

Unpacking “patient-centredness”

how knowledge is negotiated dialogically in the interweaving of genres and voices in counselling conversations

Phillips, Louise Jane; Scheffmann-Petersen, Michael

Published in:
Sociology of Health and Illness

DOI:
[10.1111/1467-9566.13118](https://doi.org/10.1111/1467-9566.13118)

Publication date:
2020

Document Version
Early version, also known as pre-print

Citation for published version (APA):
Phillips, L. J., & Scheffmann-Petersen, M. (2020). Unpacking “patient-centredness”: how knowledge is negotiated dialogically in the interweaving of genres and voices in counselling conversations . *Sociology of Health and Illness*, 42(6), 1456-1472. <https://doi.org/10.1111/1467-9566.13118>

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain.
- You may freely distribute the URL identifying the publication in the public portal.

Take down policy

If you believe that this document breaches copyright please contact rucforsk@kb.dk providing details, and we will remove access to the work immediately and investigate your claim.

Unpacking “patient-centredness”: how knowledge is negotiated dialogically in the interweaving of genres and voices in counselling conversations

Louise Phillips (Roskilde University, Roskilde, Denmark) and Michael Scheffmann-Petersen (Region Zealand and Roskilde University, Roskilde, Denmark)

Abstract. In the literature, difficulties in implementing policy principles of patient-centredness are often understood as obstacles to patient-centred care leading to a gap between the ideals and practice. This article proposes that what are often identified in the literature as obstacles can be usefully construed as intrinsic tensions that cannot be eradicated. It offers a theoretical framework for exploring the tensions that builds on Bakhtin’s theory of dialogue and Foucault’s theory of power/knowledge. The framework is designed to “unpack” the tensional, context-specific nature of “patient-centredness” through empirical exploration of how particular forms of “patient-centredness” are produced through tensional meaning-making in particular contexts. The use of the framework is illustrated in an analysis of how “patient-centredness” is ascribed specific meanings and enacted in collaborative telephone counselling conversations in a Danish patient-centred programme entitled “Active Patient Support”. The analysis shows how the interweaving of genres and voices works to manage the patient’s uncertainty in ways that both empower *and* self-discipline the patient. The discussion explores the implications of the specific form of “patient-centredness” articulated in the conversations with respect to patient empowerment and participation. It also critically reflects on the theoretical framework as a reflexive approach to tackling the tensions in “patient-centredness”.

Keywords: Bakhtinian dialogic communication theory; counselling conversations; genres; patient-centredness; power/knowledge; voice

Introduction

“Patient-centredness” has become a central principle of health care policy in many countries. In health care policy, the dominant conception of the “patient” has shifted from a passive target of medical intervention to an active participant in collaborative decision-making (Armstrong 2011, Liberati et al. 2015, Sullivan 2003). “Patient-centredness” emanates from recognition of the value of knowledge and preferences rooted in patients’ lived experiences (Epstein and Street 2011, Mead and Bower 2000, Thompson 2007). In some health care contexts, the term “person-centredness”, rather than “patient-centredness”, is preferred in order to signal a holistic, “whole person” approach as opposed to the biomedical reductionism implied by a centring on the “patient” (Edvardsson et al. 2008) and in order to stress the importance of a meaningful, rather than just a functional, life (Eklund et al. 2019). In this article, we choose the designation, “patient-centredness”, rather than “person-centredness”, since “patient-centredness” is more commonly used in the Danish health care policy context to which the practice analysed belongs.

In the literature, it is often pointed out that “patient-centredness” has multiple meanings and that there is no consensus on its definition or how to apply it in practice (Castro et al. 2016, Kitson et al. 2012, Liberati et al. 2015). Across the different usages of the terms, a set of common ideals can be identified. According to the ideals, patients and health care professionals collaboratively create knowledge and reach decisions about the patient’s care. In this understanding, patients become empowered as “active patients” and health care professionals shift from being authoritative experts to facilitators in shared decision-making (Gardner and Cribb 2016, Liberati et al. 2015, Sullivan 2003). The ideals are based on a democratisation of knowledge whereby scientific, including biomedical, knowledge loses its monopoly on truth, multiple ways of knowing are recognised as legitimate, and patients are recognised as experiential experts (Armstrong 2011, Phillips 2011, Renado et al. 2018). “Patient-centred” care, in principle, actively cultivates the

production of hybrid knowledge across biomedical and experiential knowledge forms (Renado et al. 2018). All usages of patient-centredness draw on the concepts of “empowerment” and “participation”. Participation, at the individual level, “concerns a patient’s rights and opportunities to engage in decision-making about his care through a dialogue attuned to his preferences, potential and a combination of his experiential and the professional’s expert knowledge” (Castro et al. 2016: 1930). “Empowerment” entails the capacity of individual patients and patient groups to gain control over their health as active agents and hence improve their quality of life and well-being (Castro et al. 2016: 1927).

Several studies of patient-centred care point at a gap between the ideals and the practice of patient-centredness, indicating that the policy principle of patient-centredness is hard to implement (Gardner and Cribb 2016, Hsieh et al. 2016, Lord and Gale 2014). Asymmetrical power dynamics are highlighted in many of the studies. For example, Lord and Gale (2014) showed in a study of stakeholders in National Health Service hospital trusts in England that, in spite of intentions, the institutional biomedical voice tended to dominate and subjective experience was devalued. To take another example, Hsieh et al. (2016) demonstrated in a study of patient-centred care in oncologist-patient interactions that, rather than treating patient preferences as a value to be respected, the oncologist often manipulated patient preferences in order to persuade patients to accept a course of action based on the oncologist’s assessment

A number of studies suggest strategies for closing the gap between the ideals and practices of “patient-centredness” by eradicating the obstacles that prevent its full implementation. These strategies include education (Nolan et al. 2004), the use of person- and relationship-centred principles for the design of the built environment (Davis et al. 2009), the shaping of practice by research-based knowledge (Quinlan 2009) and the formulation of a clear definition of “patient-centred” care (Castro et al. 2016). In this article, we aim to contribute to research on patient-

centredness by proposing, and illustrating the use of, a theoretical framework - The Integrated Framework for Analysing Dialogic Knowledge Production and Communication (IFADIA) - which asserts that what are commonly understood in the literature as implementation difficulties can be usefully construed as tensions intrinsic to “patient-centredness” rather than obstacles that it is possible to eradicate. Drawing on a combination of Bakhtin’s theory of dialogue and Foucault’s theory of power/knowledge and discourse, the theoretical framework, IFADIA, conceptualizes “patient-centredness” as a complex, tension-ridden product of dialogic meaning-making. A basic assumption is that “patient-centredness” is constructed in situated, dynamic meaning-making, and hence its meaning is not fixed. IFADIA is designed to “unpack” the tensional, situated nature of “patient-centredness” through empirical exploration of how particular forms of “patient-centredness” are produced through tensional meaning-making in particular settings. By revolving around such empirical exploration, the framework offers a reflexive approach to tackling the tensions. It is argued that, given the inexorability of the tensions, reflexivity is the most appropriate strategy for narrowing the gap between the ideals and practice of “patient-centredness”.

Our IFADIA-based approach shares with some socio-material studies an interest - drawing on Foucauldian theory of governmentality - in how disciplinary power is in play in “patient-centredness” in shaping the conduct of patients (e.g. Foucault 1991, Gardner 2017, Gardner and Cribb 2016, May et al. 2006). However, our approach concentrates on meaning-making in conversations and takes less account than socio-material approaches of how patient-centredness is enacted through sociotechnical arrangements including technologies, embodied habits, spaces and architecture. We recognize this as a limitation of our approach. At the same time, our IFADIA-based analysis does provide insight into how “patient-centredness” is enacted as a form of disciplinary power through the operation of one particular set of technologies: genres that frame, and hence circumscribe, meaning-making by stipulating ways of acting (Bakhtin, 1984, 1986).

Moreover, we attend to the affordances of the telephone as a non-human actor. The telephone enables a form of communication which is embedded, in both time and space, in the settings of patients' everyday lives rather than the institutional health care setting.

In order to illustrate how IFADIA can be used to “unpack” the tensional, situated nature of “patient-centredness”, the article applies the framework in analysis of a patient-centred health care programme entitled “Active Patient Support” under the auspices of the health administration of Region Zealand, Denmark. In the programme, nurses engage in regular collaborative telephone counselling conversations with patients with chronic illnesses. Since the tensions identified in the analysis are intrinsic to patient-centredness, they are not signs that “Active Patient Support” has experienced particular difficulties with implementing patient-centred care.

The analysis using IFADIA shows how “patient-centredness” is enacted in the negotiation of knowledge through the intermeshing of genres and voices. It homes in on dynamics of inclusion and exclusion. In doing so, the analysis of the operation of disciplinary power in the enactment of “patient-centredness” attends to how self-discipline *and* empowerment simultaneously are in play and explores the tension between them (Petrakaki et al. 2018).

The focus is on how particular genres serve as technologies which set boundaries for dialogic meaning-making in ways that both empower the patient as an active participant in collaborative decision-making about self-care and circumscribe participation, leading to self-discipline in line with plans for action preferred by the nurse.

In the following, we outline the study's theoretical framework, IFADIA, and the design of the action research project before presenting the analysis of counselling conversations. Finally, in the light of the results of the analysis, we explore the implications of the situated enactment of “patient-centredness” in the counselling conversations with respect to patient

participation and empowerment and critically consider the theoretical framework as a reflexive approach to tackling the tensions in “patient-centredness”.

Theoretical framework

The Integrated Framework for Analysing Dialogic Knowledge Production and Communication (IFADIA) has been developed by Phillips (2011) and combines Bakhtin’s theory of dialogue (1981, 1984, 1986) and Foucault’s theory of power/knowledge (1972, 1977, 1980). IFADIA builds on the social constructionist premise that social reality - including knowledge and subjectivities - is *constituted*, rather than reflected, in meaning-making in communication processes. Thus, the research in this article shares with other social constructionist research on knowledge production in health care a focus on “knowing” as a social activity taking place through the negotiation of meaning in situated communication processes (e.g. Hsieh et al. 2016, Liberati et al. 2015, Quinlan 2009).

However, the approach taken in this article is also distinctive because IFADIA draws on Bakhtin’s theory to conceptualise all communication as “dialogue” in the sense that meaning is produced relationally in the tension between multiple – and often contradictory and opposing – voices (Bakhtin, 1981, 1984, 1986). In contrast to a phenomenological understanding of dialogue as authentic communication based on experience of direct unmediated contact with others (Craig 1999: 138), a Bakhtinian approach asserts that “life by its very nature is dialogic” qua the centrality to human life of relational meaning-making (Bakhtin 1984: 293). Meaning-making is relational and dialogic in two senses: first, meaning is produced through the intertextual relations of utterances to

other utterances and, second, it emerges in social interaction in which the participants address each other's voices.

In Bakhtin's understanding, voices are both the media for speech or the uttered speech of embodied persons and also discourses, ideologies, perspectives or themes (Bakhtin 1981). People can articulate many voices, including contradictory ones constructing competing knowledges and identities. Moreover, they can address not only the voices of the addressee in the conversation but also the voices of others not present in the conversations. Bakhtin describes the latter as "internal dialogism"; in any instance of talk, people simultaneously engage in dialogue with themselves and with others who are not present ("inner others") (Bakhtin 1984). The meaning of an utterance is created in the interplay between the utterance, past utterances and responses in specific situations across a polyphony of voices. In addressing others in dialogue, people do not merely *reproduce* the voices of others and the knowledge and self-identities articulated in those voices. Rather, voices are reworked to create hybrid knowledge and multi-voiced selves by appropriating perspectives in a process of "re-accentuation" whereby people invest them with their own "accents" and thus make them their own (Bakhtin 1984). Bakhtin asserts that the unity that emerges in meaning-making is the tensional product of two competing tendencies, the centripetal tendency towards unity and the centrifugal tendency towards difference: in the interplay between voices, a unity is formed but, as a result of the play of difference across voices, that unity is an unstable, polyphonic/multivoiced one, full of contradictions (Bakhtin 1981: 272).

From a Bakhtinian perspective, then, dialogue is riddled with tensions as meaning is co-produced across multiple voices. IFADIA differs from other Bakhtinian approaches to the tensions in dialogue (eg. Hong et al. 2017, Renado et al. 2018) in adding a Foucauldian take on discourse and power/knowledge which asserts that our knowledge of the world and our experience of self and others come into being in the social production of meaning in historically contingent

discourses that exclude or marginalise other ways of being, knowing and doing and are materialized in institutions and practices (Foucault, 1972, 1977, 1980). To conceptualise the workings of power in the constitution of self and other in patient-centred communication, we draw specifically on Foucault's theory of governmentality which conceptualises technologies of self through which subjects are governed (eg Foucault 1991) and Rose's further development of Foucault's thinking. Rose (2007) argues that, in contemporary health care, individuals are constituted as self-disciplining "biocitizens" with individual moral responsibility for making choices about their lifestyle and treatment and, more generally, for self-governance to support their own well-being.

Although dialogue is linked to power in most dialogic communication theories, the linkage is often left largely unexplored (Hammond et al. 2003). By adding Foucault's theory of discourse and power/knowledge, IFADIA becomes analytically equipped for, and oriented towards, reflexive, empirical exploration of the ways in which the inevitable play of power/knowledge works, through dynamics of inclusion and exclusion in the articulation of discourses, to enable *and* set the boundaries for ways of being, knowing and doing.

Combining Bakhtin and Foucault, IFADIA conceptualizes discourses as "voices" and adds Bakhtin's concept of "genre" in order to further theorise dynamics of inclusion and exclusion. Each voice constructs a particular form of knowledge and particular subjectivities. In meaning-making in the interplay between different voices – and in our case, the making of the meaning of "patient-centredness" - certain voices, and therefore certain forms of knowledge and subjectivities, dominate and others are marginalised. Genres frame, and hence circumscribe, meaning-making across voices by stipulating ways of acting (Bakhtin, 1984, 1986). Like voices, genres are never just reproduced but re-worked: "[a] genre is always the same and yet not the same, always old and new simultaneously" (Bakhtin 1984: 106). Together, the intermeshing of voices and genres bring "patient-centredness" into being in ways, that through the operation of disciplinary power, make

possible *and* set the boundaries for participants' ways of knowing. A moral order is created in which certain forms of knowing lie within the borders of what is normatively legitimate and morally acceptable within the terms of the voices, while other forms of knowing exceed the limits. These forms of knowing become materialized in sociotechnical arrangements, spaces, technologies and bodies. In our analysis, we show how genres operate as technologies that, by circumscribing participants' ways of acting, lead to self-governance in relation to living with chronic illness within the terms of the moral order of the voices articulated in the conversations.

Empirical material, analytical focus and questions

As noted above, this article illustrates the use of IFADIA in analysis of counselling conversations belonging to a Danish patient-centred health care programme entitled "Active Patient Support" (APS). The term "patient" figures in the title of the initiative but, in line with a more holistic approach, the counselling team and other professionals attached to APS refer in daily practice to the participants as "citizens". In APS, nurses offer patients with chronic illnesses regular telephone counselling over a period of up to nine months. The dual aims of APS are to improve the quality of life of the participating patients and decrease health care costs by reducing the frequency of hospitalisation. Building on recognition of the value of knowledge and preferences rooted in people's lived experiences, nurses and patients in APS engage in collaborative decision-making in the counselling conversations. The nurse and citizen jointly decide on areas to work on together. Based on the principles of participation and empowerment, the nurse and patient share responsibility for developing strategies of "self-care", and citizens are understood as "active patients" who are empowered in the sense that they gain enhanced agency in relation to coping with their illnesses in their everyday lives.

The counselling conversations analysed in this article were also the object of analysis in an action research project which we (the co-authors of this article), carried out as university researchers together with the counselling team of nurses and a group of citizens in the APS programme. The health administration of Region Zealand was motivated to initiate the action research project by a wish to strengthen the adherence of the APS programme to “patient-centredness”. In line with the APS programme, the action research project is also based on a collaborative design. The design included a series of four all-day workshops in which we (the co-authors of this article) and the nurses carried out joint analyses of six counselling conversations that we, the university researchers, had selected from the fifty conversations they had recorded. This article presents our own analyses which we have carried out following the workshops (see Phillips and Scheffmann-Petersen [2019] for an account of the use of IFADIA to design the action research project and cultivate reflexivity about the tensions in counselling conversations and the action research process itself). The extracts that are analysed in this article emanate from two of the six conversations that were the object of joint analyses. We have selected them because they represent instances in which a plan for action comes into being (example 1) and is sustained (example 2).

Our analysis explores how “patient-centredness” is enacted in dialogue as nurses shift between different genres and articulate different voices within the genres. As noted above, genres - as ways of acting - and discourses - as ways of representing objects and subjects in meaning - enable *and* constrain what can be said. Within each genre, particular voices are articulated that *re-accentuate* particular forms of knowledge. The analysis homes in on how “patient-centredness” is invested with particular meanings through dynamics of inclusion and exclusion in the interweaving of genres and voices. It looks at the shifts between genres, focusing on how each genre frames talk - and thus contributes to the operation of disciplinary power in the local enactment of “patient-centredness” - by stipulating a way of acting within a normatively

prescribed moral order, that if internalized by the patient, leads to self-governance. It also attends to the hierarchical relations between the voices, focusing on which voices dominate and which are subordinated. The analysis addresses the following analytical questions:

- How do particular genres frame talk – and hence contribute to the local enactment of “patient-centredness” - by stipulating particular ways of acting in talk within a normatively prescribed moral order?
- How do the nurse and citizen negotiate knowledge through the re-accentuation of voices in which they appropriate perspectives as their own by investing them with their own “accents”?
- In the interplay between centrifugal and centripetal movements in genres that stipulate ways of acting, how is power in play in the enactment of “patient-centredness” in the tension between opening up for multiple voices (centrifugal movement) and closure towards a normatively prescribed solution (centripetal movement)?

Through initial analysis of transcriptions of audio-recordings prior to the action research workshops, we, the co-authors of this article, had identified three different conversational genres which we then analysed together with the counselling team of nurses in the workshops. In the analysis below, we have built on the joint analyses in the workshops by systematically applying IFADIA in interplay with the material. The three genres are as follows. The “genre of the sparring partner” stipulates the activity of sparring in decision-making about creating a plan for action in relation to coping with specific problems - as a step on the path to well-functioning self-care at the end of the APS programme. The genre of inquiry stipulates the activity of inquiring into the citizen’s experiences and preferences. The genre of caring support stipulates the activity of giving emotional support to the citizen.

The analysis of the following two examples shows how “patient-centredness” is enacted through the re-accentuation of experiential knowledge in the collaborative creation (example 1) and maintenance (example 2) of a plan for action. The two examples are from the second and third telephone counselling conversations between the nurse, Susanne, and the citizen, Linda (pseudonyms).

The collaborative creation of a plan for action by the containment of uncertainty across genres

In the first part of the example, the nurse, Susanne, co-articulates the genre of inquiry and the genre of the sparring partner:

1 Susanne: *Linda, have you written some things down that we should talk about today?*

2 Linda: *No, I didn't have anything other than the hospital thing.*

3 Susanne: *I think we should try to make a plan together for what we should focus on in the future.*

4 Linda: *Yes*

5 Susanne: *Have you had any thoughts about preventive measures?*

6 Linda: *About what, did you say?*

7 Susanne: *Preventive measures. It's about, well we know that if you live with a chronic illness,*

8 *heart disease, lung disease or whatever. We know from experience that there are some things*

9 *that are good for you like doing exercise because it helps both physically and mentally. Have you*

10 *had any thoughts in that direction?*

11 Linda: *no.*

The nurse, Susanne, articulates the genre of inquiry when she opens up for the perspective of the citizen, Linda, on what they should talk about (line 1). Although Linda does not accept the invitation to come up with a topic for joint consideration, Susanne articulates the genre of the sparring partner in decision-making about a plan for coping with Linda's chronic illness as a step on the path to well-functioning self-care at the end of the APS programme. Here, she invites Linda to work out a plan for action together with her on the basis of a sense of *joint* responsibility: Susanne says that "*we*" should try to make a plan together for what "*we*" should focus on (lines 3-4). Linda, by responding with a "yes", expresses minimal acceptance and Susanne continues to inquire into Linda's perspective in relation to a plan: "*Have you had any thoughts about preventive measures?*" By inquiring into Linda's perspective, Susanne is more dialogic than if she had responded along the lines of "let's make a plan". But, at the same time, she steers the dialogue in a particular direction by using the term, "*preventive measures*" which invokes the voice of the health care professional, expressing an expert health care perspective. Linda indicates that she does not know what "*preventive measures*" are and, to address this, Susanne explains what the jargon means in everyday language. She signals that the knowledge is experiential: "*we know from experience*" (line 8). But, in saying "*we know*" (lines 7 and 8), she re-accentuates experience-based knowledge as authoritative health care knowledge in the voice of the health care professional. The whole turn (lines 7-10) articulates the genre of the sparring partner as the knowledge is packaged as information that can inform decision-making about a plan for action. It ends with a question which co-articulates the genre of the sparring partner and the genre of inquiry – "*Have you had any thoughts in that direction?*" - and a negative response to this question ("No").

Despite Linda's negative response to her question, Susanne continues to articulate the genre of the sparring partner and opens up a little more for Linda's perspective:

12 Susanne: *No, but I think, Linda, what would you think about having it as a focus next time?*

The subjective modality, “I think”, signals that Susanne is building on her own subjective voice as opposed to a disembodied expert position. Linda then addresses Susanne’s health care perspective and Susanne responds:

13 *Linda: You’re thinking about exercise, dieting or?*

14 *Susanne: Yes, exercise. And you spoke at some point too about weight loss. All the things that*

15 *contribute, that we know from experience can contribute to, getting better.*

In asking Susanne whether she was thinking about exercise, Linda asks for elaboration on Susanne’s agenda for sparring without accepting the agenda as her own and thus without accepting the position as partner in sparring. Susanne confirms that Linda was right when she thought about exercise and then she implies that Linda has herself, in an earlier conversation, invoked a voice of health care, articulating health care knowledge (line 14). Susanne ends by further supporting the voice of health care through invoking experience-based knowledge again (“*all the things that contribute, that we know from experience*”). Linda responds by expressing full acceptance of Susanne’s agenda for sparring as a *joint* endeavour:

16 *Linda: Okay. Well, we can try.*

Susanne then invokes the genre of inquiry to open up for Linda’s thoughts:

17 *Susanne: What do you think about that?*

Linda offers only partial acceptance, thus expressing uncertainty about whether she can live up to the terms of the joint agenda - an uncertainty that was also present in her previous turn in the formulation “we can try” (line 16):

18 *Linda: Yes (laughs) If I can.*

In response to this expression of uncertainty, Susanne continues to invoke the genre of inquiry,

inviting Linda to elaborate on the grounds for her uncertainty:

19 Susanne: *What are you thinking in relation to, when you say, if you can?*

The shift from the genre of the sparring partner to the genre of inquiry can be understood as a result of Susanne's orientation to Linda's positioning of herself as uncertain about whether she can cope with the terms of the plan. By inviting Linda to reflect on the grounds for her uncertainty, Susanne opens up for an internal dialogue within Linda as well as dialogue between Linda and Susanne. The shift in genre from sparring to inquiry creates a centrifugal movement that opens up for multiple voices by creating space for Linda to reflect, in internal dialogue, on whether she has the capacity to begin a new diet. The genre of inquiry frames the interaction as a dialogue about Linda's ambivalence in relation to committing herself to the plan. The genre addresses a voice of "undecidedness" in Linda which is expressed when Linda positions herself as ambivalent in relation to her commitment to the plan.

In the subsequent sequence of turns, Linda presents an account of her experienced history of failed diets in the voice of everyday experience, articulating embodied, experiential knowledge, and Susanne backs Linda up in the genre of caring support:

20 Linda: *Yes, well, it's because I've been on diets hundreds of times. And I've given up every time.*

21 Susanne: *Yes.*

22 Linda: *I've sometimes lost 10 kilos but after a bit I've put it all on again. So it's a bit yoyo-like.*

23 Susanne: *But Linda, it's really difficult for lots and lots of people. You're not the only one who*

24 *finds it really difficult. And it can also be difficult to maintain your faith or gain faith if you*

25 *experience time after time that it doesn't work. I mustn't force you onto a diet. That's not the*

26 *point, in my view.* .

27 Linda: *I'm aware of that.*

Within the terms of the genre of caring support, Susanne recognises Linda's grounds for uncertainty

as legitimate. First, both Linda and Susanne present their claims in an objective modality, giving weight to their experiential knowledge as a form of evidence (lines 20, 22, 23-25). Linda presents general evaluative claims that apply to all her own personal experiences of dieting (lines 20, 22). Following this (lines 23-26), Susanne offers general evaluative claims but, in her case, they apply to people in general - a “generalized other” - and are articulated within the genre of caring support. Susanne and Linda co-construct a moral order in which Linda’s experiences are normatively validated and experiential forms of knowledge have authority as “evidence”. The shift to the genre of caring support brings with it a centripetal movement – that is, closure towards a normatively prescribed solution - as Susanne normalizes and hence legitimates Linda’s uncertainty about her capacity to stick to the plan by invoking the voice of the “generalized “other” who has experienced the same difficulties. Susanne also signals clearly that her role is not to force Linda to make a decision based on her (Susanne’s) perspective as opposed to Linda’s voice of experience (lines 25-26). Linda affirms Susanne’s point (line 27).

In her next turn, Susanne uses all three genres:

28 Susanne: *If you are interested in it, I'd like to have a dialogue with you about it? What have you*
29 *experienced before? And what thoughts do you have about it and about why it's gone wrong for*
30 *you? And maybe we can try together to find a way I can support you. It may be that it's not this*
31 *we should be working with right now but maybe something completely different? Now we're*
32 *talking about exercise and diets but sometimes one also has to look at the motivation for*
33 *things. And where do you think the focus should be so it doesn't get too overwhelming?*
34 Linda: *yes.*

With the first question (line 28), Susanne invites Linda, in the genre of the sparring partner, to engage in dialogue about finding a solution and, with the second and third questions (lines 28-30),

she speaks with a genre of inquiry to ground this dialogue in Linda's own experiences. In this way, she opens up, along centrifugal lines, for shared exploration across voices. Following this, she co-articulates the sparring partner genre and the genre of caring support in saying, "[a]nd maybe we can try together to find a way I can support you". Through the hedge, "maybe", Susanne's utterance is constructed as a suggestion that Linda would be able to reject by exercising her agency. Susanne then suggests that the exploration they are going to engage in may lead them to finding out together that Susanne's view on weight loss does not suit Linda (lines 30-31). Susanne backs her suggestion up by invoking the authoritative voice of the health care professional and implying that she (Susanne) has exclusive insight based on an expert gaze: *Now we're talking about exercise and diets but sometimes one has to look at the motivation for things* (lines 31-33). She ends with a question – straddling all three genres - making clear that the plan that they will construct together has to build on Linda's premises: *And where do you think the focus should be so it doesn't get too overwhelming?* (line 33). This exclusive insight based on an expert gaze stresses *the primacy of Linda's own experiential knowledge*, rather than external expertise, as the basis for joint decision-making, opening up, along centrifugal lines, for the voice of the other. Linda gives a minimal acceptance (line 34).

In the final sequences before the end of the conversation, Susanne co-articulates the genre of caring support and the genre of the sparring partner:

35 Susanne: *Because I would really like to help and support you.*

36 Linda: *Yes, well, that's always good. Because I have a high weight, so it would be good for everything.*

38 Susanne: *Should we have it as a focus point for next time?*

39 Linda: *Yes we can.*

40 Susanne: *And remember, Linda, you're allowed to put your foot down and say that I'm actually*

41 *not ready right now.*

42 Linda: *No but I'd like to try. We can always see how (laughs). Because I'm a master at giving up*

43 *It would be great if there's someone who can support you a bit.*

44 Susanne: *I would really like to try and will do my best to support you in it.*

Susanne's first utterance here is a clear statement of support in relation to the plan for action. Linda accepts it and, by referring to the benefit in the light of her "high weight", provides further backing for her dieting and exercise plan. In so doing, Linda speaks within the terms of the genre of sparring partner designed to support the plan for action. Susanne then opens up for Linda's opinion about whether to focus on the plan next time (line 38) and Linda affirms that she would like to (line 39). Susanne recognizes Linda's earlier reservations appreciatively and offers Linda the opportunity of rescinding on the plan (lines 40-41). Thus, Susanne continues to manage uncertainty by presenting the plan as open to challenge on the basis of Linda's preferences, in a centrifugal movement. Linda rejects this opportunity, in a centripetal movement, affirming her positioning within the genre of sparring partner whilst acknowledging uncertainty in relation to the question of success due to her experience of failure ("*I'm a master at giving up*", line 42). Through referring to this experience, Linda brings experiential knowledge into play as rhetorical support for building uncertainty with respect to success into the course of action. Whereas, in earlier utterances, Linda used her history of giving up to argue *against* the choice of weight loss as a possible plan for action along centrifugal lines, she now uses this history in a centripetal direction to support the point that the plan may not be successful. This implies that the plan is now in place and that following it entails shared recognition of the possibility of failure. Linda then speaks within the sparring partner genre in showing appreciation for Susanne's commitment as a sparring partner: "*It would be great that there's someone who can support you a bit*" (line 43). By abstracting from herself, Linda echoes Susanne's general claims and thus consolidates her position as a *supported* partner within the terms

of the genre of the sparring partner. Finally, Susanne co-articulates the genres of the sparring partner and caring support in affirming her commitment as a *supportive* sparring partner - “*I would really like to try*” (line 44). Here, Susanne suggests a degree of uncertainty in relation to the outcome, echoing Linda’s uncertainty and thus *both* showing solidarity with Linda in the genre of caring support *and* reinforcing the view that the plan is in place with uncertainty built into it.

Both Linda and Susanne are now enrolled with joint responsibility for the success of the plan. Susanne’s combination of the genres of inquiry and caring support consolidate a “we” that is committed to the plan. Re-accentuated within the voice of the health care professional, experiential knowledge configures personal feelings of uncertainty as insufficient grounds for not trying the diet. This is because Linda’s grounds for uncertainty are normalized as shared by everyone. Implicit here is the normative point that, if others can lose weight, then so too can Linda. The normality of uncertainty both legitimates Linda’s uncertainty and also makes it possible for Linda to succeed despite her uncertainty. Thus the combination of the genres of inquiry and caring support creates a centripetal movement which, on the one hand, recognises Linda’s uncertainty and, on the other hand, de-legitimises Linda’s grounds for doubt. Uncertainty becomes contained within the safe bounds of the plan rather than remaining an external threat. This development is clear in the final turns of the sequence in which Linda demonstrates that she has accepted the plan as a collaborative endeavour, adopting the position of supported partner in the genre of the sparring partner.

This example has shown how experiential knowledge is harnessed in a centrifugal direction across three genres in order to create a joint plan for action that embraces different voices and is designed to enhance the citizen’s capacity for self-help. The centrifugal movement is in play in the opening up, in the genre of inquiry, for citizen’s reflections based on their experiential knowledge in order to build the citizen’s capacity for self-help. Along centripetal lines, the singular

knowledge of experience, re-accentuated in the authoritative voice of the health care professional, is tied to the plan for action through the articulation of the genre of the sparring partner in conjunction with either the genre of inquiry or the genre of caring support. The centripetal movement works to contain uncertainty within the terms of the plan for action and thus furthers closure in the form of acceptance of the plan for action.

The maintenance of a plan for action by the containment of uncertainty across genres

This second, and brief, example emanates from the conversation that immediately followed the conversation in the first example. At this stage, Linda is now in the process of carrying out the plan and the example focuses on its maintenance. It shows how experiential knowledge is re-accentuated in shifts between the three genres in ways that further consolidate Linda's continuing uncertainty as an integral element in the plan:

1 Susanne: *When we talk about exercise, what do you think about exercise, when you hear the*
2 *word exercise? And the reason why I'm asking you, Linda, what you think about when I*
3 *mention the word exercise, is simply because I know that a lot of people, when we talk about*
4 *exercise, most people imagine that it's to do with running 10 kilometers and that can be a bit of*
5 *an impossible mountain to climb. And I also hear you say that you have your exercise bike and*
6 *you mention walks and you know what, all of that is completely fine [...].*

7 Linda: *Yes, I just need to do it a bit more often because a walk and a cycle once a week is*
8 *probably not quite enough.*

9 Susanne: *No, but you have been out walking and I've also heard you say that you've cycled on*

10 your exercise bike, so you have got started. Sometimes things happen even if the weighing
11 machine doesn't show it.

12 Linda: Yes, but that's where I want to see results.

13 Susanne: I can understand that. Are there any ways where you think you could organise your
14 training – whether it's a walk or a go on your exercise bike - are there any times during the
15 day?

16 Linda: I also sat and thought about that, but I've just had two days where I've been feeling bad
17 and so I haven't done anything [Susanne: No].

In the first turn, Susanne opens up, in the genre of inquiry, for Linda's thoughts about exercise (lines 1-2). Explaining her reasons for asking, Susanne re-accentuates experiential knowledge within the terms of the voice of the professional health care expert (lines 2-5). Susanne then co-articulates the genres of the sparring partner and caring support in confirming the legitimacy of the activities preferred by Linda – using her exercise bike and going for walks (lines 5-6). The status of Susanne's utterances as expert knowledge is underscored by their re-accentuation as points that do not just apply to Linda but to people in general – the “generalized other”. Expert knowledge is located within a moral order whereby its validity is grounded in experience conforming to norms for everyday behaviour – rather than being grounded in scientific evidence. Linda responds in the genre of sparring with statements that indicate that she is acting in line with the health care knowledge presented by Susanne but is experiencing frustrations over not losing enough weight and not exercising enough (lines 7-8, 12). Susanne responds in the genre of inquiry with a question about how Linda can organise her training (lines 13-15). This shift from the genres of the sparring partner and caring support to the genre of inquiry can be understood as a way of responding to Linda's frustrations: the inquiry question opens up for Linda's reflection on how she could refine

the course of action. Linda indicates that she was already thinking along these normatively prescribed lines but has been constrained by ill-health (lines 16-17).

There is a high degree of intertextuality between this example and the preceding example. This is clear from the ease with which Linda, in this example, takes on the position as supported partner within the genre of the sparring partner, showing her commitment to the plan which she is now in the process of following. As in the preceding example, experiential knowledge is invested with normative weight in the voice of the health care professional as Linda's difficulties are configured as completely in line with the experiences of the "generalized other" and therefore normal and morally acceptable. And, as in the preceding example, the way in which experiential knowledge is re-accentuated in the voice of the health care professional creates a centripetal discursive movement in which Linda's personal voice, expressing her uncertainty, is marginalized. Linda's personal voice loses value in their relation – as a voice that they should take particular account of - as it is equated with the voice of the "generalized other". At one and the same time, Linda's personal grounds for giving up are stripped of their legitimacy *and* she is provided with caring support. Since Linda, in this second example, is in the process of carrying out the plan, the centripetal movement creates and supports a stronger enrollment of Linda in the plan than in the preceding example. Thus the three genres can be understood as technologies of patient-centred practice that detach the patient's subjective experience from decision-making. Such a detachment, May et al. (2006: 2017) argued, is a key effect of technologies in the form of guidelines, protocols and decision-making tools for patient-centred practices.

Conclusion and further perspectives on inclusion and exclusion in the enactment of patient-centredness

As noted in the introduction, several studies point at a gap between the ideals and practice of patient-centredness. In this article, we have proposed that what are often identified in the literature as obstacles to the implementation of “patient-centred” care can be fruitfully understood as tensions intrinsic to “patient-centredness”. Thus the issue, from our perspective, is *not* that “patient-centredness” is difficult to implement in practice but that patient-centredness in practice is an unstable product of dialogic meaning-making and hence an inherently complex, tension-ridden entity. Our theoretical premise, building on IFADIA’s combination of Bakhtin’s dialogue theory and Foucault’s theory of knowledge/power and discourse, is that meaning-making in dialogue is based on dynamics of exclusion and inclusion.

Our analysis in this article explored how “patient-centredness” was enacted through tensional meaning-making in the interweaving of genres and voices in counselling conversations in the Active Patient Support programme. The interweaving of genres and voices constructed a normatively prescribed moral order in which the citizen was morally responsible for regulating her own weight by following a plan for dieting and exercise that the nurse and citizen co-created. Thus, to use Rose’s terminology, the citizen was inscribed as a self-disciplining biocitizen with personal responsibility for making choices about her lifestyle and health care and, more generally, for self-governance to support her own well-being (Rose 2007). Central to the enactment of “patient-centredness” in the counselling conversations was an orientation to tackling the patient’s uncertainty and strengthening her capacity for self-help. Dynamics of inclusion and exclusion both enabled and circumscribed the citizen’s scope for action. These dynamics were in play through genres that stipulated activities of sparring, inquiry and caring support, leading to the enrollment of the citizen as a partner in sparring in ways that made resistance to the emergent plan for action

difficult. Resistance became difficult since the nurse, by invoking the voice of the “generalized other”, normalized the citizen’s uncertainty with respect to following the self-care plan and hence de-legitimised uncertainty as grounds for not trying (the first example) or giving up (the second example). Hence the three genres served as decision-making technologies (May et al. 2006) that enabled and circumscribed the citizen’s way of acting in normatively prescribed directions. In particular, the genres worked as decision-making technologies by detaching the patient’s subjective experience from the decision-making process. As noted above, May et al. (2006: 2017) have identified such a detachment as a key (unintended) effect of technologies of patient-centred practice.

This ascription of personal responsibility to the citizen may entail the individualization of responsibility along neoliberal lines. While self-discipline is integral to inscription in *any* discourse, it takes a particularly strong form in the neo-liberal discourse since the individualization of responsibility and the self-governing, responsibilised, ‘enterprising’ subject are defining characteristics of neo-liberal discourse (Fotaki, 2011). According to Mol (2008), such individualization occurs when a “logic of choice” is in operation in which the patient’s scope for action is reduced to the making of treatment choices on the basis of the health professional’s non-negotiable knowledge. Mol contrasts the “logic of choice” with the “logic of care” in which the health professional and the patient share responsibility and collaboratively arrive at decisions for the patient’s care through the negotiation of knowledges. In the counselling conversations analysed in this article, the logic of care is clearly in operation as the nurse and citizen take *shared* responsibility for the plan through negotiating knowledge in voices that present experience-based knowledge claims.

IFADIA draws attention to dynamics of inclusion and exclusion in the logic of care. The centrifugal force towards multiple voices is in interplay with the centripetal force that excludes

the voice of resistance in the movement towards closure in the form of a plan. Thus collaborative decision-making about the plan is characterized by the tension between empowerment – the extension of the citizen’s agency in making decisions and acting in relation to living with chronic illness - and self-discipline – inscription as a self-governing, self-monitoring subject in a discourse of self-care that circumscribes, as well as enables, the citizen’s agency along the normative lines of the discourse (Rose, 2007).

We have arrived at insight into the tension between self-discipline and empowerment by working with IFADIA by virtue of its analytical attention to power in the form of dynamics of exclusion and inclusion. Through IFADIA’s interest in these dynamics, it attends not only to the unintended effects of patient-centredness but also opens up for the further development of patient-centred practice – not least, the enhanced inclusion of multiple voices - through reflexivity about the workings of the dynamics. It follows from the position that the tensions in “patient-centredness” are intrinsic that the resulting dynamics of inclusion and exclusion cannot be ironed out through strategies to close the gap between the ideals and practice of patient-centred care. The article’s theoretical perspective points at reflexivity as the most appropriate strategy for dealing with the intrinsic tensions and concomitant power dynamics. Reflexivity draws our attention to precisely *how* particular knowledges and participant subjectivities emerge out of the negotiation of meanings in the interweaving of genres and voices (Phillips et al. 2013, Finlay 2002, Olesen and Nordentoft 2018). Reflexivity about the tensions entails sensitivity to how the interactional moves of participants in dialogue are performative in co-creating social realities and, by excluding alternatives, reproducing power relations.

Therefore, in the action research project attached to the Active Patient Support programme, we have worked to cultivate that reflexivity through joint analyses with the counselling team of nurses of extracts from counselling conversations including the ones analysed in this article

(see Phillips and Scheffmann-Petersen 2019, 2020). One of the methods used was the “forum play” in which nurses did not just talk about practice but repeatedly acted out different ways of tackling the tension between self-discipline and empowerment in a specific conversational situation. This method was designed to generate embodied learning from “within practice” (Phillips and Scheffmann-Petersen, 2019, 2020). We suggest that the strategy of reflexivity in the action research process helped to strengthen the logic of care in the Active Patient Support programme. It did so as nurses gained a reflexive awareness of the tension-ridden play of power in patient-centred communication and also concrete strategies for tackling the tension between self-discipline and empowerment which they could put to use in counselling conversations to further the *sharing* of responsibility through the negotiation of knowledge across genres and voices.

Acknowledgements

We would like to thank Region Zealand for funding the research and all the participating citizens and members of the counselling team of nurses for their contributions to the research. We would also like to thank the anonymous reviewers and the Dialogic Communication Research Group at Roskilde University for their helpful comments on a draft of the article.

Ethics Approval

Ethics approval from a board of ethics was not required for this article as it is not customary in Denmark. The research was carried out in full accordance with the norms for ethical practice followed in Region Zealand, Denmark. Full participant consent was obtained in line with ethical guidelines in Region Zealand.

Funding

The authors disclosed receipt of the following financial support for the research, authorship, and/or publication of this article. Both the authors received financial support from the Centre for Data and Development Support, Region Zealand, Denmark, to carry out the research presented in this article. Michael Scheffmann-Petersen carried out the research as a postdoctoral project that was fully funded by Region Zealand. The research was based on an action research project on the Active Patient Support programme which the coauthors, citizens, and the counselling team of nurses attached to the programme carried out.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Address for correspondence: Louise Phillips, Department of Communication and Arts, Roskilde University, Universitetsvej 1, 4000 Roskilde, Denmark. Email: louisep@ruc.dk. Orcid ID: <https://orcid.org/0000-0001-7493-9430>

References

- Armstrong, D. (2011). The invention of patient-centred medicine. *Social Theory & Health*, 9, 410–418.
- Bakhtin, M. (1981) *The Dialogic Imagination: Four Essays*. Ed. M. Holquist (Ed.). C. Emerson & M. Holquist (trans). Austin: University of Texas Press.
- Bakhtin, M. (1984) *Problems of Dostoevsky's Poetics*. Ed. and Trans. Carly Emerson. University of Minneapolis: Minnesota Press.

- Bakhtin, M. (1986) *Speech genres and other late essays*. University of Texas Press, Austin.
- Castro, E. M., Van Regenmortel, T., Vanhaecht, K., Sermeus, W. , Van Hecke, A. 2016 Patient empowerment, patient participation and patient-centeredness in hospital care: A concept analysis based on a literature review, *Patient Education and Counselling*, 99, 1923–1939.
- Craig, R. T. (1999) Communication theory as a field, *Communication Theory*, 9, 119–161.
- Davis, S., Byers, S., Nay, R., and Koch, S. (2009) Guiding design of dementia friendly environments in residential care settings: considering living experiences, *Dementia*, 8, 185–203.
- Edvardsson, D., Winblad, B. and Sandman, P. O. (2008) Person-centred care of people with severe Alzheimer's disease: current status and ways forward. *Lancet Neurology*, 7, 362–67.
- Eklund, J., Holmströma, I., Kumlina, T., Kaminsky, E., Skoglunda. K., Högländera, J., Sundlerc, A., Condénd, E. and Summer, M. (2019) Same same or different? A review of reviews of person-centered and patient-centered care. *Patient Education and Counselling*, 102, 3–11.
- Epstein, R. M., Street, R. L. (2011) The values and value of patient-centered care. *Annals of Family Medicine*, 9, 100–103.
- Finlay, L. (2002) Negotiating the swamp: the opportunity and challenge of refl exivity in research practice. *Qualitative Research*, 22, 209–230.
- Foucault, M. (1972) *Archaeology of Knowledge*. Routledge. London.
- Foucault, M. (1977) *Discipline and Punish: The Birth of the Prison*. Penguin, Harmondsworth.
- Foucault, M. (1980) Truth and Power. In C. Gordon (Ed.) *Power/Knowledge. Selected Interviews and other Writings 1972-1977*. Harvester Wheatsheaf.
- Foucault, M. (1991) 'Governmentality', trans. Rosi Braidotti and revised by C. Gordon. In G. Burchell, C. Gordon and P. Miller (Ed.) *The Foucault Effect: Studies in Governmentality*, pp. 87–104. Chicago, IL: University of Chicago Press.

- Gardner, J. and Cribb, A. (2016) The disposition of things: the non-human dimension of power and ethics in patient-centred medicine, *Sociology of Health & Illness* 38, 7, 1043–1057.
- Gardner, J. (2016) Patient-centred medicine and the broad clinical gaze: measuring outcomes in paediatric deep brain stimulation, *BioSocieties*, 12, 2, 239–256.
- Hammond, S., Anderson, R. and Cissna, K. (2003) The problematics of dialogue and power, *Communication Yearbook*, 27, 125-157.
- Hong, X., Falter, M. and Fecho, B. (2017) Embracing tension: using Bakhtinian theory as a means for data analysis, *Qualitative Research*, 17, 20–36.
- Hsieh E., Bruscella, J., Zanin, A. and Kramer, E. (2016) “It’s not like you need to live 10 or 20 years”: Challenges to patient-centered care in gynecologic oncologist-patient interactions, *Qualitative Health Research*, 26, 1191-1202.
- Kitson, A., Marshall, A., Bassett, K. and Zaitz, K. (2012) What are the core elements of patient-centered care? A narrative review and synthesis of the literature from health policy, medicine and nursing, *Journal of Advanced Nursing*, 69, 4-15.
- Liberati, E., Gorli, M. and Moja, L. (2015) Exploring the practice of patient centered care: the role of ethnography and reflexivity, *Social Science & Medicine*, 133, 45-62.
- Lord, L. and Gale, N. (2014) Subjective experience or objective process: understanding the gap between values and practice for involving patients in designing patient-centred care, *Journal of Health Organisation and Management*, 28, 714–30.
- May, C., Rapley, T., Moreira, T., Finch, T. and Heaven, B. (2006) Technogovernance: Evidence, subjectivity, and the clinical encounter in primary care medicine, *Social Science & Medicine*, 62, 1022-1030.
- Mead, N. and Bower, P. (2000) Patient-centredness: a conceptual framework and review of the empirical literature, *Social Science & Medicine*, 51, 1087–1110.

- Mol, A. (2008) *The Logic of Care: Health and the Problem of Patient Choice*. London: Routledge.
- Nolan, M., Davis, S., Brown, J., Keady, J. and Nolan, J. (2004) Beyond person-centred care: A new vision for gerontological nursing, *International Journal of Older People Nursing*, 13, 45–53.
- Olesen, B. R. and Nordentoft, H. (2018) On slippery ground: Beyond the innocence of collaborative knowledge production, *Qualitative Research in Organisations and Management: An International Journal*, 13, 356-367.
- Petrakaki, D., Hilberg, E. and Waring, J. (2016) Between empowerment and self-discipline: Governing patients' conduct through technological self-care, *Social Science & Medicine*, 213, 1069–1076.
- Phillips, L. (2011) *The Promise of Dialogue: The Dialogic Turn in the Production and Communication of Knowledge*. Amsterdam: John Benjamins Publishing Company.
- Phillips, L., Kristiansen, M., Vehvilainen, M. and Gunnarsson, E. (Eds.) (2013) *Knowledge and Power in Collaborative Research: A Reflexive Approach*. London and New York: Routledge.
- Phillips, L., & Scheffmann-Petersen, M. (2019) Inclusion and exclusion in action research on person-centered health care: A framework for cultivating the tensions in dialogue. In L. Hersted, O. Ness, & Frimann, S. (Eds), *Action Research in a Relational Perspective: Dialogue, reflexivity, power and ethics*. London: Routledge.
- Phillips, L. and Scheffmann-Petersen, M. (2020) Minding the gap between the policy and practice of patient-centeredness: co-creating a model for tensional dialogue in the ‘Active Patient Support’ program. *Qualitative Health Research*. Published online.
- Quinlan, E. (2009) The ‘actualities’ of knowledge work: an institutional ethnography of multi-disciplinary primary health care teams, *Sociology of Health & Illness*, 31, 625-641.
- Renedo, A., Komporozos-Athansiou, A. and Marston, C. (2018) Experience as Evidence: The Dialogic Construction of Health Professional Knowledge through Patient Involvement, *Sociology*,

52, 691-715.

Rose, N. (2007) *The politics of life itself: Biomedicine, power, and subjectivity in the twenty first century*. Princeton, NJ: Princeton University Press.

Sullivan, M. (2003) The new subjective medicine: taking the patient's point of view on health care and health, *Social Science & Medicine*, 56, 1695–1604.

Thompson, A. (2007) The meaning of patient involvement and participation in health care consultations: A taxonomy, *Social Science & Medicine*, 64, 1297–1310.