don't even really get to touch on that, really. And that's sort of an - an important part of it too. (Dr White)

Roles enacted by health professionals were also shaped by their own emotional responses (e.g., frustrations, helplessness, enjoyment, delight) entwined with evaluative judgements regarding ‘patienthood’ (e.g., expressed through classifications of patients as good/bad; passive/active; responsible/irresponsible, logical/illogical). In the next section, we examine how emotions and judgements served both moral and reasoning functions for how professionals enacted their roles.

**Roles of professionals entwined with emotions and judgements of patienthood**

Participants emotions entwined with judgements of patients (based on cultural health capital), shaping participants’ tolerance for non-adherance and investment in person-centredness. The moral overlays implicit in the value laden language used by participants to classify patients’ as compliant or non-compliant, and choices and behaviours (as evident in the theme above) as either *good* or *bad* did not fully account for the structural distribution of resources and capacities associated with choices and opportunities for adherence. This had negative implications for some patients in terms of their involvement, access to support, and attributions of responsibility and blame. Taking a position of authority, participants were able to determine and enforce norms, such as the degree of tolerance for when patients did not change ‘lifestyle’ behaviours, as discussed below.

All professionals reported working in a constrained system (e.g., with limited consultation times, quality outcome frameworks, limitations on referral networks, fee for service; fragmentation between health and social services; waitlists; medical training). However, examples were also provided of working within, outside, or against these constraints, when patients were considered deserving of such actions. Examples of working around resource constraints included waiving eligibility criteria for subsidised care, above the universal provision of government subsidies; waiving eligibility criteria for participation in group programs; providing more regular visits than stated in the guidelines; extending consultation times beyond the standard times; and organising overnight stays in hospital for day surgery. However, participants’ willingness to negotiate the constraints of system was contingent on patients meeting the expectations of professionals.

Being a ‘good’ patient was inherently linked with meeting the expectations of the self-management field. Patienthood was linked to a ‘duty’ to adhere to treatment recommendations and lifestyle advice. In particular, when patients met professionals’ expectations (e.g., displayed cultural health capital – such as medical knowledge, proactive and instrumental attitude to health, efficient communication of relevant information) negative emotions were buffered, and patients were afforded the status of the good and responsible patient:

“So I’m expecting him to be [compliant] – and he is, that’s the good thing about Julian. It’s his role in taking some sort of role in his health. I expect him to be willing to set goals for himself in various areas, whether it’s exercise or whatever. And that was one of the heartening things about the last consultation is that he had enrolled and attended an exercise program. And [our relationship] is supportive, professional. I respect him. I think he’s got a lot of strengths” (Dr Eagles).

 Patients strengths, such as those Dr Eagles referred to Julian as having, included insightfulness, articulate, efficient communicators of ‘relevant’ information, perceptive of bodily functions, accurate knowledge of symptoms, flexible problem solving, and mostly compliant. Good patients were perceived as engaged and involved in their care in the ‘right’ way - open and keen to find out information about their condition, and not only asked questions, but asked the ‘right’ questions; and were organised (e.g., taking notes, bringing lists; remembering dosage and names of medications). Good patients were also perceived as rational (e.g., not too emotional, and not holding irrational beliefs), and described as confident, determined and motivated (e.g., a “go-getter type person”). They were seen to possess medical knowledge and capabilities (e.g., adjusted insulin appropriately), as good consumers of healthcare resources (e.g., did not miss appointments); and not over reliant on medical intervention, taking steps to change their lifestyles in addition to using drug and surgical treatments. Stressing the expectation of individual responsibility Dr Li stated: “It's not just me giving you blood pressure tablets. You've got to exercise. You've got to eat well” and “your lifestyle cannot be, absolutely cannot be, what it was before”.

 ‘Good’ patients engendered positive feelings for participants, creating a sense of ease to interactions, which motivated professionals to invest in the patient. As Simon illustrates: “yeah, it's really easy - it's easier to enjoy or easier to keep going. If you find they're engaging you want to come and give them more”.

 Emotional responses such enjoyment and frustration were commonly expressed by participants in relation to interactions with patients. It was not that these emotions in and of themselves were positive or negative, rather in what actions were generated from such emotions. Frustrations mostly stemmed from patients not following treatment recommendations, but also stemmed from interactional difficulties, primarily attributed to patient rather than professional deficits (e.g., lacking medical knowledge,sophistication /competence- patients providing irrelevant information, not understanding information, not asking the ‘right’ questions). Legitimisation of patient capital and compliance lessened the negative affect on the interaction of difficult emotions. For instance, despite feeling frustrated with Julian for not following up on a screening procedure, Dr Eagles continued to engage in investigative work with Julian to better understand why. Although this involved time, effort and emotional work, Dr Eagles recognised (and valued) Julian’s displays of cultural health capital (e.g., understanding and using medical information; efficiency in communication, sense of responsibility, long term orientation to health), and described Julian as insightful and mostly compliant. To support Julian, Dr Eagles strategically engaged with the health system in ways which were not accessible to all patients. He provided support with tangible benefits for Julian’s future wellbeing, discussed personal grooming and relationship issues, provided weekly consultations, negotiated reduced payments with specialists, and facilitated an overnight stay in hospital – beyond what the hospital initially stated would be provided.

In a few instances, a sense of deservingness was associated with patient vulnerability rather than capital, with participants referring to some patients as needing ‘nurturing’ and ‘handholding’. This also brought support not available to all patients, through caring gestures from participants such sending get-well cards, follow up calls, and other small acts of kindness such as sharing DVDs and discussing topics of interest to patients (e.g., politics).

When patients’ behaviours and cultural health capital did not match the expectations of professionals, management of emotions was more difficult, as interactions lacked the ease and comfort expressed in relation to ‘good’ patients. The challenging nature of these interactions were expressed by participants as “It’s like getting blood from a stone” (Jenny) and “when they’re” lacking in confidence, you’ve got to work very hard with them” (Emily). Accordingly, patients perceived as ‘bad’ were treated differently from good patients. For example, in contrast, to the investment in Julian exemplified by Dr Eagles, other health professionals perceived ‘bad’ patients as less deserving of their investment and time. For instance, unlike Dr Eagle’s positive assessments of Julian, another health professional Kate, held predominantly negative impressions of her patient Rhonda, and subsequent investment in the interaction was markedly lower than Dr Eagles. Kate had consultations with Rhonda every second month for over a year, throughout which her emotional experience was mostly negative. Kate perceived Rhonda as lacking in insight, unable to provide relevant information efficiently, as non-compliant, “manipulative”, dishonest, unreliable, and a time waster; and as not valuing her professional expertise: “I don’t feel like I’m being used as a resource”. This threatened Kate’s expert identity. Kate reportedly withdrew support, did not utilise her motivational interviewing skills, or extend all available options to Rhonda. Instead, Kate exerted authority over the interaction and held Rhonda accountable for her (in)actions:

I mean, I feel like we’ve gone over the territory a few times, especially with exercise.  And, so I’m kind of less inclined to really, you know, drill down into what are you going to do when and what are the barriers.  […] I don’t know why some patients more than others you feel more personally, like you are happy to play more of a backing them, supporting them, like, constantly giving role.  And other patients you’re like, well actually, you know, “I can tell you what you need to do but you’ve got to decide to do it.”  And so that’s a bit like with her …I don’t really roll with resistance…she needs to be brought to account.

Expectations of individual responsibly and problematising adherence with the individual were common in participants’ accounts. Struggles to achieve health outcomes were mostly attributed to individuals lack of motivation and unwillingness to change lifestyles rather than structural constraints such as culture, age or class. Further, the misalignment between professionals and patient priorities, tended to be the patients’ responsibility to overcome, as illustrated in Emily’s comment:

It’s like, this stuff’s impacting you, so you can’t actually do what I need you to do so we’re sitting stagnant in regards to what we’re trying to work on because there’s so much other stuff that’s a barrier at the moment.

Also contributing to blame was the lack of time and resources for professionals and patients to explore and address the complexities of living with a chronic condition*.* Temporal aspects *(*e.g. fast pace of clinics and time crunch of consultations) were the most commonly reported constraints impacting on exploring psychosocial aspects of care and activities such as goal-setting. While some participants expressed a sense of autonomy in how they allocated their time, as Emily indicates, autonomy was limited by institutional constraints (wait lists, structured consultation times):

“I’m completely flexible, yeah. I try not to go over half an hour for follow-ups, just because of waiting list times and things […]. Some people are like, “I can’t do this unless I see you once a week.” And then unfortunately we have to put some boundaries in and go, “Well, we actually don’t have the resources”.

**Discussion 1200 / 1077**

Contrasting professionals’ general perceptions of practice with accounts grounded in acutal patient-professional interactions revealed the situational and relational nature of self-management support. Our findings revealed that self-management support is a ‘field’ in which capital is exchanged (e.g., cultural health capital) with some people better able to benefit from these exchanges than others. Our findings align with previous research showing that traditional roles, where professionals take a more authoritative rather than collaborative position, persist as do established clinical routines, oriented around condition and symptom management for keeping people out of hospital (Blakeman et al., 2010; Entwistle et al., 2018; Morgan et al., 2017). Extending previous findings, we illuminated subjectivities of clinical practice which shaped how roles were enacted.

Enacting the role of partner, requires participants to work in ways that challenge longstanding authority and assumptions around what constitutes ‘good care’, and requires professionals to negotiate matters of morality and identity. Managing changing logics of practice from care and control to sharing responsibility and control was difficult and complex for most participants in our study to realise. Participants highlighted an awareness of the changing logics – expressing value in patient involvement and autonomy in goal-setting and planning, yet enduring institutional logics (e.g., patients as passive recipients of care) and ‘doxa’ were pervasive in practice. Professional knowledge was considered ‘practical’ and ‘rational’, as distinct from lay knowledge – subjective and illogical, therefore retaining its own ‘logic’ of authority (Bourdieu, 1990). This was one way in which the power relations and hierarchy in the field were reproduced.

Different constructions of person-centredness exist throughout the literature (see Pluu (see Pluut, 2016; Rogers et al., 2005). In an analysis of discourses of patient-centeredness from scientific articles, Pluut (2016) articulated three constructions of patient-centredness, labelled as ‘caring for patients’ – with patients positioned as recipients of medical decisions and prescription; ‘empowering patients’ – underpinned by informed choice and patient autonomy; and ‘being responsive to patients’ – regarding patient preferences for participation. While elements of each of these constructions of patient-centredness were present in our study, the actions of participants closely aligned with Pluut’s ‘caring for patients’ construction of patient-centredness. Professionals’ roles tended be more traditional, than partnership based, and self-management support was oriented around what professionals’ thought was in the best interest of patients; rather than what patients may have valued for living well with their condition.

For health professionals and patients to be partners in healthcare, a reconfiguration of ‘professional work’, is needed, which unifies the medical and social aspects of self-management support (Morgan et al., 2017; Entwistle et al., 2013). Participants drew distinctions between ‘medical’ and ’socially oriented’ professional work with symbolic boundaries and threats to professional identity at play. The idea of ‘new work’ (i.e., sharing responsibility and control, engaging with social aspects of self-management) did not translate into practice. A lack of opportunities for patient involvement, was accompanied with attributions of responsibility, masking the impact of interactions and structures from being recognised. Individualising failure and non-compliance raises issues for the equitable and fair provision of healthcare (Abrams et al., 2018), and potentially subjects individuals to victim blaming.

While our findings point to patients being judged on their moral character through legitimisation (or not) of cultural health capital, Fix et al., (2018) urge researchers to “not replicate the problem, by passing judgement” onto professionals engaged in self-management support (p. 2231 ). Health professionals, as do patients, “need to be thought of as people, within their socio-cultural context – the context of the clinical world in which they work” (Fix et al., 2018, p. 2231). The socio-political context in which patients and professionals are mandated from above to change behaviour reinforces professionals’ construction of ‘good doctoring’ and ‘good patienthood’. This directs us “upstream” to consider how social and structural patterns of the field are co-constituted in patient-professional interactions.

Institutional change is needed for the values of person-centredness to be embedded in practice. Participants constructed the healthcare system as fast-paced, disorganised, fragmented and resource-scarce, and indicated limitations in training, time and resources shaped their capacity and capabilities for ‘adequately’ providing person-centred, self-management support. As other studies have reported (e.g., Franklin et al., 2017), time was the most significant barrier reported by participants. Time constraints can make it difficult for professionals to think beyond everyday and routinised work practices, generating a lack of reflexivity of practice within the system. However, without acknowledging and addressing systemic and structural factors, even if more time is allocated for self-management support, professionals may still lack the expertise or confidence to truly realise and support what matters most to patients. Improving access to referral networks may also not provide the answer, as not all patients will want referrals, or act on these referrals. Yet, knowing that support is available for professionals to support a broad range of patient needs, if they do happen to go deeper into the world of patients, might help them to feel more prepared to do so. Arguably though, to support people to live well with their chronic conditions, changes are needed not only within the healthcare system, but within fields structuring lifestyle practices and social practices of both patients and professionals (e.g., government, educational and social institutions; food and beverage industries).

**Conclusion**

Bourdieu suggested that “to change the world one has to change the ways of world-making, that is the vision of the world and the practical operations by which groups are produced and reproduced” (Bourdieu, 1989, 23). The type of inequality which occurs for patients not able to mobilise the capital valued in the field of healthcare, according to Bourdieu, is very difficult to challenge, as it is reproduced in an embodied system of values and practices. It is argued that those who are exposed to inequality in this way, gradually apply the dominant perspective, therefore the dominant perspective for the most part comes naturally even to them. We argue any change in policy and practice regarding those who are negatively affected by this reproduction (both patients and professionals) need to give due consideration to the sort of inequalies which occur in healthcare interactions. Arguably, the ‘taken for granted’ assumptions of individual responsibility which orient negative social representations and unrealistic expectations onto patients lacking capital, needs to be questioned and challenged more fully to support people to live well with their chronic conditions. For if the deeply embedded assumptions of self-management remain unchallenged, self-management support risks being of most benefit to the more powerful of actors - patients with capital and in better position to meet the expectations of self-management.

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