

“It’s Not Like You Need to Live 10 or 20 Years”: Challenges to Patient-Centered Care in Gynecologic Oncologist–Patient Interactions

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Abstract

The literature suggests that the patient-perspective approach (i.e., eliciting and responding to patients’ perspectives, including beliefs, preferences, values, and attitudes) to patient-centered care (PCC) is not a reliable predictor of positive outcomes; however, little is known about why the patient-perspective approach does not necessarily lead to positive outcomes. By using discourse analysis to examine 44 segments of oncologist–patient interactions, we found that providers’ use of patient-perspective contextualization can affect the quality of care through (a) constructing the meanings of patient conditions, (b) controlling interpreting frames for patient conditions, and (c) manipulating patient preferences through strategic information sharing. We concluded that providers’ use of patient-perspective contextualization is an insufficient indicator of PCC because these discursive strategies can be used to control and manipulate patient preferences and perspectives. At times, providers’ patient-perspective contextualization can silence patients’ voice and appear discriminatory.

Keywords

discourse analysis; patient-centered care; provider–patient communication; patient-centeredness; patient perspectives; preferences; qualitative; USA

Patient-centered care (PCC) is a central value in medical education and is often viewed as an important indicator of quality care (Greiner & Knebel, 2003). PCC is defined as “providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions” (Institute of Medicine, 2001, p. 6).

Despite the emphasis on PCC in clinical care (Epstein & Street, 2011), evidence-based research has yielded mixed findings. In particular, researchers have found that (a) not all patients prefer patient-centered communication (Swenson et al., 2004) and (b) PCC does not always lead to positive clinical outcomes (Rathert, Wyrwich, & Boren, 2013). Some researchers suggested that providers’ different communicative strategies for PCC may have distinct impacts on patient outcomes (Michie, Miles, & Weinman, 2003). Based on a review of 30 studies, Michie et al. (2003) argued that PCC can entail two different communicative styles, patient activation approach (i.e., empowering patients to take control in the care process) and patient-perspective approach (i.e., eliciting and responding to patients’ perspectives, including beliefs, preferences, values, and attitudes). In addition, compared

with the patient activation approach, the patient-perspective approach may not be an effective strategy for PCC and may be a less reliable predictor of positive outcomes (e.g., improved physical health, adherence, satisfaction, or well-being; Michie et al., 2003).

Although provider–patient communication has been central to previous investigations of PCC (Michie et al., 2003; Robinson, Callister, Berry, & Dearing, 2008), little is known about the pathways between the communicative processes of PCC and patient outcomes (Rathert et al., 2013). Because our goals are to extend this line of research and tackle the puzzle of mixed findings in PCC research, we will examine the potential dilemmas of and challenges to the patient-perspective approach to PCC.

In a recent review, Rathert et al. (2013) concluded that examining the interpersonal coordination of care and

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exploring patient experiences are necessary to understand the processes and impacts of PCC in different settings. Other researchers have also argued that examining actual provider–patient interactions, rather than relying on participants' self-report, is essential to better understand the pathways between PCC and health outcomes (Epstein & Street, 2011; Hudon, Fortin, Haggerty, Lambert, & Poitras, 2011; Peters, Hibbard, Slovic, & Dieckmann, 2007). This is because communication is an emergent, dynamic process in which both providers and patients actively co-construct and continuously negotiate various meanings that emerge during interactions (Heritage & Maynard, 2011; Hsieh, 2010). In fact, providers and patients often differ in their evaluations about their own and each other's communicative competence, which also does not correlate with the quality of actual interactions (Cegala, Gade, Broz, & McClure, 2004; Kenny et al., 2010). The dialogic and multivocal nature of meanings can create tensions in and challenges to social interaction as participants make sense of competing, even conflicting, meanings (Bakhtin, 1981; Goldsmith, 2001). We propose that individuals' management and negotiation of meanings when they engage in the patient-perspective approach to PCC can provide insights into how and why certain communicative strategies may lead to problematic outcomes (Gee, 2014).

To understand when and how provider–patient communication can facilitate a desired outcome, we need to examine what is said and how it is said, and the meanings the participants typically attribute to particular ways of saying things (Beach, 2012; Goldsmith, 2004; Gutzmer & Beach, 2015). We operationalized Michie et al.'s (2003) patient-perspective approach as patient-perspective contextualization: a discursive frame that uses specific contextualization cues to (a) highlight a patient's values and perspectives, (b) emphasize the interpersonal and relational aspects of patients' care, or (c) discuss how a patient's unique characteristics can shape the delivery and process of care (Hsieh & Zanin, 2013). By examining how gynecologic oncologists and patients negotiate patient-perspective contextualization and its corresponding challenges, we will investigate why the patient-perspective approach does not necessarily lead to positive outcomes.

Method

Participants and Procedures

This study is a part of a larger ethnographic study conducted from January to October 2012, examining the illness experiences of patients who were newly diagnosed with gynecologic cancer in a large teaching hospital. In

total, 29 patients and 3 oncologists (i.e., MDs with gynecologic oncology specialty) from a teaching hospital are included in this study. All participants are female. The average age of the oncologists was 43.7 ($SD = 11.6$). The age range of the patients was 42 to 89 ($M = 61.9$; $SD = 10.9$). The patients received a \$10 gift card for each video-recorded medical appointment.

For this study, we examined data collected during the patients' first medical appointment, including only interactions between patients and oncologists. In these encounters, the patients and the oncologists often have multiple interactions, which typically include a formal examination in the exam room and discussions about potential diagnosis and treatment options in the consultation room. We treated each patient–oncologist interaction as a data segment. In total, 44 video-recorded segments (553.25 minutes) of the first medical visits were included in the study. The average time per segment is 12.6 minutes ($SD = 8.5$), averaging 1.5 segments per patient. All recordings were transcribed verbatim. The first author assigned pseudonyms to all participants, archived all segments, de-identified the data, and reviewed all transcripts for accuracy. Patients' pseudonyms start with C (e.g., Cara) and oncologists' start with P (i.e., Pam, Pearl, and Piper). Of the 44 segments, 9 were with Pam, 33 were with Pearl, 1 was with Piper, and 1 was with Pearl and Piper together. Patients' ages are rounded to the nearest multiple of 5 and are listed as superscript next to their names at the beginning of each excerpt. Transcripts are italicized to reflect author emphases. All research procedures have been approved by the institutional review board of the University of Oklahoma.

Data Analysis

We choose discourse analysis as our analytical lens for theoretical and practical reasons. When examining our video-recorded interactions, we noticed that patients and providers often revisit the same topics throughout these initial encounters. Discursive analysis provides us the tool to explore discursive meanings that are generated through the turn-by-turn interactions at the micro level as well as the sequential placement and interactions of the larger medical discourse at the macro level (Akman, 2000; Hsieh, 2004). Discourse analysis emphasizes the importance of contexts and contextualization cues when examining discursive forms (i.e., the communicative strategy) and discursive functions (i.e., what is accomplished by the communicative strategy), providing insights into individuals' orientation to and understanding of emergent meanings through social interactions (Gumperz, 1982). By critically examining

the tensions between discursive forms and functions and reflexively exploring the taken-for-granted practices, discourse analysis can inductively illuminate problems in provider–patient communication (Gee, 2014).

Using the earlier definition of patient-perspective contextualization, we used NVivo 10 to code all data (i.e., ethnographic notes, video data, transcripts, and analytic memos) independently. For micro-level analysis, we focused on sequential interactions in consecutive turns, identifying the moments when a patient or an oncologist adopts patient-perspective contextualization in their talk. For macro-level analysis, we viewed the conversations as a whole, identifying moments that meanings of patient-centered contextualization are dialogically invoked and shaped by earlier or later discussions (Bourdieu, 1977; Gadamer, 2005; Ricoeur, 1976).

We identified a collection of 163 instances across 44 segments where providers and patients participate in patient-perspective contextualization. We then focused our analysis on challenges to patient-perspective contextualization, defined as instances where competing meanings were generated. Throughout the study, we held weekly meetings to review our individual memos, examine specific instances, and revise the list of categories as we explored and clarified the forms and functions of patient-perspective contextualization. We finalized a list of different functions of patient-perspective contextualization and explored their corresponding impacts. The first author then reviewed the data to identify exemplars for each function.

Results

Patient-perspective contextualization, as a discursive frame, highlights the unique characteristics of the patient, acknowledging the distinctive needs, preferences, and circumstances of each patient. Providers' use of patient-perspective contextualization can affect the quality of care through (a) constructing the meanings of patient conditions, (b) controlling interpreting frames for patient conditions, and (c) manipulating patient preferences through strategic information sharing.

Constructing the Meanings of Patient Conditions

Patient conditions generate meaning through comparisons with other points of reference (Gutzmer & Beach, 2015). It is not uncommon for oncologists in our study to offer multiple treatment options while providing interpretive frames to assist patients' decision-making.

Excerpt 1

101 Pearl (P): But sometimes doing no
 102 harm is the right answer. That's
 103 sort of our golden rule in medicine
 104 is that you don't want to do more
 105 than you need to and in order to
 106 value that rule of do no harm, you
 107 want to do what's necessary but not
 108 necessarily more.
 109 Caimile⁸⁰: Yeah. Cause more problems
 110 than it's worth. Well, you know,
 111 I- I really . . . I'm an old lady.
 112 I mean, let's face it. So I . . . I
 113 don't like the idea of having too
 114 much done, you know. It sounds sort
 115 of . . .
 116 P: Yeah and I think that's fairly
 117 wise.

In Excerpt 1, Pearl first provides an evaluative frame to the patients' treatment decision, invoking the values and principles of do no harm and suggesting that more treatment may result in negative, rather than positive, outcomes. Caimile responds by initiating patient-perspective contextualization, emphasizing her advanced age (Line 111; "I'm an old lady"). She then explicitly shares her preference (Lines 112-114; "I don't like the idea of having too much done"), which was quickly supported by Pearl (Lines 116-117). By noting that Caimile is "fairly wise," Pearl not only supports Caimile's identity claim but also evokes the cultural image of the elderly wise person. From this perspective, although Pearl presents a plan of limited treatment options, Caimile actively engages in the construction of meanings of her unique characteristics. Together, Pearl and Caimile co-construct Caimile's identity as a wise old lady and share the sense-making and decision-making process of the illness event.

Patient conditions are not objective, absolute facts; rather, they often entail different sources and aspects of information that require interpretation (Kong & Hsieh, 2012; Pitaloka & Hsieh, 2015). For example, the following interaction took place when Celine informed Piper that she was not sure what to tell her adopted daughter about her cancer diagnosis.

Excerpt 2

201 Piper (P): If [your daughter is] a
 202 worrier then, let's hopefully get—
 203 Celine⁵⁵ (C): She's from India,
 204 she's East Indian. She's very
 205 quiet, very reserved, you know, and
 206 um internalizes everything.

207 P: Yeah, and I mean, I- I don't know
 208 her well enough, I don't want to
 209 direct you one way or another, but
 210 I'm gonna keep my fingers crossed
 211 that this is—
 212 C: Great, good.
 214 P: We would keep our fingers crossed
 215 anyway, but I think that there are
 216 a lot of features of this [tumor]
 217 that are suggestive of good things
 218 and not bad things . . . so.
 219 C: Okay.

Initially, Piper explicitly states that she does not want to influence Celine's understanding about her prognosis (Lines 208–209; “I don't want to direct you one way or another”). However, when Celine's specific conditions are referenced, Piper then provides an optimistic frame for Celine to interpret her physical condition (Lines 215–218). Patients do not necessarily have the interpretive schema to understand the meanings of their physical condition; however, providers, as medical experts who are familiar with reading the physical signs and patient conditions, can be valuable in assisting patients in understanding meanings of their conditions in relation to their Lifeworlds.

Providers' framing of the meanings of patient conditions can be particularly important when there are competing or conflicting frames for interpretation. For example, Excerpt 3 shows the interaction after Carmen expressed her concerns about her earlier CT scan that suggested her uterus cancer may have metastasized to her lungs.

Excerpt 3

301 Pam (P): I'm doubtful that we'll
 302 see much just because you're
 303 sitting here looking fairly
 304 normal. You know, people with a
 305 belly full of tumors come in, and
 306 they don't feel good.
 307 Carmen⁶⁵(C): Um-hum.
 308 P: You know, they are—
 309 C: I feel great.
 310 P: Yeah.

By asserting her professional knowledge and experiences, Pam contradicts the diagnostic information obtained through CT scan by noting that Carmen's

seemingly “normal” appearance was different from patients with a large number of tumors (Lines 301–306). Carmen readily supports Pam's assessment (Line 309) and accepts her interpretive frame. In both Excerpts 2 and 3, patients affirmatively welcome and support their providers' discursive frames that construct the meanings of their conditions.

Controlling Interpretive Frames for Patient Conditions

Providers' effort to help patients develop an interpretive frame allows patients to derive meanings of their conditions. However, a patient's unique characteristics can present an interactional dilemma to a provider, especially when they pose risks to limit the availability or success of care. For example,

Excerpt 4

401 Pearl: So we start off by trying to
 402 get into this peritoneal cavity. In
 403 you, it may not be feasible because
 404 of your previous surgery. So just
 405 to, you know, warn you.
 406 Caimile⁸⁰: hmm..mm.

By “warning” (Line 405) Caimile that her pre-conditions may preclude certain treatment options, Pearl prefaces patients' unique conditions as a limiting factor. From this perspective, recognizing patients' unique circumstances does not necessarily mean respecting their needs or values. Oncologists face particular tensions when discussing a patient's condition as a limiting factor, which often implies less satisfying outcomes. Nevertheless, by explicitly orienting patients to recognize their unique conditions and their corresponding impacts through patient-perspective contextualization, providers in our study were able to control the meanings of available treatments.

Patient-perspective contextualization, from this perspective, is not about addressing patients' needs and preferences. Instead, patients' conditions and providers' use of patient-perspective contextualization serve as resources to provide interpretive frames to assess the appropriateness and success of providers' recommended treatments. For example, in Excerpt 5, Pearl proposed to Carol to just “watch and wait and see cancer grow” (Line 503).

Excerpt 5

501 Pearl: The harm of waiting and
 502 watching is, you know, that we could
 503 watch and wait and see a cancer
 504 grow, but if it is [cancer], I'm
 505 not sure that matters to you a whole
 506 bunch because the treatment would be
 507 similar either way. It's not like
 508 you need to live 10 or 20 years.

509 Carol⁹⁰: Hmm..Noo . . . (.2) Well,
 510 I had already decided that if the
 511 doctor had said something about
 512 hysterectomy that I wouldn't go
 513 that route.

Readers would notice that Carol's response, while agreeing with Pearl, was less than enthusiastic. Her initial filled pause ("hmm") serves as a minimal confirmation of the surprise source turn (Wilkinson & Kitzinger, 2006). Although she appears to agree with Pearl by saying "no," Carol's prolonged pronunciation, pause, and fillers ("well") indicate that Pearl's comment was not quite expected (Wilkinson & Kitzinger, 2006). Although Carol was 90 years old, Pearl's comment (Lines 507–508; "It's not like you need to live 10 or 20 years") still came as a shock to her.

We suspect that because providers initiate such patient-perspective contextualization as a way to achieve their communicative goal (i.e., encouraging patients to accept their treatment recommendation), they may choose to adopt a more aggressive, blunt frame to define the meanings of patient conditions. Excerpt 6 provides a similar example.

Excerpt 6

601 Pearl (P): But I don't know if I
 602 am even going to be able to get
 603 up into the upper abdomen without
 604 going through mesh and that would
 605 be an incredibly morbid procedure.
 606 And you're not the healthiest egg!
 607 Cailey⁷⁰ (C): Um.

608 P: So I think already, we're talking
 609 about anesthesia and a surgery
 610 that we're going to have to get
 611 you through, so trying to do more
 612 and more stuff is not going to be
 613 in our best interest.

614 C: Just do the best you can. You
 615 know . . .

616 P: Yeah.

Pearl explicitly discusses potential limitations of her treatment. She provides an evaluative frame by bluntly

referring to the treatment as "incredibly morbid" (Line 605) and explicitly referencing the patient's condition as a limiting factor (Line 606; "you are not the healthiest egg"). Similar to Excerpt 1, Pearl invokes the medical adage of do no harm (Lines 611–613) to frame the meaning of the decision to be conservative in treatment. In addition, by commenting that it's not going to be in "our" (as opposed to "your") best interest, Pearl aligns with the patient and suggests that the goals are shared between her and Cailey. Despite initial hesitance/surprise (Line 607), Cailey eventually accepts Pearl's interpretation of her condition and surrenders her illness to Pearl's care (Lines 614–615). In such situations, patients were cautioned about how their conditions can bring additional complications to their current procedure and limit their current treatment options.

Research in the areas of speech acts and pragmatics has suggested that language users often control meaning through blocking alternative interpretations (Asher & Lascarides, 2001; Blutner, 1998). In other words, by preemptively denying alternative meanings, the speaker can direct audiences to his or her intended meaning. Although PCC typically involves acknowledging patients' unique conditions, we noticed a particular type of patient-perspective contextualization in which the provider explicitly emphasizes that patient characteristics do not influence their treatment process.

Excerpt 7

701 Pearl (P): So this is not something
 702 that I can take out of you without
 703 removing almost your entire bladder
 704 . . .

705 Cailey⁷⁰ (C): Yeah.

706 P: Which makes very little sense
 707 to do. So we're going to have to
 708 approach this still curatively, but
 709 with radiation. Which is how most
 710 vaginal cancers are treated. Very
 711 few of them are operated on. So I
 712 don't want you to feel like, "oh
 713 shoot, she's not going to operate
 714 on me because I'm older . . .," or
 715 whatever. It's very—Most vaginal
 716 cancers get radiated. And that's
 717 just the way they're treated.
 718 And they're treated relatively
 719 successfully.

What is interesting in Excerpt 7 is that Pearl initiates patient-perspective contextualization by explicitly referencing Cailey's advanced age and arguing that it is not the cause of her treatment recommendation. Pearl's

narrative in arguing that her treatment recommendation is normative and equally positive (Lines 715–717; “Most vaginal cancers get radiated. And that’s just the way they’re treated”) suggests that there are alternative meanings of Cailey’s condition that she tries to preemptively address by blocking an alternative interpretation: Elderly people be denied access to aggressive, curative care. From this perspective, Pearl did not use patient-perspective contextualization as a patient-oriented style of communication; rather, it was treated as a confounding factor that may bias Cailey’s understanding of meanings and required to be preemptively addressed to avoid perception of inequality in health care delivery.

In summary, as providers use patient-perspective contextualization to control the interpretive frame for their narratives, their discursive strategies do not aim to achieve patient-centeredness. Instead, these contextualization cues serve as resources that allow providers to orient patients’ understanding of their conditions and guide their interpretation of providers’ intended meanings.

Manipulating Patient Preferences Through Strategic Information Sharing

Incorporating patients’ attitudes and preferences to facilitate shared decision-making is central to PCC. For example, it is not uncommon to hear our providers saying “you are in charge” or “you are the boss” at the beginning of meetings. Excerpt 8 is a typical example. The interaction took place as soon as Pearl entered the room.

Excerpt 8

801 Pearl (P): All right. Well, you’re
802 in charge. You’re the one that has
803 to live with all this, so we—
804 Charlotte’s Husband: I’ve been
805 living with her long enough. I can
806 live with her some more.
807 P: Okay. So we know your uterus,
808 tubes and ovaries are gone, right?
809 Charlotte⁶⁰: Yeah.

By issuing these statements at the beginning of consultation sessions, the providers explicitly acknowledge their practices of patient-perspective contextualization.

However, we observed several incidences in which providers actively manipulate their narratives and medical information to influence patient preferences. In this section, we want to use examples from Charmaine’s medical encounter to illustrate the complexity of such practices. Excerpt 9 takes place when Pearl first met Charmaine.

Excerpt 9

901 Pearl (P): We’re trying to figure
902 out who you are, what your daily
903 life’s like, what you’re able to
904 do, what you’re able to function,
905 whether you’re willing to be
906 disabled, you know, by surgery and
907 everything else in order to live
908 for three years. You know? We, we
909 have to figure out whether you’re
910 somebody who really wants to live
911 ten years—
912 Charmaine⁷⁵ (C): Mm-hm.
913 P:—or really wants to live two years
914 but doesn’t- not real sure they
915 need to go through this at all. So
916 um, we’re going to try and get to
917 know you.

A closer examination of Excerpt 9 suggests Pearl’s complex management of patient-perspective contextualization when she compares the outcomes of different treatment options. Despite Pearl’s conclusion with a patient-centered remark (Lines 916–917; “we’re going to try and get to know you”), her juxtapositions of these two options have subtly indicated her preference. She initially describes the aggressive treatment option to be for someone who is “willing to be disabled, you know, by surgery and everything else in order to live for three years” (Lines 905–908), but later emphasizes that this option is for someone who “really wants to live ten years” (Lines 910–911). Pearl’s change in estimated life expectancy from 3 to 10 years post-surgery is intriguing. After all, although it may be reasonable to expect 75-year-old Charmaine to live another 3 years, 10 years can be a big stretch particularly when she is facing a poor prognosis. Pearl then proposes an alternative plan that is for someone who “really wants to live two years but doesn’t- not real sure they need to go through this at all” (Lines 913–915). As Pearl presents Option 2, she initiates a repair, changing “doesn’t” to “not real sure.” This allows Option 2 to be considered appropriate for a larger group of people, encouraging anyone with doubts about the aggressive option to see this as a viable option. In addition, by emphasizing that one may not feel that they “need to” (as opposed to “want to”) go through the aggressive treatment, Pearl injects a sense of indignation to Option 1 as Option 2 provides better quality of life (i.e., ridding the possibility to be “disabled”). In short, although Pearl explicitly acknowledged that the appropriate choice is subjective, depending on the patient, she framed the two options in a way that was indicative of her bias (e.g., quality, rather than quantity, of life should take priority).

We know that Pearl was pressuring Charmaine to choose the less aggressive treatment option also because

of the following interaction, which took place after approximately 5 minutes of conversation from Excerpt 9.

Excerpt 10

1001 Pearl (P): I mean you want to go
 1002 for it?
 1003 Charmaine⁷⁵ (C): Yeah, probably.
 1004 P: You don't want to just go, go on
 1005 hospice and get-not be treated?
 1006 C: No, I don't like hospice.
 1007 P: You'd rather be treated and-
 1008 C: Yeah.
 1009 P: And go for as long as you can
 1010 get?
 1011 C: Yeah.
 1012 P: Okay, so we'll-we're gonna make
 1013 some decisions here. First, do you
 1014 want any therapy, yes or no? You
 1015 say yes.
 1016 C: [Sighs].
 1017 P: That's the chemo. Any therapy at
 1018 all? Any treatment that can-
 1019 C: Oh yeah.
 1020 P:-that can kill the cancer.
 1021 C: Yeah.
 1022 P: That's a yes. Okay. Do you want
 1023 surgery to try to remove the
 1024 cancer, and then have, you know,
 1025 six weeks of recovery, possible
 1026 complications, risk of strokes,
 1027 heart attacks, all those things
 1028 that, you know, a big surgery
 1029 in an older person risks? Or do
 1030 you want us to take some middle
 1031 ground where we just give you
 1032 chemotherapy and hope that you
 1033 live two or three years?
 1034 C: Mm, I don't think so. I think
 1035 I'd rather try to get it gone.
 1036 P: You're thinking you're an
 1037 aggressive type?
 1038 C: Mm-hm.
 1039 P: Okay, well that's-I wasn't
 1040 expecting that answer. So that's
 1041 interesting. Okay.

In Excerpt 10, Pearl's repeated questioning and rephrasing of questions after Charmaine indicated her preference (Line 1003) is conspicuous. Such communicative patterns suggest that although Charmaine views her answers to be responsive to Pearl's questions, Pearl considers Charmaine's answer problematic (e.g., Charmaine does not understand the meaning of her choice or has made a wrong decision). Pearl tries several different types of repairs (Schegloff, 1992), including repeating the trouble-source turn but saying it more clearly (Lines 1009-1010), reformulating the trouble source (Lines 1004-1005 and 1036-1037), and becoming

more specific by providing the specifications of the sort of questions she meant to ask (Lines 1012-1014; 1017-1018; 1022-1033). It is important to note that Charmaine repeatedly indicates her preference despite Pearl's continued repairs, which treat Charmaine's talk as nonresponsive, inaccurate, or problematic answers to her questions. Pearl's repairs can create significant social pressure as Charmaine shifts from full-sentence statement (Line 1006) to minimal responses (Lines 1008 and 1011; "yeah") and even sighs (Line 1016). In the end, Pearl declares that Charmaine failed to provide an expected answer and concludes the discussion on this topic (Lines 1039-1041). In short, Excerpt 10 provides an excellent example that demonstrates providers' inquiry about patients' intentions, beliefs, and values do not necessarily help to empower patients.

As providers weave patient preferences into their discourse, their narratives can discourage patients from making their preferred choice. From this perspective, patient preferences are not a value to be discovered or honored in the delivery of care; rather, providers identify and manipulate patient preferences to meet their strategic therapeutic objectives. For example, after expressing her surprise (Lines 1039-1041), Pearl left the room and asked Piper to step in and explain the surgical procedures. Piper talked for about 10 minutes, providing extensive and graphic details about the surgery and the anticipated long recovery, often in long monologues.

Excerpt 11

1101 Piper: [We are] kind of deciding
 1102 how you feel about having a big,
 1103 big surgery because this surgery
 1104 is serious business. It'll be a
 1105 [inaudible], will cut you kind of
 1106 from above your belly button all
 1107 the way down [drew the incision
 1108 line on an anatomy picture], we'll
 1109 try to take out your uterus, your
 1110 tubes, your ovaries, your omentum-
 1111 yeah, all of this, I can draw all
 1112 of this for you [started drawing
 1113 on the laminated anatomy chart with
 1114 a red crayon] so uterus, tubes and
 1115 ovaries, so that's the first part
 1116 here. We need to take some lymph
 1117 nodes out in your pelvis. That's
 1118 here and here. Also up here. What
 1119 it also includes is that fatty pad,
 1120 that fatty apron, so that's the
 1121 omentum, we would take that out.
 1122 And what we would like to do is
 1123 take out all of the disease. The
 1124 goal of a big surgery like this is
 1125 to make sure that we cannot see any
 1126 more disease left in your abdomen
 1127 when we're done.

Excerpt 12

1201 Piper (P): It's absolutely better
 1202 to recover from a lesser surgery
 1203 than a larger surgery. Does that
 1204 make sense?
 1205 Charmaine⁷⁵: Yeah.
 1206 P: So what's the downside? Why
 1207 wouldn't we do this on everyone?
 1208 That's the next question. So
 1209 what we also know is that the
 1210 people who live the longest after
 1211 surgery or after they've been
 1212 diagnosed with their ovarian
 1213 cancer are the people who are
 1214 treated with surgery first and we
 1215 get all the disease out. That's
 1216 the big surgery. So we have to
 1217 decide kind of whether we gamble
 1218 doing a surgery upfront and not
 1219 get all the disease out. Those
 1220 people don't do all that well.
 1221 And whether we think that you can
 1222 gamble and survive and do well
 1223 and recover well from a big, big
 1224 surgery that we know would be an
 1225 upfront surgery rather than one
 1226 that was tempered by chemotherapy
 1227 at the beginning. Does that make
 1228 sense?

In Excerpts 11 and 12, Piper shifts into a performance mode as her narratives become more prosodic (Bauman & Briggs, 1990). Although she demonstrates interests for patient preferences (Lines 1101-1103) and checks for patient understanding (Lines 1203-1204 and 1227-1228; "Does that make sense?"), a closer examination of her narratives suggests a complex picture. She first draws the incision line "all the way down" and names the various organs that will have to be removed (Lines 1109-1110; "your uterus, your tubes, your ovaries, your omentum"). Then after concluding that she'd remove "all of this" (Line 1111), she initiates a repair by volunteering to draw and repeating the names of all organs to be removed again (Lines 1111-1121). The repeated announcements of organs to be removed coupled with drawings of each organ as she names them can be intimidating as most people do not think of organs in a spatial or anatomical manner. Seeing the number of organs to be removed or the space that will be emptied can be scary for a layperson. In addition, throughout the interaction, Piper repeatedly frames the surgical option as a big or "big, big" surgery (Lines 1102-1103, 1124, 1216, and 1223) that is like a "gamble" (Lines 1217 and 1222) with serious and uncertain consequences (Lines 1104 and 1217-1222). Eventually, by the time Pearl reentered the room, Charmaine had changed her mind.

Excerpt 13

1301 Charmaine⁷⁵: I think I'd rather have
 1302 the chemo first.
 1303 Pearl: I thought if we got real
 1304 specific with you, you might
 1305 understand. So I think at your
 1306 age—then we usually try to be
 1307 gentler.

Excerpt 13 suggests that Piper and Pearl (i.e., "we") worked a coordinated front, providing "real specific" information in such a way to influence patient preferences so that Charmaine "might understand." The detailed information about the surgery and recovery was designed to change Charmaine's mind.

In summary, despite the fact that patient preferences were consistently emphasized and attended to in these provider-patient interactions, the providers did not solicit Charmaine's beliefs, attitudes, or preferences to engage in shared decision-making. When Charmaine's preferences differed from the providers' desired option, they pressured her through discursive structure (e.g., repeated questions) and content (e.g., providing extensive and graphic details about the surgery) with increasing intensity to manipulate patient preferences. However, once a patient conforms to their recommended treatment, they quickly support the patient's decision (see also Excerpt 1). In Charmaine's case, although significant negative information of the surgical option was shared, there was, in fact, little discussion about the pros and cons of the nonsurgical option.

Discussion

Reviews of PCC have noted that the patient-perspective approach does not consistently contribute to positive outcomes (Michie et al., 2003; Rathert et al., 2013). Our study extends this line of research by demonstrating that eliciting and responding to patients' perspectives does not necessarily constitute appropriate and effective PCC. By examining provider-patient interactions, our study is one of the first to demonstrate why the patient-perspective approach to PCC can result in problematic outcomes (e.g., reduced provider-patient trust and patient satisfaction, and gaps in providers' and patients' assessment about the quality of provider-patient interactions).

First, providers and patients may have competing needs and expectations in PCC. Providers in our study routinely incorporate forms of speech that appear to honor patient perspectives and respect patient decisions by minimizing their influence over the decision-making process. For example, providers often make explicit statements that emphasize patient autonomy (Lines

801-802, “you are in charge”) or patient preferences (Lines 916-917, “we’re going to try and get to know you”). Rather than offering a subjective, expert opinion, a provider may explicitly reference his or her desire to not influence the patient’s attitudes or beliefs (Lines 208–209, “I don’t want to direct you one way or another”), frame the treatment as a routine, normative procedure (Lines 716-717, “that’s just the way they’re treated”), or explicitly cite ethical principles (Lines 105–106, “to value that rule of do no harm”). In these situations, providers’ recommended treatments were guided by external norms or standards, making their attitude to the proposed treatments unclear (e.g., are these treatments recommended because the providers think that they are the best?). The desire to minimize providers’ influences over patients’ decision-making is rooted in modern, Western medicine, which emphasizes patient autonomy and self-determinism (Ryan & Deci, 2011; Williams, Teixeira, Carraça, & Resnicow, 2011). By conceptualizing beneficence as medical paternalism (Rothman, 2001) and an ideal patient as an informed patient who is capable and willing to assume all responsibilities in their illness events (Kapp, 2007), a provider may be reluctant to offer an explicit, directive recommendation (e.g., “you should do this because you are too old.”).

However, as a layperson involved in a complicated illness event (e.g., gynecologic cancer), a patient may not have the necessary health literacy to ask the necessary questions or make informed decisions. This is particularly true for patients in our study, who are visiting the oncologists and learning about their cancer diagnosis for the first time. During the stages of cancer diagnosis and treatment, patients rely heavily on health care providers as a major source of information to help guide their treatment-related decision-making (Rutten, Arora, Bakos, Aziz, & Rowland, 2005; Thorne, Oliffe, & Stajduhar, 2013). Recent studies also argue that not all patients wish to engage in shared decision-making (Cousin, Schmid Mast, Roter, & Hall, 2012; Levinson, Kao, Kuby, & Thisted, 2005). A provider who is unwilling to offer explicit recommendations based on their expert knowledge can pose significant stress and confusion to a patient newly diagnosed with cancer. It is important to note that emerging understanding about patient autonomy requires providers to ensure that patients share the necessary conditions and resources (e.g., medical knowledge and individual agency) to make informed decisions (Dy & Purnell, 2012; Pantilat, 2008). From this perspective, if providers refrain from offering their expert opinion in PCC for fear of compromising patient autonomy despite a patient’s lack of communicative competence or reluctance to decision-making, they may, in fact, compromise the quality of care and cause unnecessary stress for patients.

Second, although exploring patient preferences is fundamental to PCC (Dy & Purnell, 2012), referencing or soliciting patient perspectives during a medical encounter is an insufficient indicator of PCC. Our findings demonstrate that providers may solicit patient perspectives to determine their corresponding discursive strategies. If the patient proposes or accepts their preferred treatment (e.g., Excerpts 1 and 13), providers offer support for patients’ decision and conclude the discussion on treatment decision-making. For example, Pearl complimented Caimile’s decision of not pursuing aggressive treatment (Lines 116-117, “I think that’s fairly wise”). Despite the intense discussions about treatment preferences (Excerpts 9–13), once Charmaine asked for the less aggressive treatment, Pearl immediately supported her decision (Lines 1303–1305, “I thought if we got real specific with you, you might understand.”) In these situations, providers concluded the topic on treatment options once a patient offers his or her decision. One may argue that these scenarios resemble the expected provider–patient interactions in PCC because the providers are attentive to and supportive of patients’ perspectives.

However, when a patient presents preferences different from a provider’s (explicit or implicit) preferred choice, providers in our study adopt various strategies to discourage a patient from committing to his/her initial preferences. For example, a provider may provide an evaluative frame that discourages certain options (e.g., Lines 604-605, “that would be an incredibly morbid procedure”; Lines 1223-1224, “a big, big surgery”), challenge a patient’s characteristics or beliefs (e.g., Line 606, “you are not the healthiest egg!”; Lines 507–508, “It’s not like you need to live 10 or 20 years”), or refuse to transition to the next topic after the patient has offered her decision (e.g., Excerpts 9–11). In these situations, providers do not treat patient perspectives as characteristics, attitudes, or beliefs to be honored; rather, patient perspectives serve as a strategic resource for providers to orient patients’ understanding and interpretation of meanings. They assume the role of “salesmen,” adopting a variety of tactics and utilizing any available resources and power to manipulate and influence patient decision-making (Karnieli-Miller & Eisikovits, 2009).

Although some researchers suggested that these strategies can serve as “nudges” to encourage certain behaviors without restricting individual choice (Thaler & Sunstein, 2008), others argued that these can be potentially problematic persuasion tactics to influence individuals’ decision-making (Zikmund-Fisher, Windschitl, Exe, & Ubel, 2011). This is because a patient who wishes to resist a provider’s recommended treatment may be under tremendous pressure to change his or her attitudes and beliefs, resulting in negative experiences with providers’ patient-perspective approach to PCC. Patients in our study

express their lack of agency through their acknowledgment of the provider's power (Lines 614-615, "Just do the best you can"), minimal responses (Lines 1008 and 1011), and passive resistance (Line 1016). On the other hand, providers in our study strategically reinforce the power asymmetry through their control over the content and process of provider-patient interaction, creating an authoritative pressure for patients to conform to their assessment (see also Karnieli-Miller & Eisikovits, 2009).

It is also important to note that the problems we observed can have a compounding effect. For example, when a provider continues to pressure a patient to change his or her preferences through discursive tactics and feels obligated to refrain from providing an explicit recommendation to avoid medical paternalism, the patient is inevitably forced into a guessing game that will not end until she or he chooses the "right" answer according to the provider. Such processes are likely to increase patients' stress and frustration.

Finally, our findings demonstrate that patient-perspective contextualization has multiple functions and meanings in medical discourse, some of which can be unnerving to patients. For example, although a provider may use a patient's unique conditions as a discursive frame to facilitate understanding of treatment options, their discursive frame may appear discriminatory (e.g., "you are not the healthiest egg" or "it's not like you need to live 10 or 20 years"). A patient may develop doubts about the provider's fiduciary position, become concerned about the provider's alternative agenda (e.g., not wasting resources on elderly patients), and experience increased uncertainty, anxiety, or helplessness, all of which are likely to compromise the quality of PCC (Dy & Purnell, 2012). From this perspective, how providers and patients present and negotiate the frames that emerge in the discursive process is critical to individuals' evaluation of PCC.

Several reviews have argued that patient-centeredness is "not a unitary concept but incorporates components that may be differentially helpful to patients" (Michie et al., 2003, p. 204). It is important to note that our findings do not suggest that patient-perspective contextualization is a poor communication style for PCC. Rather, we aim to highlight the complexity of a patient-perspective approach (i.e., eliciting and responding to patients' perspectives). Without consideration for a patient activation approach (i.e., empowering patients to take control in the care process), a patient-perspective approach can fail to achieve the benefits envisioned in PCC (Michie et al., 2003). In other words, as providers elicit and respond to patients' perspectives, it is essential that they also empower patients by providing necessary resources (e.g., illness-related information and control of provider-patient interactions) to think critically and make autonomous, informed decisions (Anderson & Funnell, 2010; Hsieh, 2013).

In conclusion, providers' use of patient-perspective contextualization does not necessarily mean to honor patients' perspectives. Patient preferences and needs are actively co-constructed and manipulated through providers' discursive tactics. To facilitate positive outcomes of the patient-perspectives approach to PCC, providers need to develop communicative strategies that are effective and appropriate in framing patients' unique characteristics and needs (e.g., avoiding potentially discriminatory frames and manipulating patient preferences). In addition, providers need to be sensitive to alternative interpretations and develop appropriate and meaningful strategies to orient patients to their primary frame.

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