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Article

Reflexivity on an Empirical Study about Cancer Patients' Perception of Good Caring in Light of Goffman's Theory

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Abstract

Findings from an empirical, qualitative study conducted by the first author regarding cancer patients' perceptions of good nursing care have previously been published. In this article, the entire research process of the study is analyzed and discussed in light of the social theories of Erving Goffman (1959, 1986), arriving at some complementary interpretations of the findings. Reflections are made specifically based on his theories concerning the interactional frames and the presentation of self in everyday life. The interviewer and the informants entered the interview situation from very different standpoints, with different expectations and objectives, social roles, theoretical backgrounds, and positions within the power structure of the clinical setting. Those differences naturally influence the interaction in the interview situation, not the least of which includes the self-presentation of the patients. The complementary insight dealt with in this article provides an important background for improving nursing care in practice as well as when planning further research.

Keywords: Goffman, self-presentation, dignity, cancer nursing, empirical study, reflexivity

Findings from an empirical, qualitative study conducted by the first author regarding cancer patients' perceptions of good nursing care have previously been published. In this article, the entire research process of the study is analyzed and discussed in light of the social theories of Erving Goffman (1959, 1986), arriving at some complementary interpretations of the findings. Reflections are made specifically based on his theories concerning the interactional frames and the presentation of self in everyday life. These reflections are not done for the purpose of finding what was wrong in former interpretations, but as an effort to examine new interpretations on a different level and from a different view (Alvesson & Sköldberg, 2009). As such, the present article represents an effort to increase the value of the formal empirical study both for practitioners and educators in cancer care as well as for the research community. These reflection and new interpretations highlighted other aspects of the interview situation and the information conveyed by the patients than dealt with earlier, facilitating, amongst other things, a new discovery of the importance of the normal daily life and the importance of dignity and respect in a situation of severe illness.

The reflections are performed from the viewpoint of Goffman's theory of self-presentation in everyday life (1959), using his theatre metaphors, and detail how the frame of the situation (background, setting, and context) may influence the verbal statements observed as well as their interpretations. Goffman introduces the metaphor of a theatre in his theory to convey the different aspects of human social interaction. He applies terms such as “teams,” “backstage,” “frontstage,” “regions,” and “region behaviors,” and speaks about “the role players performances” in front of an “audience.” A backstage team and region prepare plays for an audience, and the frontstage team and region put on the full performance. A region may be defined as any place that is bound to some degree by barriers to perceptions. A team refers to any set of individuals who cooperate in staging a single routine. Front regions are where a performance is held or may be in progress, and back regions are where actions occur that are related to the performance.

The theatre metaphors employed by Goffman do not imply that he envisages social interaction as mere play in the theatre sense of it. Rather, he portrays play as a serious interaction in which much is at stake for the actors, including human dignity and trust (Goffman, 1959). In his book, *On Face-Work* (1955), Goffman uses the terms "maintaining one's face," "save one's face," and "respect other's faces" in relation to social interaction (Goffman, 1955). He also uses the term “to be out of face” about losing one's dignity.

The analysis previously employed in the empirical study was Giorgi's (1985) modified scientific approach to Husserl's philosophical phenomenology. The essential meanings of the phenomenon of care were presented as precisely as possible as the informants experienced them in their lives. The opinions and feelings expressed by the patients in the interviews must be recognized as true for them; however, by reflecting on the study under the perspective of Goffman's theory (1959, 1986), other important aspects were brought to light, alternative dimensions were revealed, and new interpretations of why the patients told the interviewer what they did were elaborated on. Besides highlighting that there can be no such thing as pure empirical facts with respect to interview data - because empirical findings result from the idiosyncratic interplay between observations (in this case through interviews) and theories—this new exercise points to aspects of the findings and the data production process that have previously had little attention paid to them.

Methodological Considerations

The reflections made in this article can be seen as reflexivity. Lately, the term reflexivity has been discussed often in qualitative methodology. Dowling (2006) states that there are similarities between reflexivity and reflection but suggests that reflexivity is more active than reflection. She also states that the term is poorly described when applied to nursing research. Narrowly, she says, it is viewed as the analytic attention to the researcher's role, but others (Hand, 2003) argue that

reflexivity should be considered at each stage of the research project. Alvesson and Sköldberg (2009) view reflexivity as a particular, specified version of reflective research, involving reflections on several levels.

Clancy (2013) concludes that reflexivity is an active process that may, at times, be difficult and probing but is crucial to becoming self-aware, and thus, able to see any influences that could affect data collection or analysis. The aim of reflexivity is often described as a way to ensure the validity of the research. However, there are different views on reflexivity and the methods used for this purpose in the literature (Alvesson & Skölberg, 2009; Clancy, 2013; Dowling, 2006; Downing, Polzer, & Levan, 2013). Alvesson & Skölberg (2009) state that the most crucial aspect of qualitative research is not how one technically handles the different elements in the work; alternatively, what determines the value of the research is the researcher's awareness of and ability to handle the dimensions of interpretations on different levels. They describe different practical approaches to reflexivity and suggest that this process also can be done on an empirical study after the findings have been published. These reflections should not be done for the purpose of finding what was wrong in former interpretations, they say, but as an effort to examine new interpretations on a different level and from a different view (Alvesson & Sköldberg, 2009). As such, the present article represents an effort to increase the value of the formal empirical study both for practitioners and educators in cancer care as well as for the research community. In the literature two principle types of reflexivity are often described, the personal and the epistemological. For the purpose of this article we define reflexivity from both perspectives. Personal reflexivity is focusing most on the researcher's relationship with the informant while epistemological reflexivity encourages the researcher to reflect upon assumptions that are made in the course of the research and the implication of such assumptions for the research and its findings. Goffman's approach provides us with a useful tool for reflexivity in both senses.

A Short Presentation of the Empirical Study

Twenty patients, 10 women and 10 men (incidentally) with cancer who were admitted to a cancer ward for treatment were interviewed. The patients had various cancer diagnoses at different stages. Sixteen of the patients had metastases, which means that the cancer had spread to different organs and they therefore were in a life-threatening situation. Most of the patients were given life-prolonging and symptom-relieving treatments but four faced a possibility for cure. None of the patients were in the terminal stage. The majority of the patients were between 40 and 70 years of age. The informants were inpatients in a cancer ward in a university hospital in Norway and all were ethnical Norwegians. The patients were informed by a physician about their cancer diagnosis. Twelve patients had been inpatients in the ward earlier, 14 were married, two divorced, two cohabiting, and two widowed. The patients had had their cancer diagnoses for 3 months to 6 years. The primary aim of the study was to achieve insight into their perceptions on how nurses in an oncology ward can help cancer patients cope with their life situations as an important element of good care.

Giorgi's (1985) approach to phenomenology was chosen as the research methodology because the aim of the study was to elucidate essential meanings of the phenomenon of care as the informants experienced it in their life world as precisely as possible. Giorgi also argues that caring is a genuinely experiential phenomenon for both the recipient and the giver and has developed a scientific step-by-step approach to phenomenology inspired by Husserl's philosophical phenomenological method.

The essential findings that emerged were that the cancer patients wanted to be given an opportunity to talk about their difficult emotions concerning the future and the illness, but wanted to decide themselves to whom, when, and about what. All of the patients identified one or two nurses who they felt cared more about them than the others, these being the nurses whom they

trusted and with whom they wanted to talk. The patients also wanted to be empowered to receive good and honest information and have the ability to discuss their treatments with their physicians. However, most of them wanted the doctor to decide in the end, but all the patients wanted to take part with the nurses in decisions regarding their daily lives. The patients also very much appreciated meeting knowledgeable and experienced nurses in the ward. Nurses such as these made the patients feel safe and secure and alleviated bodily, psychological, and existential suffering. The findings were previously published (Kvåle, 2006; Kvåle, 2007; Kvåle & Bondevik, 2008; Kvåle & Bondevik, 2010).

Reflexivity on the Study in Light of Goffman's Theory

The Frame of the Interview Situation

According to Goffman (1986), individuals who interact with one another in a situation define the situation by the setting, their backgrounds, and the context in which they find themselves; in his writings, he labels this the frame of the situation. He defines the frame as "a scheme of interpretation in which the events and activities to which we attend are organized and made sensible" (Goffman, 1986, p.10). In the empirical study, the interviewer and informants entered the interview situation with very different "schemes of interpretation." The context was the social institution of a hospital ward where, in Goffman's terms, they belonged to different teams and regions and had different roles that influenced their own individual "standards and perspectives." The informants were all seriously ill cancer patients in need of treatments and were experiencing life situations that, naturally, were very demanding. They were very much dependent on the staff, strongly in need of support and help, and highly sensitive to the staffs' attitudes towards them. In other words, the staff members were in powerful positions in many situations. The following quote from an informant in the study exemplifies this power discrepancy:

> The nurses told me that the doctors did not allow them to give me more pain medication. That was very hard. I told them that I had needed more. So at last, I got it. When the nurse told me that I could have no more, and I had to suffer, I ... (crying)

The interviewer was not a member of the ward staff but was employed in a nursing college, which can be defined as outside the ward's "region" in terms of Goffman's metaphor. She was not a member of the audience the informants were playing for every day in the hospital, but when she entered the interview situation, she took on the role of the audience in the situation. She was not a part of the patient's team but was probably defined as a member of the staff's team by the informants. According to Goffman, the individuals of an establishment are not members of a team by virtue of staff status but only by virtue of the corporation that they maintain. A specific social type Goffman describes is the person who plays the role of "confidant." Confidants are individuals to whom the performer confesses his challenges, shortcomings, and what Goffman labels "sins" (understood as "sins" against social expectations and the normal flow of life). These confidants are located outside the regions and regard the information they receive as an expression of friendship and trust. There is a possibility that some of the patients saw the interviewer as a person who played the role of a confidant since they were very open about their views. The quote above can be seen as an example of this openness and trust, especially when asking about her view on why this happened. However, we can assume that, most often, the interviewer is seen as part of the power structure in the social structure of the cancer ward. This could be because one of the staff nurses was the first to inform the participants of the study when asking them—on behalf of the interviewer—about informed consent to participate.

In Goffman's view, the frame of the situation also involves furniture, décor, physical layout, and other background items that supply the scenery, as well as what he labels the personal front, which includes the player's rank, clothing, sex, age, speech patterns, bodily gestures, and so forth, which he says can be divided into appearance and manner. In the study, the interviews most often

took place in the patients' rooms where the patients were either sitting in a chair or lying on a bed. They were either in their own clothes or in the hospital's sleeping suits; the interviewer was dressed in her everyday clothes. The patients gave permission to record the interviews. This means that the patients were in unfamiliar contexts and settings that might make them insecure and uncomfortable. The researcher, however, had been part of the clinical context and setting for many years and was familiar with both the context and setting. This might contribute to a power imbalance in favor of the researcher in the situation. However, the researcher was also in an unfamiliar and vulnerable situation when doing interviews. She was very much dependent on the patients' willingness to share their thoughts and views with her, and for that, they also had power. If the interviews had taken place in the patients' homes, the context, the setting, and their roles would be different. The informants—again, in line with Goffman—would have been in their own "territories and surroundings," and the power imbalance might be more in favor of the informants. The interviewer's role would have been that of a guest who had to depend on the willingness of the informant to let her come into their familiar home setting, a setting that they themselves knew and defined.

Even though the interviews took place in a hospital ward, the frame related to the patients' home spheres was invoked now and then by the patients in the interview situation. The patients frequently expressed concerns with matters pertaining to their ordinary daily lives, inviting the researcher into a territory in which the researcher had no particular knowledge. This "frame switching" from the hospital setting to patients' home spheres took place both in the interview situation and between patients and staff members in the ward, as revealed in the interviews.

The Informants and Researcher's Backgrounds and Objectives

The only information the informants received about the study before they entered the interview situation was a short letter about the study that was given to each patient by a staff member in which they obtained informed consent. Most of the patients agreed to take part in the study—even when assured in the letter that they were free to say no and that their decisions would have no influence on their stay in the hospital. The informants` objectives for wanting to participate in this study might have varied. The patients were informed that the main objective of the study was to improve present and future care of cancer patients based on the understanding that the information provided would influence the teaching of students in nursing and other health-related fields. Goffman (1959) claims that performers often foster the impression that they have ideal motives for acquiring the role in which they are performing. We know, from previous research, that altruism is defined as the main reason for taking part in studies, but we also know that individuals assess the potential benefits and risks to themselves (McCann, Campbell, & Entwistle, 2010; Willis, Robinson, Wood-Baker, Turner, & Walters, 2011). A potential beneficial objective for taking part in the actual study could also be to gain support for choices made—or choices to be made—as part of their own coping strategies, such as letting themselves decide when and with whom they wanted to talk about their difficult emotions as well as what they wanted to disclose. Another hidden objective might be to create their own stories by telling the researcher what their perceptions of good care were, as well as whatever else they might want to reveal to the nurses. We know that telling their life stories to someone that has time and interest in listening to them may help seriously ill persons find meaning and hope, and make order out of chaos (Frank, 2013; Synnes, 2012). The following quote is an example:

> My daughter is going to have a baby, and I have to call her at home all the time to find out how everything is going. I want to talk about this event with the nurses.

Part of her story might be that, in spite of the illness, she was still a grandmother who was worried about her expecting daughter and anxious to have a grandchild.

The researcher's background when she entered the interview situation was that of a teacher in a postgraduate course on cancer nursing. She was not a member of the staff in the ward, but she knew most of them. She had several years of experience in clinical cancer nursing beforehand as well as considerable theoretical knowledge of the phenomenon of care. The researcher's primary objective was to determine the patients' coping strategies and achieve insight into how nurses in an oncology ward can help patients cope with their life situations as an important aspect of providing good care. In accomplishing that, she also hoped to improve her own teaching methods. But, because of the researcher's theoretical background, one of her objectives was also to reflect on whether the theories of care that she employed captured the patients' perceptions of what was important for good care. She also wished to refine her methods for ensuring that the patients' voices were heard from the perspective of "those wearing the shoes know where it hurts."

After the presentation of herself and the study, the researcher first attempted to gain an understanding of the patients' perceptions of care by asking them what the word "care" meant for them, but most of them had difficulties answering the question. But, by asking whether a specific nurse in the ward gave them better care than the others did, as well as what it was she did and said that gave them these feelings, they were able to provide practical examples of what care meant for them. Sometimes, it seemed as if they were not as interested in whether what they were receiving from the nurses could be labelled as "care" as long as it was important and beneficial for their treatments and daily lives in the ward right then. According to Goffman (1986), people relate things to their own goals in life and bring different cultural elements into a situation, for example, the concept of care, frequently without openly discussing them since they tend to be part of their "taken-for-granted" cultural outlooks on life. However, the interpretive frames of the researcher and patients overlapped in some measure, but the extent of this overlap cannot be easily assessed.

The discussion so far highlights that situational frames may switch within the same social situation, in this case, in an interview situation and that possible concurrence between the interviewer and interviewees' understandings of the interview situation cannot be taken for granted. Furthermore, as will be dealt with later on, an interview situation comprises a contested space where both the interviewer and the informant continuously introduce new elements that may change the definition of the situation as possible new mutual understandings are achieved.

The Meeting Between the Informants and the Researcher

According to Goffman's perspective, when an individual enters the presence of another, he usually seeks either to acquire information about him or to bring into play information about him that they already possess. However, he maintains, complete information about the other person or group is rarely available, and the individual may look for cues and expressive gestures to use as predictive devices (Goffman, 1959). In addition, the extent to which the informants wish to reveal their innermost feelings in the interview may be influenced by the interviewer's personal front (in Goffman's terms) such as her appearance and manners. Informants will treat the interviewer based on her perceived role and the impression she gives them, their perceptions of her attitude toward them, her competence, and her trustworthiness. Thus, the interviewer will be observed by the informant in the interview situation as she tries to create a desired impression on them, and hence, the observed interviewer will influence the informants and their behaviors in the interview situation.

To uncover fully the nature of a situation, Goffman claims (Goffman, 1959) it would be necessary for the individual to understand the actual outcome or end product of the activities of others during the interaction. To enhance a common understanding of the situation, before commencing with the interviews, the interviewer presented herself as a lecturer for students who were studying cancer nursing. She also explained that the purpose (outcome) of the interview

process was to familiarize herself with the informants' perceptions of what she should teach the students regarding good care. By doing that, the researcher aimed to establish a shared purpose with the informants. Although this information might have motivated the informants to cooperate with the researcher—possibly due to altruism, as mentioned above—it may also have contributed to bias, shifting informants' attentions, to some extent, from their own experiences to what they thought may be useful for future students to know as well as toward meeting the expectations of the researcher. Although the researcher sought to establish confidence, openness, and cooperation, the patients could still have been influenced by an understanding of what was useful to share, which contrasted from the understanding of the researcher. Hence, the informants and the researcher, being part of the same interview situation, might still have created different realities from each other. As mentioned above, the interviewer also had a theoretical pre-understanding of the phenomenon of care and a purpose for the study that the informants were lacking, and therefore, were unable to share.

When doing qualitative interviews with potentially vulnerable people, such as cancer patients in difficult life situations, the informants' impressions of the interviewer, especially her trustworthiness, will be of utmost importance in determining what they reveal of their innermost, often chaotic, emotions (Frank, 2013). The interviewer was aware that this trust had to be earned before she entered the most sensitive theme of the interview—the patients' desires to express difficult emotions regarding the disease and their futures to the nurses in a cancer ward—therefore, she left this theme until near the end of the interview. The informants, however, appeared to be open and honest about their life situations and their needs and seemed to trust the interviewer more than could be expected as a stranger. The interviewer's personal front might be of utmost importance for earning this trust, but as mentioned above, the patients' wishes to tell their "illness narratives" (Frank, 2013; Synnes, 2012) to someone not belonging to the staff might also be a reason for their openness and honesty.

Doing qualitative interviews with people who are going through difficult life situations raises many ethical questions (McIlfatrick, Sullivan, & McKenna, 2006). It is important to prevent harm to the patients by respecting their dignities and their autonomies at all times. The interviewer was a stranger to the patients; hence, she endeavored to avoid delving too deeply into the patients' difficult and troubled emotions—even if doing so may have elucidated responses that are more comprehensive. The interviewer tried to make her questions open and not leading to let the patients fully decide their responses. As highlighted earlier, the patients were informed that the interviewer was not a member of staff in the ward but was employed in a nursing college, which can be defined as outside the ward's region in terms of Goffman's theatre metaphor. She was also not a member of the audience they were playing for every day in the hospital. It could be assumed that the patients would talk more freely about their feelings and needs to someone not directly involved in their care. However, even if some of the quotes mentioned above indicate that the patients might have seen the interviewer as a confidant, it is likely that they considered both the staff and the interviewer as belonging to the same team and region (in Goffman's terms), and thus, having the same barriers. The informants knew that the interviewer was under a strict patient confidentiality agreement. However, we can assume that they did not trust her fully not to inform the staff of what they were telling her, or that they simply did not take the chance to reveal too much. This could be especially true since they knew that the findings would be presented to another audience (health personnel) as a message from the players (the patients) in future articles and teachings.

The researcher's position, as well as how her intentions were perceived, formed part of the frame of the situation and probably influenced the information the patients deemed relevant and meaningful to present to her. The experiences given to the researcher were not necessarily everything that could have been disclosed, but rather, the insights and thoughts that the patients

specifically wanted to share with her and that they felt meaningful to share for the purpose of the study. Furthermore, in the light of Goffman's theory, the informants might have planned how to take control of their own performances in the interview situations by expressing themselves in ways that promoted their own plans and objectives. Regardless of the particular objective that each individual had in mind and the motive for having this objective, it would probably be in the interest of the respondents to influence the conduct of the interviewer.

Reflexivity on Some of the Findings

To Appear Favorable

Social interaction, in accordance with Goffman's theory (1959), will always involve several different aspects, including a subjective perception of what could be achieved in the situation, what sense could be made of the situation, and how a preferred identity and self-presentation could be maintained in front of one another. The informants in the study were in need of help and very much dependent on the staff's attitudes. Therefore, they might have wanted to be part of a positive interchange in which staff members were rewarded with praise and respect from the patients, and patients were reassured of receiving appropriate care whenever needed, and more important, honest information from staff members as part of care and a good and trustful relationship. An example to demonstrate the patients' potential desires to appear favorable in relation to the interviewer and staff—one that presents the staff as being benevolent and having good intentions—can be exemplified by the answers given by informants when asked to identify one or two nurses who provided better care than the others did:

> All the nurses are very kind. I am satisfied with everything. The nurses are never sulking and angry or answer in a bad way. I have never met a nurse that did not show me respect.

In this way, the patients portrayed themselves as good patients who were satisfied with everything and who were not critical of anyone, and at the same time, stressed respect as a key element in their interactions with nurses. Throughout the entire interview, the patients never complained about the care they received from the nurses; they only said that some nurses were better than others were and gave examples of why they believed this to be true. By pointing out that some nurses were better than others were, the patients indirectly implied that some were less competent or less caring, but this was never explicitly stated in the interviews.

Breaking Down the Barriers Between the Teams in the Ward

According to Goffman (1959), a basic problem in many performances is that of information control, where the audience must not be allowed to acquire information about the situation that may harm the team. In other words, the team must be able to keep its secrets and have its secrets kept. When two teams present themselves to each other for the purpose of interaction, the members of each team work to appear trustworthy, to demonstrate that they are what they claim to be and aim at what they claim to be aiming at. Goffman declares that the image that one status grouping is able to maintain in the eyes of the audience regarding another status grouping will depend upon the performers' capacities to restrict communicative contact with the audience. The cultural values of an establishment will determine, in detail, how the participants are to feel about various matters, and at the same time, establish a framework of appearances that must be maintained.

One message from the informants that was presented to the researcher could be seen as a wish to break down the barriers between the team of nurses and the team of patients by not restricting communicative contact. Clearly, in Goffman's terms, the patients wished to have the nurses on their team and to "perform together with them on the same stage." They wanted to talk to the nurses about what was important in their private lives, and they wanted to discuss everyday things such as embroidery with them, as the patients expressed:

> It is good when the nurses discuss various interests with the patients, not only the patients amongst themselves. It is good when the nurses are together with us. One of the nurses is making a national costume for her daughter. She brought the embroidery and showed it to me. We shared a common interest that had nothing to do with the stupid disease. It was something more in life.

By this statement, informants implied that they wanted a relationship with the nurses, one based more on friendship than that of a conventional patient-staff relationship, by showing that they had something in common and expressed that the relationship deepened when they got to know more about each other's private lives. They expressed that a caring nurse would also be interested in their families as well as what they did when they were not in the hospital, such as their hobbies. They wanted to establish human-to-human relationships; however, one of the patients also expressed concern about developing too close of a relationship with the nurses because it might be more difficult for them when she died. She concluded, however, that this is part of life. The overall descriptions of caring nurses were that they treated patients as fellow human beings rather than just as patients. This could be seen as important for keeping their dignities: "They see you as a person and are interested in what you are doing when you not are in the hospital. They care about you and ask about how your family is managing." The following quote may suggest that the patients felt as if they could play together on the same stage with the nurses more frequently than with the doctors:

> The nurses are always here, day and night. It is important to have nurses you can trust doing their best in every situation, and I feel they do. I suppose this is also important with doctors, but I am not so close to them.

Most of the patients, however, wanted to share in the decision-making process with the doctors regarding their disease and their treatments. They did not want the doctors to restrict communicative contact with them in this situation. The doctors' cultural values and innermost feelings determine how they communicate with the patients and to what extent they prefer to inform and discuss treatments with them. One of the patients, who wanted to decide on his treatment himself, stated that he was "a difficult patient." This can be a way of acknowledging that he did not behave in the way that he perceived was expected of him, even if nobody had actually called him difficult. Each participant in the interaction endeavors to know and keep his place. According to their own presentations to the researcher, some of the patients in the study kept their places by accepting that they did not have enough knowledge to be on the same stage as the doctors were when it came to making decisions about their treatments. Although (aligned with empowerment thinking), they could argue that they are the primary experts regarding their own bodies.

> I have not a strong wish to take part in making decisions. The doctors know what they are doing and what they do is right. I have so much respect for their profession that I do not believe that my decision will be better than theirs.

Using Goffman's metaphors, in most of the informants' views, the role of the doctors' team was to decide on the treatment backstage, and the role of each patient was to accept the doctors' decisions when it was presented to them as the audience. The findings are mixed with regard to decisions about treatment of the disease, but most of the patients sought enough information to be able to understand the doctors' performances more than to take part in the discussion as equal role players on the same stage. They accepted not having the same levels of expertise and authority regarding health matters as the doctors and let them decide in the end. Some of the patients, however, expressed desires to have a say in the final decisions about their treatments and to play a new "sick role":

> The patient needs to be secure before talking about their needs. When the staff understood how bad it was (the pain), they took it seriously. Now I get things the way I want. The nurses and doctors must have enough time to sit down and find out what the patient's needs are.

To take time to listen to the patients' views is important for not violating their dignity and trust, but also for being able to give the right treatment. The patients must be respected for wanting to be what they claim to be and to stay in character.

Ill people often have to play roles that involve meeting certain expectations (Frank, 2013). However, part of the informants' responses might stem from attempts to hold on to their dignity and the role they "played" before they were diagnosed with life-threatening diseases and became patients in a hospital ward. But, most of the patients wanted to discuss their treatment while allowing the doctor to decide because of their lack of competence. This can be seen as shared decision making. The implications for practice drawn from the findings in this study indicate that even in today's well-informed society it cannot be assumed that all patients want to participate in decisions about the treatment of their disease. Goffman (1959) suggests that the performer tends to conceal or underplay those activities, facts, and motives that are incompatible with an idealized version of himself. This can be seen as staying in character. The informants' presentations of themselves and their need for care and help can be seen as struggles to hold on to this character, feel less diminished, and not lose their dignities. The patients emphasized the importance of being treated as adults and shown respect:

> The nurses take me seriously and treat me as an adult and are very good listeners. They encourage me to tell them my wishes, listen to my questions, and always give me an answer. They also showed me respect as an individual, not only as a patient, when they remembered my name without looking at my papers.

Another quote can be seen as gratefulness to the nurses for not letting them lose their dignities:

> I cannot stay in a dark room. I have to have the light on, night and day, and I have to have fresh air and an open door. I cannot be in the same room as patients who want to turn off the light and have the door closed. I told the nurses, and they tried to find patients who were willing to share the room with me. They never joked about it, and that was important because it is very serious for me.

The patients expressed that they wanted partnerships with the nurses through their desire to take part in all decisions about their daily lives and care; they wanted to be empowered by being respected, listened to, and valued as well as given honest information. They gave an example on how this respect could be demonstrated:

> The knowledgeable nurses can discuss what types of drugs are best for me. When I get nausea for instance, they give me two choices, and when I am in pain, they tell me I can have something else if my pain medication is not good enough. They tell me that different drugs have an effect on different sorts of pain.

Many patients emphasized good information as an important aspect of care and wanted the nurses and doctors to be honest with them: "Honesty is important. I have told them ever since I got ill that I do not want to be cheated." Knowledge gives them power and to be cheated is to not show them respect. To be partners in the decisions regarding how to administer their treatments was also important: "The nurses administrated the chemotherapy in a way that enabled me to go home for some hours. They postponed the treatment for a couple of hours. That was very good."

The patients expressed, as already mentioned, that they preferred to talk about normal life, their hobbies, and their families with the nurses instead of talking about the "stupid disease" all the

time, as some expressed it. These conversations about daily life activities seemed to help them to feel normal and to keep hold on themselves: "I want to live as normally as possible. I want to talk about what I am doing at home. I want to talk about ordinary things." This has also been found by other researchers (Frank, 2013; Synnes, 2012). However, the patients wanted an offer to talk about their difficult emotions, but they themselves wanted to decide with whom, when, and about what. If there had been a need, they said, they would not have hesitated to talk to the nurses about their difficult emotions. All the patients considered it important that the nurses did not lead the conversations but answered their questions and did not "dig deeply into the patients' emotions," as it was explained. One patient suggested that, if the nurses had asked questions the patients had not wanted to answer, they must not be angry but instead be honest and say, "Dear nurse, I do not want to answer your question now, but thank you for asking." If the next day the patients wanted to talk, they could say, "I did not want to talk about it yesterday, but I am glad you asked." This quote can be seen as the informant's wish to present himself as a strong person who copes with his difficult life situation in his own way. This can, in the light of Goffman's theory, be seen as a way to keep hold on the self and not lose dignity. However, some of the informants expressed that they wanted to talk to their families and friends about their innermost feelings: "I talk to my family, my wife, and those who are interested in talking to me. Those close to me are open about the disease. I have many others than the nurses to talk to." We can assume that these are the confidants, in Goffman's terms, in the patients' lives to whom they confess their "sins."

Conclusion and Closing Remarks

Much appears to be at stake for the informants in the interviews, as has been amply exemplified and highlighted by some theoretical insight from Erving Goffman. The informants seem to be involved in multiple layers of social interactions that involve themselves in exchanges of both health information and symbols of identity and belonging. They seek confirmation, support, and advice from the expert interviewer at the same time as they seek social interchanges at equal levels and they seek greater influence on treatment and care. They talk about their illnesses while still wanting very much to go on with their normal lives and the non-clinical settings of their daily lives. In this complex social interchange of the interview situation, the need for an expert listener who is not part of the regular staff of the hospital is clearly appreciated, and sharing illnesses and hospital experiences for the future benefit of cancer care appears meaningful to the patients. Still, being met as a fully social person in which most of the social life is outside the clinical setting, and experiencing dignity and being treated with respect seem very much at stake for the informants as well. Regarding their desires to hold on to the normality of daily life outside the hospital setting, this is probably not only merely related to the need to appear as a fully social person, but also likely represents a genuine effort at sustaining a normal and complete life.

By applying Goffman's theoretical perspectives we have shown that the reflexivity becomes better-informed assumptions by, for instance, pointing out how individuals who interact with one another in a situation define the situation by the setting, their backgrounds, and the context in which they find themselves. By doing the interpretations from this viewpoint, the present article increases the value of the formal empirical study both for practitioners and educators in cancer care as well as for the research community.

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