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cocreating a model for tensional dialogue in the 'Active Patient Support' program

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**Minding the gap between the policy and practice of patient-centeredness: co-creating a model for  
tensional dialogue in the ‘Active Patient Support’ program**

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**Abstract**

Several studies identify obstacles to patient-centered care that can be eradicated by bridging the gap between policy goals and practice. In this article, “patient-centeredness” is theorised as an unstable entity riddled with intrinsic, ineradicable tensions. The purpose of the article is to propose a reflexive approach to the tensions as the most appropriate strategy for narrowing the gap between policy and

practice. The reflexive approach is illustrated in an account of an action research project on a Danish, patient-centered initiative, “Active Patient Support”. The account focuses on the development of a dialogic communication model through collaborative, reflexive analyses of the tensions in the enactment of “patient-centeredness” in dialogue between health care practitioners and citizens – in particular, the tension between empowerment and self-discipline. Finally, the conceptual expansion of one of the dimensions of patient-centeredness, “health practitioner-as-person”, is discussed as a platform for reflexivity, and the limitations of reflexivity are addressed.

## **Minding the gap between the policy and practice of patient-centeredness: co-creating a model for tensional dialogue in the ‘Active Patient Support’ program**

### **Introduction**

“Patient-centeredness” has become a central principle of health care policy in many countries. It is the product of a development which began after the Second World War and, from the 1990’s onwards, has accelerated as part of a so-called dialogic turn - a general societal tendency in which collaborative ways of generating and communicating knowledge have proliferated across fields including health and social care (Aubert & Soler, 2006; Phillips, 2011, 2012). A basic ideal of the dialogic turn is the democratization of knowledge whereby multiple ways of knowing (including experiential, embodied knowledges) are recognized as legitimate knowledge forms and, as a result, knowledge and identities – including the roles of “expert” and “patient” - have become objects of heightened negotiation. According to this ideal, placing the patient in the “centre” in patient-centered communication entails

that patients take on the role as empowered “active patients” and “co-producers” in the management of their health, and health care practitioners shift from being authoritative experts to being facilitators in shared decision-making (Eliacin et al., 2014; Liberati et al., 2015; Sullivan, 2003).

Several studies of patient-centeredness describe a gap between the policy goals and practice, suggesting that the policy principle of patient-centeredness is difficult to implement in practice (Applequist et al., 2017; Franklin et al., 2018; Gardner & Cribb, 2016; Hsieh et al., 2016; Lord & Gale, 2014). A number of researchers point to the multiple meanings and lack of a clear, common definition of patient-centeredness as a factor underlying implementation problems (Eklund et al., 2019; Langberg et al., 2019; Lord & Gale, 2014). To contribute to developing a clear definition of patient-centeredness and hence improving its implementation, several scholars have carried out systematic reviews of the literature and extrapolated a number of dimensions that define the nature of patient-centeredness (e.g. Castro et al., 2016; Eklund et al., 2019; Langberg et al., 2019; Mead & Bower, 2000).

In the reviews, shared or collaborative decision-making is recognised as a key component of patient-centered communication. However, the reviews tend to refer to collaborative decision-making either as if it were a straightforward process, or as if it could become straightforward were the dimensions of patient-centeredness to be properly followed. A starting-point for this article is that the understanding of collaborative decision-making as a straightforward process reflects a general tendency in the dialogic turn to romanticize dialogue as a purely inclusive process in which participants engage in “authentic” communication characterised by symmetrical power relations (Phillips, 2011, Phillips et al., 2012, 2013, 2018). In this article, we apply a theoretical framework – based on a combination of Bakhtin’s theory of dialogue and Foucault’s theory of power/knowledge and discourse – that theorizes dialogue in patient-centered communication as complex processes of tension-ridden meaning-making

involving dynamics of exclusion as well as inclusion. According to this framework, knowledge, identities (for example, citizen identities as “active patients” and health practitioners’ identities as “facilitators of collaborative decision-making”) are negotiated in dialogue. Power is in play such that certain forms of knowledge and identities dominate and others are marginalized or silenced (see also Gardner & Cribb, 2016).

The theoretical framework presented in this article proposes a view of implementation difficulties as *intrinsic tensions* in patient-centeredness, not obstacles that can be eradicated through the application of all the dimensions of patient-centeredness. The article suggests that the gap between the policy and practice of patient-centeredness can be narrowed through a reflexive approach to the intrinsic tensions. The purpose of the article is to demonstrate the value of this reflexive approach as a contribution to practice-oriented research on patient-centeredness. We illustrate the approach by giving an account of its use in developing a dialogic communication model in an action research project on the Danish, patient-centered health care program, Active Patient Support. The research question that we addressed in the action research project is as follows. ***How can the gap between the policy and practice of patient-centeredness be narrowed by the development of a dialogic communication model through a reflexive approach to the intrinsic tensions in patient-centeredness?***

Our analysis of the action research workshop with patients in the program produced the insight that, in patients’ reflections, the different dimensions of “patient-centeredness” were not discrete but rather intertwined in complex, tensional meaning-making. This insight fundamentally shaped the subsequent stage of the action research process – the workshops with the counselling team of nurses in which we and the nurses carried out collaborative, reflexive analyses of the intrinsic tensions in patient-centeredness. The product of the collaborative, reflexive analyses in the workshops with the counselling team was a dialogic communication model that cultivates and conceptually

expands the dimension of patient-centeredness, “health-practitioner as person”, which had previously been one of the dimensions identified in the literature but has been removed in the most recent reviews. In our account of the action research process, we highlight the conceptual expansion of the dimension of patient-centeredness as a central component of the reflexive approach and hence as itself a key contribution to practice-oriented research.

We first give an account of how patient-centeredness is defined in terms of a set of discrete dimensions in the literature and present our theoretical framework and the methods applied in the action research project on Active Patient Support. Following this, we illustrate how we developed a dialogic communication model by working in the action research project with a reflexive approach to the intrinsic tensions in patient-centeredness. We do this with illustrative extracts from the action research workshops which formed the fora for collaborative knowledge production. We show how, in the action research workshop with patients, we discovered that the dimensions of patient-centeredness were intertwined in patients’ reflections on their participation in the program. Then, building on this insight, we demonstrate how, in the action research workshops with the counselling team of nurses, we engaged with the nurses in collaborative, reflexive analyses of a tension between empowerment and self-discipline. The tension arose in the specific ways in which the dimensions of “patient-centeredness” were intertwined in counselling conversations. In conclusion, we critically discuss the complexities of a reflexive approach to working with the tensions in “patient-centeredness”, and in particular, the tension between empowerment and self-discipline. We also address the limitations of reflexivity and argue for the conceptual expansion of the dimension of patient-centeredness, “health practitioner-as-person”, as a central component of the reflexive approach.

## **Defining the concept of patient-centeredness**

As noted above, a series of systematic reviews of the usages of “patient-centeredness” in the research literature have, across the different usages, identified clusters of principles. A standard principle is that patients are empowered as active participants in collaboratively creating knowledge and co-producing decisions about their own care together with health practitioners (Liberati et al., 2015; Sullivan, 2003). This principle is based on the democratisation of knowledge whereby a plurality of voices, articulating multiple forms of knowledge, are recognised and heard (Armstrong, 2011; Phillips, 2011; Renedo et al., 2018).

The categorization of the concept of patient-centeredness in terms of five dimensions in Mead and Bower’s systematic review in 2000 has been particularly influential. Using Mead and Bower’s categorization as their baseline, Langberg et al. (2019) have carried out a more recent systematic review between January 2000 and June 2017 in order to generate an up-to-date definition of the concept. Langberg et al. arrived at five dimensions (2019, p. 1231): “sharing power and responsibility”; the “therapeutic alliance”; “patient-as-person”; “biopsychosocial”; and “coordinated care”. “Sharing power and responsibility” means that the patient and health care practitioner engage in collaborative decision-making in an egalitarian doctor-patient relationship (Langberg et al., 2019, p. 1232). “Empowerment” and “participation” are central components of this dimension: the patient is empowered as an active participant in decision-making. The “therapeutic alliance” consists in valuing, and giving priority to, the relationship of mutual respect between the health care practitioner and the patient (Langberg, et al., 2019, p. 1232). “Patient-as-person” entails that the health care practitioner strives to understand the patient’s experience of illness in terms of the meanings that the patient herself

ascribes to illness in the context of her past and present life situation (Langberg, et al., 2019, p. 1233). The “biopsychosocial” dimension is often described as a holistic, “whole person” approach encompassing understanding the patients' illness not only in relation to biomedical, but also mental and social, aspects (Langberg, et al., 2019, p. 1233). The final dimension, “coordinated care”, consists in a focus on the management of the patient’s care across the different parts of the health care system (Langberg, et al., 2019, p. 1233). This is the only dimension which did not figure amongst those identified by Mead and Bower. Langberg noted an increase in its mention from 2009 onwards. The systematic reviews of the literature map the different usages of “patient-centeredness” at a relatively high level of abstraction and do not go into depth with specific practices whereas much of the literature covered in the systematic reviews includes analyses of specific practices. However, both the systematic reviews and the reviewed literature share an understanding of the dimensions as separate entities that together make up “patient-centeredness”. Moreover, some of them suggest that a clearer definition of patient-centeredness can contribute to narrowing the gap between the policy and practice of “patient-centeredness” and further its implementation (e.g. Eklund et al., 2019; Langberg et al, 2019; Lord & Gale, 2014).

As noted earlier in this article, analysis of patients’ reflections on their participation in the program – in interplay between the theoretical framework and the empirical material - produced the insight that the above dimensions of patient-centeredness were intermeshed with one another in complex, tensional processes of dialogue in which power is always in play. Instead of an approach directed at eradicating the tensions and establishing symmetrical power relations, the article illustrates the use of a reflexive approach to the tensions as a way of helping practitioners to further “patient-centeredness” and hence narrow the gap between policy and practice. In developing this reflexive approach in the action research process, we carried out a conceptual expansion of the dimension,



“doctor-as-person” which is a dimension of patient-centeredness in Mead and Bower’s review (2000) that Langberg (2019) removed on the grounds of its sparsity in more recent articles.

## **Theoretical framework**

The theoretical framework underpinned the whole research process, including the design of the action research process and the reflexive approach applied in collaborative analyses of the tensions in counselling conversations and of the tensions in the research process itself. The framework is entitled the “Integrated Framework for Analysing Dialogic Knowledge Production and Communication” (IFADIA) and draws on 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 identities -is *constituted* in meaning-making in communication processes (e.g. Gergen, 1994).

By building on social constructionism, IFADIA has an affinity with other social constructionist approaches to reflexive action research (e.g. Cunliffe, 2002; Ripamonti, 2016; Shotter, 2010). It also shares with other social constructionist research on knowledge production in health care a focus on knowing as a social activity taking place in the negotiation of meaning in communication processes in specific contexts of practice (e.g. Hsieh et al, 2016; Liberati et al., 2015; Quinlan, 2009). However, IFADIA is distinctive because it draws on a combination of Bakhtin’s theory of dialogue and Foucault’s theory of power/knowledge and discourse. In Bakhtin’s understanding, voices are not just the media for speech or the uttered speech of embodied persons but also discourses, ideologies, perspectives or themes (Bakhtin, 1981). The same person may articulate multiple voices, including contradictory ones that construct competing knowledges and identities. People simultaneously address

the voices of the addressee in the conversation and the voices of others who are not present (“inner others”) (Bakhtin, 1984, 1986). The meaning of an utterance does not lie in the utterance itself but is created in the interplay between the utterance, past utterances and responses in specific situations across a polyphony of voices. 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 one, full of tensions (Bakhtin, 1981).

Applying IFADIA as a theoretical framework entails an analytical focus on these tensions. In assigning analytical centrality to tensions, IFADIA is in line with Stewart and Zediker’s approach to dialogue as tensional, ethical practice (2000), the Bakhtinian, tensional approach to data analysis proposed by Hong et al. (2017) and also the Bakhtinian analysis carried out by Renedo et al. (2018) of how, in patient-centered care, the negotiation of knowledge forms across different voices creates hybrid knowledge. It differs, however, in adding a Foucauldian take on discourse and power/knowledge. Foucault asserts that our knowledge of the world and our subjectivities – our experience of self and others – come into being through the social production of meaning in historically contingent discourses that exclude or marginalise other ways of being, knowing and doing (Foucault, 1972, 1977, 1980).

Combining Bakhtin and Foucault, IFADIA conceptualizes discourses as “voices”. Each voice constructs a particular form of knowledge and particular subjectivities. In meaning-making through the interplay between different voices – and in our case, the making of the meaning of “patient-centeredness” - certain voices, and therefore certain forms of knowledge and identities, dominate and others are marginalised. IFADIA adds Bakhtin’s concept of “genre” in order to theorise dynamics of

inclusion and exclusion further. Genres frame, and hence circumscribe, meaning-making across voices by stipulating ways of acting (Bakhtin, 1984, 1986). The intertwining of voices and genres brings “patient-centeredness” into being in particular ways that make possible *and* set the boundaries for participants’ ways of being, knowing and acting.

IFADIA treats critique of dynamics of inclusion and exclusion as the basis for a reflexivity that can lead to the further development of practices. Reflexivity is not meant as a basis for eradicating exclusion. For Bakhtin, since both centrifugal and centripetal forces are generative of meaning-making, it would not make any sense to attempt to eliminate the centripetal forces that lead to the dominance of certain voices. And, for Foucault, since meanings are always constructed in discourses that exclude alternative ways of organizing the world, a dominance-free zone for equal relations is an illusion. Reflexivity is a well-established research strategy for dealing with the consequences of the social constructionist, post-foundational position that all knowledge is a situated and contextual product of contingent representations of the world rather than a neutral, context-independent foundation (Cunliffe, 2002; Ripamonti et al., 2016). Reflexivity draws our attention to precisely *how* particular knowledges and identities emerge out of the negotiation of meanings in the interweaving of genres and voices. In the action research process, we paid reflexive attention to the tensions in dynamics of inclusion and exclusion *both* in the counselling conversations *and* in the action research process itself. In this article, we focus on the former; for an analysis of the latter, see Phillips & Scheffmann-Petersen (2019). In relation to analyses both of the counselling conversations and the action research process, it is important to recognize as an inexorable limitation of reflexivity that the critique of power relations produced through reflexivity is circumscribed since it is itself discursively constructed from a particular perspective and imbued with power, entailing the exclusion of other perspectives. We return to the limitations of reflexivity in the article’s conclusion.

IFADIA's approach to reflexivity embraces sensitivity towards bodily experiences and emotions as among the dynamic forces that bring social realities into being. It follows the social constructionist and post-structuralist suggestion that attention to feelings of discomfort may, by challenging our sense of certainty, jolt us out of a position of control and towards recognition of how our interactional moves are performative in co-creating social realities (Cunliffe, 2002). In particular, IFADIA draw on Cunliffe's theorization of reflexive learning as "an embodied (whole body), responsive understanding in which we are 'struck'" (2002, p. 42). Central to being "struck" is the "feeling that there is something important we cannot quite grasp in the moment". "Being struck" may stimulate reflexive learning in which tacit knowing forms the basis for the creation of explicit knowledge (Cunliffe, 2002, p. 42). Because this reflexive learning has its roots in situated meaning-making in everyday practice, it encompasses "a responsive knowing-from-within" as opposed to intellectual critique from outside practice (Cunliffe 2002, p. 47). In this article, we show how the action research workshops nurtured reflexivity both from outside and from within practice.

### **The Active Patient Support program and the action research design**

The Active Patient Support program (APS), and the program's action research project which we use as an illustration of our reflexive approach to the tensions in "patient-centeredness" in this article, were the initiatives of the health administration in the Zealand Region, Denmark. APS is designed for citizens with chronic illnesses who make relatively frequent use of the health service and have a relatively high number of hospital readmissions. In APS, individual citizens receive regular telephone counselling from their own personal support nurse over a period of six to nine months (the nurse phones the patient every one or two weeks for 30 minute conversations). The aims of APS are to

improve the quality of life of patients and cut health care costs by reducing the frequency of hospitalisation.

While the program is entitled Active Patient Support, the counselling team refer to the participants as “citizens”, rather than “patients”. This reflects a holistic thinking that underpins the literature on “person-centeredness” in which “person” is used rather than “patient” in order to challenge the weighting of medical expertise implied by a centring on the “patient” (Edvardsson et al., 2008) and to stress the importance of a meaningful, and not just a functional, life (Eklund et al., 2019; McCormack and McCance, 2006). The epithet, “active patient”, in the title of the Active Patient Support program is a reflection of the continued dominance of the term, “patient”, in Danish health care discourse. The contrasting use of “active patient” in the program title and “citizen” in the counselling team’s everyday work practice and in the action research project may reflect the tension identified and tackled in the action research project between empowerment and self-discipline. Empowerment extends the citizen’s agency as a (whole) person whereas self-discipline inscribes the citizen as a patient within a neo-liberal discourse of self-care infused with the norms of professional health care expertise (Petракaki et al., 2016; Rose, 2007).

The Zealand Region health administration’s motivation for commissioning the action research project was to strengthen the adherence of the APS program to the ideals of patient-centeredness. A major concern was to try to avoid the individualisation of responsibility – a risk associated with the identity of “active patient” – and, instead, to try to further empowerment through collaborative decision-making about strategies of self-care in which both nurses and citizens share responsibility for the process and outcome.

In common with other kinds of action research, the action research project was organized in spiral cycles of planning, acting, observing and reflecting, and sought to democratize research relations and further social transformation through the participation of researchers and actors in the field under study in the co-production of knowledge and practice change (see e.g. Reason & Bradbury, 2013). At the same time, it represented a distinctive kind of action research by virtue of IFADIA's social constructionist, Bakhtinian understanding of voice as an unstable product of situated meaning-making (rather than a manifestation of a human inner core), and its post-structuralist commitment to the critical interrogation and destabilization of taken-for-granted truths as the products of discourses. These two features underpin the integration into IFADIA-informed action research of reflexive analyses of the tensional, power-imbued, negotiation of knowledge and identities across voices (Phillips & Scheffmann-Petersen, 2019).

The participants in the action research project were two university researchers (the co-authors of this article), seven participating citizens (six women and one man) in the APS program and all members of the APS counselling team of nurses (all female). The participants spoke Danish very well and had no communication disabilities. All citizens in the APS program were invited to participate in the action research project by the nurses; seven of the citizens accepted the invitation. The action research process consisted of three strands. In the first strand, the two university researchers, "followed" seven citizens through the course of APS by means of qualitative interviews, audio recordings of counselling conversations and reflective log books in which citizens recorded their experiences and thoughts. In the second strand, the university researchers built on their analysis of the material produced in the first strand to design an all-day workshop with citizens where we used two dialogue methods, image elicitation and creative non-fiction writing, to facilitate the co-creation of knowledge about citizens' experiences of APS. In the third strand, the knowledge generated in the first

and second strands was harnessed to design a series of four all-day workshops in which the two university researchers and the counselling team of nurses together carried out joint analyses of the tensions in selected audio-recordings of counselling conversations and engaged in forum play about counselling situations.

The goal was to create a dialogic communication model through collaborative, reflexive processes that would strengthen APS as a program in which nurses and citizens share responsibility for developing empowering strategies for tackling citizens' illnesses. Below, we first give an account of our analysis of the workshop with citizens which indicated that the citizens drew on the dimensions of patient-centeredness in dynamic meaning-making. In the subsequent accounts, we illustrate how, in the workshops with the counselling team of nurses, we built on this understanding of the dimensions by working with Mead and Bower's (2000) "doctor-as-person" dimension – re-labelled as "health care practitioner-as-person" - in order to develop the two components of the dialogic communication model, namely, reflexive dialogic awareness about the tensions in "patient-centeredness" and a toolbox of concrete strategies for tackling the tensions.

### **Understanding the role of the "active patient" in APS**

In the first extract from the workshop with citizens, the citizens, Martin and Marianne, reflect on their surprise when they joined the APS project that they were expected to play a more active role than they were used to, including making decisions about what to talk about:

*Michael [researcher]: Had you expected or were you surprised that it's all about you? That it's you who has to act?*

*Martin [citizen]: I was surprised the first time we talked together and I found that it was me who had*

*to do the work.*

**Marianne** [citizen]: *I was surprised about it too. And I did have difficulty with it in the beginning.*

*What should we talk about? But she was fantastic at opening things up.*

**Louise** [researcher]: *What did she do?*

**Marianne** [citizen]: *It worked through repetition [...] and a real inquiry into my life. She took up some of the things I said in a let's-try-and-work-it-out-together kind of way. And then we started with that in the subsequent conversation, right?*

Here, Marianne invokes the dimension of “patient-centeredness” labelled “shared power and responsibility” (Langberg et al, 2019) by describing how she gained more control of her health as an active agent and hence was “empowered” (Castro et al., 2016: 1927) through the nurse’s facilitation of shared decision-making – “[i]n a let’s-try-and-work-it-out-together kind of way”. The nurse built partly on Marianne’s experiences – “a real inquiry into my life” – and partly on Marianne’s contributions to the conversation – “*she took up some of the things I said*”. In drawing on Marianne’s own experiences, the nurse also invokes the dimension of “patient-as- person” whereby the health care practitioner strives to understand the citizen’s experience of illness from the patient’s own perspective in the context of the citizen’s life.

The experience of gaining extended agency in making decisions and acting in relation to living with illness through the dimension of “shared power and responsibility” was a central theme throughout the workshop. Marianne begins by stating that Active Patient Support entails that, rather than solving the citizen’s problems on their behalf, the nurse helps the citizen to learn to tackle his or her own illness:



***Marianne** [citizen]: I just think that there are loads of things that a nurse can manage for you, but that's really about managing it for you rather than showing you the way to manage things yourselves, like contacting the GP.*

Edith supports this point:

***Edith** [citizen]: Part of it is that I've felt that it's given me some support so that I can manage the different things that I need to manage myself. And I do think that there's a lot to keep track of.*

*When I've talked to her, then it's never "that's just how it is" because it has to get right into my head so that I can think about what I can get out of this conversation.*

The dimension, "shared power and responsibility", entails respecting citizen's decision-making autonomy (Langberg et al., 2019: 1232). This implies a transparency in the decision-making process about who decides what and when. However, such transparency is not something that the citizens suggest is important to them. Edith stresses her relationship with the nurse as crucial for her participation. She ties the dimension of "shared power and responsibility" to the dimension of "therapeutic alliance" by linking the idea of shared decision-making to the close interpersonal relationship based on mutual respect and trust which she experiences with her nurse. Edith describes their alliance as a dialogic process in which she continues to reflect on her conversations with the nurse, thus engaging in an ongoing inner dialogue in relation to how to tackle particular problems or act in a particular situation. Other citizens also refer to this inner dialogue which opens up for new ways of engaging reflexively with tackling one's illness in everyday life. For example, Marianne states the following:

***Marianne**: When something started to happen with the structure of the conversations, then it all became a little easier, but it also became harder because I was put to work [...] I can go and think about our conversation for several days after I've spoken to her.*

This reflexivity can be understood in terms of Bakhtin's concept of dialogue as the creation of new inner voices through citizens' conversations with the counselling nurses; citizens internalize the nurses' voices – articulating particular forms of knowledge - and, through investing them with their own accents, make them their own (Bakhtin, 1984). In internalizing nurses' voices, power is clearly in play; we problematize this later in this article in an account of how we and the nurses identified and worked with the tension between empowerment and self-discipline that dominated counselling conversations.

According to the citizens' accounts, the nurses' inquiry into the citizens' experiences of living with illness seems to encourage a reflexivity about living with illness which invokes both the dimension "patient-as-person" in which the patient's individual experience of the illness is in focus and also the biopsychosocial dimension which entails holistic consideration of mental, physical and social aspects of tackling illness in the context of patients' everyday lives. In the following extract, the biopsychosocial dimension is invoked together with the final dimension, coordinated care, as Martha stresses how the nurse helped her to navigate through the different parts of the system and hence to coordinate her own care:

*Martha [citizen]: I also think that even though I work in the system and know what doors I should open, from there to actually opening the doors myself, I would never have managed that without her help. Never ever. She has motivated and pushed me forward.*

Martha elaborates on this, stating that before joining APS, she felt drained of energy and had lost her overview of the different parts of the system (including out-patient appointments and visits to her GP) and had also lacked resources to maintain or create social relations. Working to help Martha to coordinate her care, then, seems to involve working holistically with the biopsychosocial dimension, embracing mental and social aspects of tackling illness as well as physical aspects.

To sum up, citizens invoked all five dimensions of patient-centeredness identified in Langberg et al.'s literature review (2019), not separately but in interplay with one another as the citizens stressed the importance of relations and the coordination of care for collaborative decision-making based on shared responsibility and power. As noted earlier, the analytical result that the dimensions of "patient-centeredness" were intertwined in this way in citizens' meaning-making informed our design of the four all-day workshops with the counselling team.

Through initial analysis of transcriptions of audio-recordings prior to the workshop, we had identified three different conversational genres which shaped the negotiation of knowledge, identities and responsibility in the enactment of "patient-centeredness" by stipulating particular ways of acting in talk within a normatively prescribed moral order. The three genres identified are as follows. The "genre of the sparring partner" stipulates the activity of sparring in order to create a plan for action collaboratively in relation to coping with specific problems - as a step on the path to well-functioning self-care at the end of APS' nine-month program. 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. In the joint analyses in the workshops with the counselling team of nurses, we focused reflexively on the tensions arising when nurses adopted and shifted between these genres in order to co-create knowledge collaboratively.

### **Developing reflexive dialogic awareness: talk about practice**

The first three workshops cultivated dialogic awareness of the tensions in "patient-centeredness" - the first component of the dialogic communication model - through "talk about practice" in which we, the university researchers, and the counselling team members applied theoretical tools in joint analyses of

how the nurses' conversational moves using the genres shaped the negotiation of knowledge, identities and responsibility.

### *Example 1*

The first example is from the first workshop. In the beginning of the example, the nurse, Linda, expresses a wish for dialogue in the group about how to operationalise the genre of inquiry in practice:

**Linda [nurse]:** *But when you say inquire, could we maybe talk a bit more about what it is we do when we inquire?*

Michael points out that this is what the group is going to be focusing on in the workshop, building on the very brief definitions that the university researchers had written:

**Michael [researcher]:** *That's what we mean by operationalizing them, what are the different genres about and how do we adopt them? Is it about asking in a particular way? Or what on earth is it you do with them, because now we've only written a brief, as brief as possible, definition of them.*

Camilla then suggests that they explore how the nurses apply the genre of caring support in counselling conversations and, in particular, how the citizen can be involved in collaborative decision-making about the nature of the caring support:

**Camilla [nurse]:** *And also how can we go in and find out with a technique where to give support, what is it that's important for the person in relation to this. This also requires an analysis.*

*Freja supports this and Michael asserts that all the genres should be the object of analysis:*

**Freja [nurse]:** *Yes, that's right.*

**Michael [researcher]:** *But I think that all the genres require analysis.*

Freja points out that the analysis has to be a collaborative one, carried out together with the citizen, and sketches out an analysis linking two of the genres: joint exploration of the citizen's own perspective

(the genre of inquiry) can lead to joint considerations about how the nurse can support the citizen in coping with her illness (the genre of sparring partner):

*Freja [nurse]: Yes, now it was just an example but it has to be done together with the citizen you're talking with, the analysis, right? [Michael and Camilla: Yes] So when you have explored and brought out thoughts and feelings, you can do the analysis with the citizen and together find out what you think your role could be in relation to those thoughts and feelings and the goals the person maybe has for her life in relation to everyday life with illness. And we can also say that it involves coping too.*

Freja's utterances indicate that the group has moved towards reflexivity about how their conversational turns shape the negotiation of meanings and contribute to tensions in the enactment of "patient-centeredness".

### *Example 2*

In joint analysis, one tension that we identified and delineated was a tension that arose in the genre of inquiry between encouraging the citizen to engage in new reflections on their life (genre of inquiry), on the one hand, and, on the other hand, respecting and supporting – and hence reproducing - the citizen's current understandings (genre of caring support). Identification of the tension began with Freja suggesting that she had overused the genre of inquiry in a conversational episode in which she wanted the citizen to reflect on her actions in order to become aware of a positive development on which she (the citizen) could build. She describes how the episode did not go as planned as the citizen reacted with irritation:

*Freja: I had a conversation recently where it occurred to me that I was using one mode [the genre of inquiry] too much. It became very clear to me in the way in which the citizen reacted, and when it happened, I was thinking WOW, what went wrong here? Did I overstep a boundary? It was as if I*

*could not sense it until afterwards when I could understand that she was probably expecting me to be talking in a caring support mode. She had given me signs of wanting change which I wanted to explore further until she said, “you are asking the same questions over and over again!”[..]. I was deeply affected by not seeing it, and I am quite experienced. I could not sense that I had overstepped her boundary.[...] Since I could not see her, face-to-face, I could not see how pressurised she was. I could not sense it in our conversation.*

Freja’s storytelling exhibits a reflective awareness of her own practice: “*I was thinking WOW, what went wrong here? Did I overstep a boundary? It was as if I could not sense it until afterwards*” (lines 3-4). Freja conveys an “aha” experience in which she links theory and practice by connecting them in retrospect to a specific situation, thereby gaining a reflexive awareness of how her utterances shaped the conversation. Drawing on Cunliffe (2002), Freja’s narrative can be read as a story of how she was momentarily “struck”, creating an individual learning opportunity for Freja, and also collective learning as we continued to explore the tension in the group.

### **Developing a toolbox of strategies for tackling the tensions in dialogue: Talk in practice**

In the third and example, we show how reflexive awareness was integrated into practice in the fourth workshop through talk *in* – as opposed to *about* – conversational practice. The aim of the fourth workshop was to develop the second part of the communication model – a toolbox of concrete strategies for tackling the tensions that arise in dialogue within and across different genres. We used a forum play which is a type of role-play, inspired by the “Theatre of the Oppressed” of Augusto Boal (2009), in which participants, by becoming actors in a drama, are configured as change agents in relation to the reality portrayed in the play (Olesen & Nordentoft, 2018). Forum play is based on the

view that, when difficult situations are enacted, critical reflection on those situations can generate situated knowledge within practice (Olesen & Nordentoft, 2018).

In our workshop, the university researchers facilitated the forum play. First, nurses were invited to describe to each other one situation from a conversation with a citizen that did not go as they had planned. The nurses then chose one of the situations as the situation to be re-enacted with one of the nurses in the role of citizen, another in the role of nurse and the rest of the team as audience. The situation they chose was the episode in example 2 above in which Freja wanted the citizen to reflect on her own actions but the citizen did not engage in reflection and became irritated. They re-enacted the situation twice. The second time, the audience of other nurses were invited to come up with suggestions for alternative ways of handling the situation and to try them out in practice by swapping places with the nurse. The situation was then re-enacted repeatedly until there were no more new suggestions for which actions to take. Afterwards, the whole group (the counselling team and university researchers) engaged in reflections that pinpointed and further developed strategies that had been employed in the forum play for tackling the tensions. In the reflections after the forum play, the nurses reflected on how several of them had used metacommunication as a strategy in the forum play as they had realised during the play that the citizen did not understand the point of the questions:

**Bente [nurse]:** *yes, say it aloud.*

**Freja [nurse]:** *yes, that's what I should have picked up on. But I don't actually think that she [the citizen] asked me, "why are you asking about all those things?"*

**Bente [nurse]:** *But you could still pick up on it, you could say, "I hear that you're irritated by all the questions. The reason why I'm asking them is as follows".*

The nurse who had played the citizen in the forum play, Bente, then expressed an insight that was the product of her own experience of irritation:

*Bente: Perhaps they [citizens] also feel as if they are being bombarded with questions, that they don't have time to reflect on things before the next question.*

Freja concluded the discussion with a reflection on her reason for overusing the genre of inquiry:

*Freja [nurse]: [...] Maybe that's why I used the other genre [inquiry] too much because I was nervous about her [the citizen] feeling patronized, because she finds it difficult with weaknesses.*

Drawing on Cunliffe (2002), it can be said that Freja, in the forum play, was momentarily “struck” as she re-experienced the feeling that something was going wrong in the communication with the citizen. This feeling generated learning from “within practice”. Freja, together with the group, discovered how the citizen’s irritation was connected to the nurse’s choice of the genre of inquiry with its stream of reflexive questioning and absence of metacommunication about the nurse’s reasons for the questioning.

The above reflections in the group led to Freja’s insight that the use of dialogic tools such as the genre of inquiry can be a form of manipulation:

*Freja: What I want to say is that when I see [the forum play] I see that it's manipulative. I am trying to manipulate her to reflect and I have a hidden agenda which never occurs to her. And that's not an equal, fair dialogue.*

Freja suggests that she engaged in manipulation as she tried to encourage the citizen to reflect on her own actions (and hence gain agency in tackling her illness) but the citizen either did not understand the point of the nurse’s repeated questioning or resisted the call to reflect. This can be understood as a 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). Across the workshops, it became increasingly clear to the university researchers and the counselling team that this is the most



fundamental tension in counselling conversations. As we became reflexively aware of the tension, we were able to co-create knowledge and strategies for tackling it in practice.

## **Conclusion and further perspectives**

In this article, we have claimed that the intrinsically tensional nature of “patient-centeredness” means that the well-documented gap between policy principles and practice cannot be bridged alone by the application of the dimensions of patient-centeredness identified in the research literature. In meaning-making in patient-centered communication, the dimensions are always intertwined in complex ways involving dynamics of exclusion and inclusion. The purpose of the article was to show that it is possible to narrow the gap between policy and practice by applying a reflexive approach to the intrinsic tensions in patient-centeredness. This reflexive approach is based on the theoretical framework, IFADIA. The article has illustrated the use of IFADIA in an action research project attached to a patient-centered initiative, “Active Patient Support”. To strengthen patient-centeredness and thus narrow the gap between policy and practice, the project developed a communication model consisting of reflexive awareness about the tensions in patient-centeredness (through “talk about practice”) and strategies for tackling the tensions (through “talk in practice”).

### *Exploring the tension between empowerment and self-discipline reflexively*

The central tension which we and the counselling team identified and explored in four workshops in the action research project was between empowerment - the extension of the citizen’s agency in relation to living with chronic illness(es) - *and* self-discipline – inscription as a self-governing, ‘enterprising’ subject in a discourse of self-care that not only makes possible but also constrains the

citizen's agency along the lines of the normatively prescribed moral order of the discourse (Rose, 2007).

The tension between empowerment and self-discipline can be understood as the result of the joint articulation of two competing discourses in the contested discursive terrain of contemporary health care. Empowerment belongs to a democratic discourse of dialogue furthering the patient's agency in collaborative decision-making based on *shared* responsibility. While self-disciplining can be understood as part and parcel of inscription as a subject in *any* discourse, it takes a particularly strong form in the neo-liberal discourse since the individualization of responsibility and the self-governing, responsabilised, 'enterprising' subject are central to the neo-liberal discourse (Fotaki, 2011; Leicht et al., 2009). In some versions of patient-centered care, the two discourses are merged in such a way that the neo-liberal discourse eats into or "cannibalizes" the democratic discourse of dialogue. Fotaki (2011, p. 949) has asserted, for example, that, in contemporary welfare, "'empowerment discourse' has been co-opted by a neoliberal orientation towards the individualization of responsibility".

According to Mol (2008), neo-liberal individualization occurs when a "logic of choice" is in operation whereby the patient's scope for action is reduced to the making of lifestyle and/or treatment choices on the basis of the health practitioner's non-negotiable knowledge. Mol contrasts the "logic of choice" with the "logic of care". In the "logic of care", the health practitioner and the patient *share* responsibility and *collaboratively* arrive at decisions for the patient's care through the *negotiation of knowledge*. We claim that the use of the reflexive approach in the action research project helped to strengthen the logic of care in the Active Patient Support program in the co-production of strategies for living with chronic illness in citizens' everyday lives. It did so as nurses gained, first, a reflexive awareness of the tension-ridden play of power in patient-centered communication and, second, concrete strategies for tackling the tensions which they could put to use in counselling

conversations to further the *sharing* of responsibility through the negotiation of knowledge across genres and voices.

*Expanding the dimension of health practitioner-as-person*

The reflexive approach illustrated by its use in the action research project presents a particular way of working with the dimension of health practitioner-as-person which, under the label of “doctor-as-person”, was one of the dimensions identified in the literature review by Mead and Bower (2000) but removed by Langberg et al. (2019) because of the scarcity of references in the more recent literature. The reflexive approach’s use of the dimension of health-practitioner-as-person entails its conceptual expansion. The original dimension presented in Mead and Bower (2000) consists of practitioners recognizing how their own values and experiences shape their practice. Our formulation of the dimension embraces reflexivity about how health care practitioners’ – and researchers’ – values and experiences are embedded in discourses that construct social realities and identities in ways which exclude alternatives and therefore (re)produce power relations. As other scholars who have developed reflexive approaches to action research point out (for example, Cunliffe, 2002; Ripamonti et al., 2016; Shotter, 2010), reflexivity is about addressing how the interactional moves of participants in dialogue are performative in co-creating social realities. We see this as crucial to the value of the dimension, health practitioner-as-person, as it allows for reflexive consideration of *the specific ways* in which health care professionals reproduce power relations through the tensional enactment of patient-centeredness.

Moreover, whereas the original dimension exclusively consists in the health care practitioner’s individual introspective reflection, both health care professionals and citizens, in our model, engage collaboratively in reflexivity as the aim is that reflexivity is integrated into

conversations between health care professionals and citizens. In the Active Patient Support program, the idea is that nurses facilitate reflexive dialogue with citizens in which nurses acknowledge their different and unequal positions in the negotiation of knowledge and identities. Nurses and citizens can address the tension between empowerment and self-discipline through joint reflections on how “shared responsibility” does not mean “equal responsibility” since counselling conversations position citizens as morally committed to take enhanced control of their own health as active agents whereas nurses are only involved with their professional identities.

### *Limitations of reflexivity*

It is crucial to acknowledge that it is an unavoidable limitation of reflexivity that reflexive analyses of tensions in patient-centeredness are themselves permeated with power and circumscribed by the discourses within which researchers and health care practitioners construct meaning. Given this limitation, it is important, when practitioners integrate reflexivity into communication practices through articulation of the dimension of health practitioner-as-person, that the focus is on the tensions in dialogue not as absolute truths but precisely as a starting-point for reflexive dialogue – a reflexive dialogue that recognizes the power inequities that inevitably persist despite the democratization of knowledge with its heightened negotiation of knowledge, responsibility and identities. This should also be the case for the reflexive discussion of tensions in the action research process itself which IFADIA proposes that university researchers and researchers outside the university engage in. <sup>i</sup>

An obvious limitation of our action research project is that it did not explore how the communication model developed can be put into practice by new members of the Active Patient Support counselling team and by health care practitioners on other programs *without* their having to

carry out an action research process with university researchers. Unlike the limitation of reflexivity, this is not an unavoidable limitation but rather a challenge for further research and development work.

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

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<sup>i</sup> It is a delimitation of this article that it does not contain a reflexive analysis of the tensions that arose in the action research process; as noted earlier, we have carried out and published this analysis elsewhere (see Phillips & Scheffmann-Petersen, 2019).