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Provider-Patient Communication,

Patient-Centered Care, and the Mangle of Practice

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Abstract

Patient-centered care (PCC) is a popular movement among health services researchers, health policy analysts, and health professionals. PCC requires that patient needs, preferences, and beliefs be respected at all times. The PCC movement is an outgrowth of macrosocial trends, including the aging of the population, the growth of chronic illness, the focus on quality, the advent of managed care, and the realization that psychosocial factors impact on health. Although recognizing the import of psychosocial factors, PCC still lacks an overarching integrative theory that explains how biological and psychosocial factors can simultaneously affect health. Thus, communication research and clinical research from the PCC perspective tend toward the two poles of biomedical realism or social constructionism, neither of which offer a satisfactory account of health. To put communication research on a firmer footing with respect to PCC, and to avoid the discourse of dualism, this essay describes an integrative theory (based on "the mangle of practice") wherein health is seen as an interactively stabilized configuration of self-image, interpretive accounts, and performances. The implications of this perspective for communication research and training are discussed, and the essay concludes with a consideration of the problems that still face the PCC movement.

Provider-Patient Communication,

Patient-Centered Care, and the Mangle of Practice

The purpose of this essay is to explore how health communication research on provider-patient interaction can make a unique contribution to patient—centered care (PCC). It begins by defining PCC and placing PCC in social and historical context. PCC is seen as emerging from an increased focus on the social causes of illness. In an effort to avoid dualist debates about social versus biological causes of illness, a new theory of health is offered, one which admits the symmetrical influence of social, biological and psychological forces, and one which acknowledges the integral role of communication. The research and educational implications of this perspective are briefly explored. The essay then concludes by noting some potential problems with the idea of PCC.

The Patient—Centered Care Movement

Gerteis and her colleagues "use the term patient—centered care to describe an approach that consciously adopts the patient's perspective" (Gerteis, Edgman-Levitan, Daley & Delbanco, 1993, p.5). Patient—centered inquiry must focus on "the patient's experience of illness and health care and the systems that work, and fail to work, to meet patient's needs, as they define them" (Gerteis et al., 1993, p.5). According to this definition, PCC has seven primary dimensions: respect for patients' values, preferences, and needs; coordination and integration of care; information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety; involvement of family and friends; and transition and continuity. Communication research on provider—patient interaction is directly relevant to most, if not all, of these dimensions. Patient—centered research on provider—patient interaction emphasizes patient involvement, mutual participation in decision making, interpersonal relationships, and trust (Greenfield, Kaplan & Ware, 1985; Smith, Garko, Bennett, Irwin & Schofield, 1994; Smith & Pettegrew, 1986).

Historical Background

Much of the impetus for PCC originated from dissatisfaction with what appeared to be a unilateral exercise of physician power. Since 1906, US law

has held that medical treatment cannot be given without patient consent (<u>Pratt v. Davis,</u> 1906; <u>Schloendorff v. The Society of New York Hospital,</u> 1914), and the attachment of information to consent (<u>Salgo v. The Leland Stanford Hospital Board of Trustee,</u> 1956) placed the law squarely on the side of increasing the patient's role in the doctor—patient relationship. The idea of informed consent has since spread to all relationships in which care is given. During that same period attempts to direct the practice of medicine more toward the total person were being made by Szasz and Hollander (1956) and Balint (1957). In the US, the bioethics movement grew rapidly following the establishment of the President's Commission for the Study of Ethical Problems in Medicine. The Commission's report, <u>Making Health Care Decisions</u>, advocated a definition of informed consent as active, shared decision making, superior to either patient sovereignty or physician paternalism (President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, 1982). The value of autonomy juxtaposed to physician paternalism thus became a major emphasis of bioethics and set a value frame for more attention to patient concerns (Smith, 1996).

<u>Growing Interest in Patient—Centered Care</u>

There is ample evidence of the growth of PCC. Three book length treatments of PCC have appeared recently (Gerteis et al., 1993; Moore & Komras, 1993; Stewart et al., 1995), and the <u>Journal of the American Medical Association</u> has announced the creation of a permanent section on the physician—patient relationship (Glass, 1996; Laine & Davidoff, 1996). Research institutes dedicated to studying medical care from the patient's point of view have opened, and the federal government has funded a series of large-scale studies of patient-centered outcomes. The results of these studies have begun to appear (Goldberg & Cummings, 1995; Tarlov et al., 1989). A search of the National Library of Medicine's Medline database reveals a recent increase in the number of publications with the phrase "patient—centered" in the title. There were 4 such articles between 1975 and 1979, 10 between 1980 and 1984, 12 between 1985 and 1989, and 34 between 1990 and 1996.

The current interest in PCC can best be understood by placing it in the context of broader societal trends. One trend underlying the move toward PCC

is the aging of the population (U.S. Bureau of the Census, 1993). This trend has implications for the health care system, since older people are more likely to have chronic illnesses, more likely to be hospitalized, and more likely to need long term care and home care (American Hospital Association, 1993). Interest in PCC is also a response to the increased prevalence of chronic illness, where the permanence of limitation and the inevitability of deterioration give rise to long term changes in behavior, identity, and biography (Benson & Marano, 1994; Corbin & Strauss, 1988b; Lubkin, 1995).

Moreover, PCC can be seen as an outgrowth of management philosophies like total quality management (TQM) and continuous quality improvement (CQI) (Berwick, 1989; Wakefield et al., 1994). Both PCC and TQM/CQI emphasize the need to reengineer processes and practices with an eye toward improving quality and outcomes. Noteworthy within the quality care movement is the effort to define and expand the role of primary care in the U.S. (Agency for Health Care Policy and Research, 1993). Primary care emphasizes the quality of care, where patient satisfaction, sustained partnership, accessibility, continuity and integration of care within family and community are central (Donaldson & Vanselow, 1996).

PCC also reflects the realization that psychosocial factors contribute to the development, prevention and treatment of illness (Glanz, Lewis & Rimer, 1990). PCC requires providers to focus on the broad biopsychosocial nature of illness rather than focusing narrowly on biomedical causes and treatments. In addition, the growth of investor-owned, for-profit managed health care corporations has increased competition in the health care marketplace and put a premium on patient satisfaction. Finally, PCC is an expression of a deeply felt compassion on the part of administrators, providers, patients, and policy makers (Gerteis et al., 1993; Moore & Komras, 1993).

Patient-Centered Care and the Study of Communication

In summary, PCC has emerged from two broad fronts. The notion of wellness has shifted from the health of the body to the health-related experiences of the patient, reflecting a broader biopsychosocial conception of illness (Engel, 1977). There has also been increased acceptance of the patient as a partner in care who participates in discussing health issues and therapy.

Physician-patient communication research has followed these trends in several ways. Notably, increased attention has been paid to patient participation and involvement, to measuring outcomes from the patient's perspective (i.e., satisfaction and perceived health-related quality of life), and to discussion of psychosocial topics in addition to bodily functions (Roter & Hall, 1992; Stewart & Ware, 1992; Street, Voigt, Geyer, Manning & Swanson, 1995).

Two distinct approaches have been taken by researchers studying communication and PCC. The first approach defines PCC and then asks how communication processes fit in to the larger PCC process (see, e.g., Gerteis et al., 1993). The second is to adopt a specific theoretical perspective in communication research and then to ask how this theory might shed light on PCC (see, e.g., Lambert & Gillespie, 1994; Thompson, 1994). Both approaches have problems. When communication is seen merely as one component process in PCC, the biomedical perspective still dominates, and the image of communication tends to be overly simplistic, focusing exclusively on a few communicative functions and almost always emphasizing clear transmission of information. When, in contrast, PCC is seen mainly as a context for communication theories to be applied and tested, a strong kind of social constructionism prevails, and conceptualizations of health tend to be impoverished. In both cases, surprisingly, research tends to have a "medical" and "institutional" bias. The physician is viewed as the interactional partner with the greatest potential impact on the patient's well-being and health. Research still takes place predominantly in medical settings, and outcomes are often of more interest to providers or theorists (e.g., adherence, utilization) than to patients.

Our challenge is to provide a heuristic framework for patient-centered health communication research that transcends these limitations while preserving contributions that have already been made. To accomplish this, the strategy we have chosen is to develop an overarching theory of health that is grounded in an appropriately sophisticated theory of communication. This theory of health is then used as a guiding framework for research. In the following section, we briefly describe a theory of health being developed by the first author. The details of this particular theory are not crucial.

Rather, we hope to illustrate the heuristic value of this general strategy for understanding health, communication, and PCC.

A New Theory of Health

This section sketches the outline of a new theory of health, a theory that attempts to move beyond the dualisms which polarize debates about PCC, holistic health and scientific medicine. Rather than seeing health as static, this perspective foregrounds the temporally emergent character of health, drawing attention to the processes of maintaining health, becoming ill, and regaining health. Neither biological nor social forces are given ontological or causal priority in explaining these processes. Instead, health is seen as an interactively stabilized configuration of biological, social, and psychological elements. The theory draws heavily on Pickering's analysis of scientific practice and culture and on symbolic interactionist and social constructionist theories of health (Conrad & Schneider, 1992; Corbin & Strauss, 1988b; Pickering, 1992; Pickering, 1995). This new theory is patient-centered in that it defines health in terms of the patient's effort to align identity, interpretations, and performances. Health is about alignment, and the patient is at the center of the aligned elements. The patient is also the one doing the work of interactive stabilization. We believe this new model of health practice might free us from debates about dualism/holism, and, in doing so, might provoke us to consider new questions about communication, health maintenance, and PCC.

Symbolic Interactionism and the Social Construction of Health

Research on interpersonal communication has been profoundly influenced by symbolic interactionism and related forms of social constructionism (Blumer, 1969; Goffman, 1963; Goffman, 1967; McCall & Simmons, 1978). The idea that selves, identities, relationships, and communities are symbolic entities, created and sustained through interaction, is at the core of this tradition. The tradition suggests that health and well-being are aspects of self and personal identity. Interactionist approaches to health are based on the following line of reasoning: Identities are created and sustained in interaction. Health is an aspect of identity. Therefore, health is created and sustained in interaction. Similarly, interpretations and meanings are

interactional creations. Health behavior is mediated by meanings and interpretations. Hence, health behavior is a consequence of symbolic interaction. Constructionist theories hold that health perceptions and behaviors are filtered through the self-system and mediated by a sense of who we are and what it means to be that type of person. On this account, our identity is the prime mover in health cognitions and behaviors, and since identity is itself the product of communicative interactions, communication must be at the very core of what it means to be healthy.

The Mangle of Practice

The main criticism of social constructionist accounts of health has been that they minimize the impact of "reality" (e.g., bacteria, DNA, etc.) on health, while exaggerating the impact of social forces. Biomedical theories of health are subject to the opposite critique. This tension gives rise to the familiar debates about dualism/holism. However, recent forms of social constructionism in the sociology of scientific knowledge argue in favor of a "pragmatic realism" that admits the symmetrical influence of the material and the social (Pickering, 1992; Pickering, 1995). Pickering's social theory, developed to account for scientific practice and culture, centers on the "mangle of practice." A mangle, literally, is an old-fashioned device with two rollers and a crank, used for pressing and wringing water out of wet laundry. Metaphorically, the mangle "refers to the overarching image of practice...which sees science as an evolving field of human and material agencies reciprocally engaged in a play of resistance and accommodation in which the former seeks to capture the latter" (Pickering, 1995, p. 23). The mangle explains how techno-scientific culture is extended into the future. It is unlike traditional realist explanations that see cultural extension as the application of scientific reason and objective observation, and it is unlike strong versions of constructionism that see cultural extension as driven solely by social and economic interests. In the mangle of practice, culture is extended by a process of open-ended modelling. Modeling involves the formation of temporarily balanced alignments of cultural elements, and these elements are interactively stabilized in an ongoing dialectic of resistance and accommodation.

Health and the Mangle of Practice

Viewed in terms of the mangle, <u>health is a temporarily stable (incipiently unstable) alignment of self-image, interpretive accounts, and performances in the material world</u>. "Healthy" is the term we use to describe alignments we prefer. Staying healthy means sustaining a preferred configuration of self-image, interpretive accounts, and performances, in the face of destabilizing resistances that periodically emerge. Regaining health means establishing a new stable configuration when a prior configuration has been destabilized by resistance.

Resistance can appear to arise in the realm of the social, as when a person is stigmatized, isolated, and treated as deviant (Goffman, 1963). Resistance can appear to be material (biological), as when a person experiences bodily failure (e.g., seizure, memory loss, incontinence) (Corbin & Strauss, 1988a). Resistance can also appear to be cognitive, as when one experiences dissonance between one's preferred and actual self-image (Charmaz, 1987). To say that resistance can appear to be social, biological, or cognitive is <u>not</u> to say that isolation, bodily failure, or discrepant identities, in themselves, will always function as resistances. Resistances are contingent on, and arise only in relation to, specific alignments. Resistance exists in the plane of practice, and its precise location with respect to the biological, social, or cognitive realms is itself at stake in practice (Pickering, 1995).

<u>Health Maintenance as Interactive Stabilization</u>

Health is maintained through an ongoing process of interactive stabilization. A stable alignment is thus an indicator of physical, functional, and emotional well-being. The temporal structure of interactive stabilization is characterized by a dialectic of resistance and accommodation (i.e., trial and error). Three elements are interactively stabilized in this process: self-image, interpretive accounts, and actual performances in the material world. <u>Self-image</u> is a person's understanding of their own identity or hierarchy of role-identities. Self-image answers the question "Who am I?" (McCall & Simmons, 1978). <u>Interpretive accounts</u> provide a two-way link between performances and self-image. On one hand, interpretive accounts map self-image to performances, answering the question, "How should a person such as I

behave?" On the other hand, interpretive accounts map performances onto self-image, answering the question "What sort of person must I be if I behave in this way?" Message design logics serve as interpretive accounts with respect to verbal behavior (O'Keefe, 1988). Finally, <u>performances</u> are embodied actions in the material world, including activities of daily living like walking, talking, eating, working, etc. (Goffman, 1959). The following two examples are meant to illustrate what is meant by self-image, interpretive accounts, and performance. These examples will also begin to illustrate the concepts of resistance, accommodation, and interactive stabilization.

First imagine a prototypically "biological" illness, appendicitis. An active, independent woman begins the day feeling healthy. That is, she enjoys a stable alignment of self-image (young, single, working woman), interpretive accounts (young, working women are independent, physically active, etc.), and performances (normal eating, sleeping, walking, working, etc.). In the middle of the night, she is awakened by shooting pain in her side, nausea, and fever. A resistance has interrupted one of her normal performances (sleeping), and thus has destabilized her healthy alignment. She perceives bodily failure to be the main destabilizing resistance. She accommodates to this resistance by going to the emergency room, where her appendix is removed. After a brief recovery, she is able to carry out all routine performances, and her healthy alignment has been re-established.

Now imagine a middle-aged man who perceives himself to be healthy, normal, and whole. He identifies strongly with his role as a husband. This is his <u>self-image</u>. He believes that to be a healthy, normal husband, he must (among other things), have an active sexual relationship with his wife. This is his <u>interpretive account</u>, his theory of how this role identity must be dramatized in interaction. Finally, imagine he has an active sexual relationship with his wife. This is the relevant <u>performance</u> in the material world.

For the time being, the man feels healthy. He has achieved a temporarily stable alignment of self-image, interpretive account, and performance. Now imagine that the man is diagnosed with high blood pressure, and his prescription medication causes him to be impotent. The impotence is a resistance that destabilizes his healthy alignment. When he realizes he is

impotent, he no longer feels healthy. The alignment between self-image, interpretive account, and performance has been destabilized, and bodily failure is the apparent cause. To regain his health, he must accommodate to this resistance. He can do so by modifying any one of the three interactively stabilized elements. He could alter his identity so that his role as a husband is minimized and his role as (say) a businessman is emphasized. He could alter his interpretive account of what it means to be a good husband, emphasizing supportive friendship rather than sexual potency, or he could modify his performance by stopping the medication.

Any one of these accommodations could potentially stabilize a new alignment of self-image, interpretive account, and performance, but none is guaranteed to. The man in our example might stop the antihypertensive medication, only to discover he was still impotent, and he had incorrectly identified the source of resistance. Restoring health by interactively stabilizing a new alignment is difficult and uncertain work. Health cannot be restored by a "mere" act of will or by positive thinking, although will and positive thinking may be part of the process of interactive stabilization that leads to restored health (Pickering, 1990). It is never known in advance which accommodations will be successful, nor is it known whether accommodations will themselves lead to the emergence of new resistances.

Implications of The Mangle of Practice for Communication Research

This section of the essay considers what research issues arise when one takes seriously the idea of health and the mangle of practice. Staying healthy is about maintaining stable alignments, about choosing paths of least resistance, and about accommodating to resistances when they emerge. So clearly, the image of the mangle raises questions about the relationship between health communication skill, interactive stabilization, resistance and accommodation. To what extent is skill at stabilization or accommodation communication skill? What communication skills are most important to the maintenance of stable, healthy alignments? How do messages function or fail to function to stabilize preferred, healthy alignments? Can we effectively measure perceived stability of alignments as a health outcome? How do messages influence and how are messages influenced by identity? How do interpretive

accounts manifest themselves in health-related interactions? Can interpretive accounts be intentionally altered in interaction? What happens when provider and patient use different interpretive accounts? How can the need for stabilization of alignments or accommodation to resistances be topicalized in provider-patient interaction? Can communicative performances themselves become unhealthy, destabilizing resistances?

Implications for the Study of Provider-Patient Interaction

As this list of questions shows, opportunities abound for communication researchers to offer distinctive insights into communication-related processes and effects that are salient to the stabilization of preferred alignments. Our strength as a discipline is that we have a practical orientation; we know how to theorize about messages and message effects; we understand how reality is constructed in and through communication; and we understand the connection between communication and relationship development. Furthermore, several lines of communication research not traditionally seen as health-related become considerably more relevant when health is seen more inclusively from the perspective of the mangle of practice (e.g., research on family communication, social support, life-span/intergenerational communication, negotiation, self-disclosure, trust, and relationship development).

We know, for example, that most of the research into doctor-patient communication has focused on the provider, particularly the physician. There are practical reasons for this emphasis, but we know that communication processes (and outcomes) cannot adequately be researched or understood by focusing on only one half of a dyad, or by focusing on only one of many relevant dyads. One implication of a patient-centered research perspective is that communication scholars should focus more attention on provider-patient, patient-spouse, and other relevant dyads.

Many of the questions that drive research in interpersonal communication generally are also of significance to greater understanding of provider-patient communication. For example, research on social cognition, person perception, and situation assessment (all aspects of interpretive accounts) and their influence on message production is of critical importance to understanding how providers and patients align, or fail to align, their

communicative moves. Research on goals and how they are reflected in participants' message production is of significance to better understanding of provider-patient communication. Research on goals is also crucial if we are to craft a better understanding of how people project and extend their present alignments into the future. The mangle suggests that this occurs via an open-ended process of (role) modelling, a suggestion supported by ethnographic studies of chronically ill patients (Charmaz, 1987).

Implications for Methods and Design

Patient—centered research on health and the mangle of practice can be qualitative or quantitative, observational or experimental, longitudinal or cross-sectional, prospective or retrospective, depending on the question being asked. Since patient—centered research is fundamentally concerned with the patient's perspective on health, illness and treatment, methods that collect data directly from patients have often been used. Thus, focus groups, in depth interviews, and self-administered questionnaires are common data collection techniques (Gerteis et al., 1993).

A common design for a study of provider—patient interaction is a cross-sectional, observational study. Interactions between providers and patients are recorded on audio or videotape (typically in a clinic or hospital setting), and patients are asked to report their satisfaction, understanding, recall, etc. on a self-administered, post-visit questionnaire. Interaction process and content are subsequently content-analyzed, and correlations are computed between features of the interaction and patients' evaluations (Hall, 1988; Roter, Hall & Katz, 1988).

This design, though it has been a fruitful paradigm for research, might be improved in several ways by taking patient—centered themes and the mangle of practice into consideration. First, experimental or quasi-experimental designs, grounded in an analysis of the mangle of practice, ought to be considered alongside observational and ethnographic studies. Existing research has documented correlations between many sociodemographic, interactional, and outcome variables, but the paucity of experimental studies and the complexity of provider-patient interaction have frustrated attempts to draw causal inferences and to develop coherent theories. Second, research should show a

preference for longitudinal designs. It is unrealistic for significant outcomes to result from a single encounter, because chronic illnesses have life-long trajectories that are still poorly understood, and because the process of becoming ill and regaining health can only be observed in longitudinal designs. Third, research ought to broaden its scope to include the home as well as the clinic or hospital. After all, the central site of illness management, except during acute phases, is the home. Fourth, research should expand its focus to include patient interactions with non-physician health professionals (e.g., nurses, pharmacists, social workers, nutritionists, etc.) and other non-physician providers (e.g., family, friends, clergy, etc.). Finally, patients must be viewed not simply as sources of data but as partners in the research process who have input into the questions being asked and the outcomes being measured, and as interpreters of research findings, who can identify and express the significance of results that are important from a patient's point of view.

These suggestions can be captured, in part, by recommending that research in this area be more epidemiological. Epidemiology is the study of the causes and determinants of the frequency distribution of disease, disability and death in human populations (Timmereck, 1994). Epidemiological research examines how biological, social, psychological, and environmental factors relate to population health outcomes over time. The next section considers what it might mean to do epidemiological communication research.

Implications for the Study of Communication and Health

Communication should be studied in various relationships a person has that potentially affect health. Spouses, kids, coworkers, friends, physicians should all be viewed symmetrically, with no a priori assumptions about which relationships have more impact on health. Physical and psychosocial outcomes, as well as the structure and content of communication, should be tracked over time. Thus, issues related to social support, marital/family communication, interactions at work, and visits with physicians would all be fair game. By following people longitudinally, focusing on the quality of interactions, we could develop evidence pointing to the real impact of communication variables on health. At the same time longitudinal research makes possible an analysis

of the temporally emergent dynamics of interactive stabilization and the

ongoing dialectic of resistance and accommodation as they relate to health.

Research on social support currently comes closest to embodying this vision of

epidemiological communication research, but even there, work is often not done

by communication researchers; most of the focus is on the presence or absence

of social relationships, and relatively little is known about how the detailed

structure and content of social relationships affect health (Burleson,

Albrecht & Sarason, 1994; House, Landis & Umberson, 1994).

<u>Implications for Communication Education</u>

Having examined how a theory of health with communication at its core

might serve as a guiding framework for research, we now turn our attention to

education and ask how health professionals, patients, friends and family

should be educated in order to achieve the goals of PCC.

<u>Training providers.</u> Kurtz and Silverman (1996) have created referenced

observation guides developed specifically to include the skills that recent

research and practice have associated with collaborative PCC. In addition to

training health professionals, the guides have been used to help patients

develop their own communication skills. The 70 plus skills described in the

guides are organized around such patient-centered tasks as understanding the

patient's perspective, building relationship, incorporating the patient's

perspective in explanations and planning, and negotiation and shared decision

making (Kurtz & Silverman, 1996; Riccardi & Kurtz, 1983).

Effective communication skills training in health care requires that

training be offered at many points during the undergraduate, postgraduate, and

continuing education process. Research needs to be done to see how best to

coordinate these efforts so they build systematically and logically on each

other. In evaluating these educational efforts, one must continually focus on

knowledge (do you know it?), competence (can you do it?), performance (do you

do it?), and results (what happens to the people involved?) (Miller, 1990).

Most current programs focus on knowledge and competence, with little focus on

performance and results (the two areas that can best be examined during

residency training or continuing education). In all of these areas,

communication scholars can contribute to development, teaching, evaluation,

and research on efficacy and outcomes associated with educational programs for health communication.

Training patients. Considerable attention has been given to the ways doctors may improve their communication, yet comparatively little work has been done on patients' communicative competence, even though patients are the ones struggling to stabilize their healthy alignments. Most existing research on patient training focuses on improved question-asking (Greenfield et al., 1985; Roter, 1984). This emphasis is justified by the consistent finding that patients ask doctors very few questions, even though nearly all patients say they want as much information from their doctors as possible. However, research and training on question asking probably should be more focused and systematic than most training efforts to date. For example, some research shows that patients asked few direct questions about the diagnosis of their medical problem, but they asked numerous embedded questions about diagnosis (Cegala, 1996). These results suggest that patients may desire more information on certain topics but for some reason(s) are unwilling or unable to ask direct questions.

The analysis of health and the mangle of practice offers one explanation for patients' frequent use of indirectness. In a healthy alignment of identity, interpretive accounts, and performances, a patient identifies herself as a knowledgeable, capable and independent person. The interpretive account says being knowledgeable means not asking 'stupid' questions. Asking a direct question about diagnosis is a risky, potentially alignment-destabilizing performance, so direct questions are avoided. But being healthy also means being able to project one's identity and performance into the future, so questions about the diagnosis and prognosis must be asked. Asking these questions indirectly is one way of accommodating to the anticipated resistance, and thereby avoiding a destabilizing performance (see also, Brown & Levinson, 1987). Being sensitive to identity concerns, a patient-centered approach to information seeking might be grounded in an assessment that is geared to the stabilization-relevant, informational needs of patients. At the same time, a dyadic approach to provider-patient communication suggests that

providers need training in responding to patients' attempts to seek information indirectly.

Patient information seeking is by no means the only communication skill of relevance to competent provider—patient interaction. For example, a dyadic perspective on provider—patient communication would suggest that patients also should employ competent information-giving strategies (e.g., in the form of more organized, detailed histories; accurate accounting of current medications). There is some evidence to suggest that patients may be reasonably competent at providing information in response to doctors' direct questions, but that they are less competent in providing issue-relevant, unsolicited information (Cegala, 1996). Thus, skills training for patients might include guidelines for staying on target and avoiding tangential information. Doctors may benefit from similar training in skills to gear their volunteered information to matters that are personally relevant to patients.

Considerable attention has been given to improving doctors' relational communication. Interestingly, little or no attention has been given to patients' relational skills. Perhaps more importantly, most research has treated information exchange and relational communication as separate dimensions of provider-patient interaction. Yet, it is unlikely that doctors and patients treat these dimensions separately (Roter & Hall, 1991). More research is needed on how doctors and patients define information and how relational messages may be conveyed by meeting information needs (i.e., we need to understand the interpretive accounts used by providers and patients).

<u>Problems with the Concept of Patient—Centered Care</u>

Although we are inspired by the promise of PCC, there are principled and practical problems with the idea. Practically speaking, PCC has not been easy to implement. Organizational inertia, resource constraints, professional dominance, conflicting interpretations, and resistance from providers and patients have all been cited as barriers to change efforts (Bedford, 1995). There is still an unfortunate tendency in many organizations to devalue patient-oriented work, and such values are embodied in systems of rewards and privileges that favor specialized, technical care over compassionate human contact (Gerteis et al., 1993). Patient-centered care has too often been

applied as a theory of hospital redesign, when a more faithful application of the idea would go far beyond the hospital. Moreover, as patient-centered initiatives have been mixed with TQM and CQI, patients' views have been lost in a frenzy of cost-cutting, downsizing, and re-engineering.

Principled objections to PCC focus on the nature of patienthood. The patient role is a negatively valued role. Entry into the patient or sick role is often a last resort, following delays and attempts at self-care. Given the negatively valued nature of the patient role, it may not be wise to design services for patients. What people want is not to have to enter the patient role at all. A researcher who acknowledges this fact would not try to inspire a kinder, gentler medical interview. Instead, we need strategies people can use to avoid or delay entry into the patient role in the first place.

Moreover, PCC, with its focus on individuality, autonomy, empowerment, and consent, has tended to foster separation at the expense of solidarity. Because patients have historically been passive and less powerful than professionals, it may be necessary to emphasize patient concerns for a time, but we should not lose sight of a mutually satisfactory therapeutic relationship as our long term goal. Finally, a focus on patient-centered care raises the spectre of medicalization, the tendency of the medical-industrial complex to define what were once seen as problems of living as medical problems (e.g., baldness, anxiety, fatigue, etc.) (Conrad & Schneider, 1992). Once defined as medical problems, medicine (rather than the individual, family, church, or state) gains jurisdiction over diagnosis and treatment. Since patienthood can often be dehumanizing and disempowering (Goffman, 1961), it is not clear that we want to encourage people with life-long illnesses to be cast permanently into the patient role. Perhaps person-centered care is what we ought to advocate. PCC is still, to a large extent, a model of biomedical care, rather than a model of health. With a theory of health such as that presented here, one which recognizes the integral importance of identity issues in the maintenance of health, one would not cast people into the patient role, except when absolutely necessary.

<center>Conclusion</center>

In this essay we have tried to critically analyze the PCC movement as it relates specifically to the study of provider-patient communication. Our analysis revealed limitations in current approaches to studying communication and PCC, and it seemed likely that some of these limitations could be overcome by adopting a new strategy toward the study of communication, health and PCC. The new strategy required an integrative, overarching theory of health, built on sound, contemporary theories of communication. One example of such a theory was described, and implications for the research and education were discussed. Based on the number of new questions raised, this general strategy for approaching the study of communication and PCC appears to have promise, but the real test will be to see if this strategy leads to productive research that increases our knowledge and improves our ability to keep ourselves and other people healthy.

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