

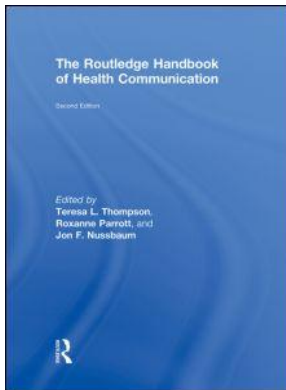
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## **The Routledge Handbook of Health Communication**

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### **Explaining Illness**

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## SECTION IV

# Mediators and Moderators of Care and Understanding

# 18

## EXPLAINING ILLNESS

### Issues Concerning the Co-Construction of Explications

*Teresa L. Thompson, Bryan B. Whaley, and Anne M. Stone*

The central function of all medical systems is to give meaning to illness by naming and defining its cause (Stoeckle & Barsky, 1980). The goal of much health communication, then, is explaining illness. There is much to be said about this topic (see Whaley, 2000). One critical issue that arises in regard to explaining illness that has received recent scholarly attention is how providers and patients co-construct the explaining illness interaction. The present analysis will describe the need for illness explanations to provide a framework for better understanding the role of co-construction of explanations between providers and patients. The chapter concludes with attention to future directions for research on explaining illness.

#### **Need for Illness Explanations**

To understand the process of explaining illness, one must begin with an understanding of the need for such explanations (Thompson, 2000). This necessity is made apparent in several ways, but most notable amongst these is the *lack* of explanations reported by most patients. Receiving explanations is not, however, associated with such feared negative effects as treatment refusal or increased side-effects (Quaid, Faden, Vining, & Freeman, 1990). The research indicates that health care providers typically underestimate patients' demands for information and overestimate the quantity, completeness, and effectiveness of the explanations they provide (Strull, Lo, & Charles, 1984; Waitzin, 1985). The same lack of reception of illness explanation is reported by patients' family members; this is especially true of parents of ill children. Illness explanation needs are well documented in the literature in that study after study demonstrates the multitudinous needs for additional information on the part of patients (Thompson, 2000). This is true across almost all health problems and provider types. Cultural factors do, however, moderate the perceived need for explanations. Individuals from some cultures and in some age groups desire less complete information than do others (Thompson, 2000).

A second factor leading to an apparent need for explanations of illness may be seen in the research that documents the effects of receiving them. Those patients who receive more adequate explanations are more likely to adhere to treatment recommendations. They also recover more quickly, experience less postoperative vomiting and anxiety, need less

anesthesia and pain medication, and are healthier, amongst many other positive outcomes (see Thompson, 2000 for a more complete discussion of this issue; see also Duggan and Thompson, this volume). The importance of the patients' perception of an illness, regardless of where it comes from, is indicated by data showing that such perceptions are key determinants of adjustment and coping (Dorian, Dempster, & Adair, 2009). Also, there are no associations between receiving illness explanations and treatment refusal or increased side-effects (Thompson, 2000).

Scholars have also examined how a patient's medically unexplained symptoms affect the provider-patient relationship (Fishchoff & Wessely, 2003; Greer & Halgin, 2006; Seaburn et al., 2005) and thus have implications for explaining illness. Specifically, Peters, Stanley, Rose, and Salmon (1998) examined the connection between lay and medical beliefs when a patient presents physical symptoms that the health care provider cannot diagnose. The authors suggested, contrary to other research findings, that patients view the physician as an ally and that patients do not adopt a biomedical model to describe their symptoms. Furthermore, Ogden et al. (2002) were interested in predictors of agreement on symptom etiology for patients with ambiguous symptoms. The authors found that physicians were more likely to define the illness as psychological if the patient was female, had a history of psychotropic medication use, and if the symptoms could not clearly be linked to a medical explanation.

Explanations that are provided to patients are also influenced by care providers' expectations and cultural/racial biases (Perloff, Bonder, Ray, Berlin Ray, & Siminoff, 2006). Racial biases must also be understood within the context of literacy level, however. Controlling for literacy levels does help moderate disparities in health function based on race (Sentel & Halpin, 2006). Similarly, the gender of both the explainer and the subject of the explanation influence explanations and attributions that are offered (Benrud & Reddy, 1998).

Research has highlighted uncertainty as a familiar experience across a variety of illnesses, including Alzheimer's disease (Stone & Jones, 2009), cancer (e.g., Clayton, Mishel, & Belyea, 2006), heart disease (Jurgens, 2006), and chronic pain (Johnson, Zautra, & Davis, 2006). Scholars have described the complexity of uncertainty experiences in illness in a number of ways. Following Mishel's (1988, 1990) work on uncertainty in acute and chronic illness, Brashers et al. (2003) identified three sources of uncertainty in the HIV illness context (i.e., medical, personal, and social sources). As Mishel (1988, 1990) described, medical uncertainty is related to insufficient information about diagnosis, ambiguous symptom patterns, complex systems of treatment and care, and unpredictable disease progression. Given that patients report that they do not receive the amount of information that they want in medical encounters, and that the information given is not clear, it is important to consider the important role that managing uncertainty may play in explaining illness.

Other theories of uncertainty have also described the complexity of the experience of uncertainty. For example, Babrow (1992, 2001) developed Problematic Integration theory to help explain how people experience uncertainty in illness. Babrow, Hines, and Kasch (2000) argued that the answers to people's questions take the form of "probabilistic orientations." For example, patients may question the likelihood of a drug helping them cope with the physical manifestations of an illness. According to Problematic Integration theory, people also evaluate their experiences. These "evaluative orientations" refer to the assessments people make after they consider the likelihood of a particular occurrence.

In addition to considering the psychosocial contextual features of explaining illness, it is important to consider the clarity of information that is used to explain illness. Problems with research on the information communicated during explanations of illness has been noted by such scholars as Tuckett and Williams (1984), whose review of this scholarship

indicated that a considerable amount of work has focused on how much information is given rather than the content or value of that information. It is more important to examine how illuminating, relevant, or helpful the information might be to patients than it is to just examine how much information is communicated. The small amount of research that has attempted to examine information offered in illness explanations has generally asked patients to rate the value of the information. While these data are useful, one might question the patient's ability to assess such value. The patient's assessment is of interest in terms of what the patient does with the information and how the patient uses it, but might not correspond with a broader perspective on the value of the information.

Patient understanding of disease fluctuates somewhat with age and with culture, with children and adults from some Asian cultures accepting magical causality, although most adults prefer biological causality (Nguyen & Rosengren, 2004). Other research has identified the role that perceived genetic causality plays in the process of understanding and explaining illness (Parrott et al., 2004).

Third, the need for explanations of illness is also determined by the difficulty of providing them. Patients generally have poor recall of explanations, provide their own interpretation of illness, and have many misconceptions about illnesses. Many patients demonstrate little understanding of the medical jargon on which most explanations rely, making the explanation process even more difficult. While it may be assumed by some that patient understanding of medical terminology has improved over time, the data fail to document such an improvement. Indeed, much medical terminology is not even understood by care providers themselves. Reliance on medical terminology by care providers results in a lack of understanding on the part of the patient and social "one-upmanship," mystification, and control. Patients sometimes sue or seek ethics consultations just to receive an understanding of the language that has been used by care providers. The literature is replete with examples of apparently simple terms used by providers that are not appropriately understood by patients (Thompson, 2000).

Research that focuses on how much information is recalled or remembered by patients, however, also generally does not take into account the sense that patients make of that information. It may well be more important to examine how useful and convincing patients find explanations provided by care providers compared to their own lay conceptions, for instance (Tuckett & Williams, 1984) than it is just to look at the objective nature of the information.

Building on this foundational understanding of the need for illness explanation, various health care providers have shared suggestions based on their experience of the types of information that should be included in explanations and the ways in which explanations should be communicated (Thompson, 2000). Such suggestions are consistent with much else that will be found throughout the present volume, in that they include the value of adapting to the patient's knowledge, literacy levels, and concerns. The patient should be put at ease and explanations should be simply expressed; the patient's explanatory model of illness should be elicited.

The act of explaining illness serves more than an instrumental function—it should also be accompanied by emotional support. The message can and should communicate interest and caring as well as information. Some explanations documented in the research, however, function to control patients rather than to provide valuable information or social support (Rabinowitz, Beckman, Morse, & Naumburg, 1994). Experimental studies of the effects of different approaches to explanation provision indicate that both sensory and procedural information are helpful. The best explanations, however, elucidate for the patient both the

procedures that he or she will be experiencing *and* the sensations that will be experienced (Thompson, 2000). Such explanations are associated with decreased pain. When sensory and procedural explanations are combined with coping suggestions, patients experience even more positive effects. This effect is especially notable with sicker, less well-educated, and poorer patients (Chwalow et al., 1990).

Given the importance of empathy in communication between providers and patients with regard to both provider and patient outcomes (Hojat et al., 2002; Larson & Yao, 2005), it is important to consider the role of empathy in explaining illness. Other research has provided in-depth observation of care providers who seem to be especially good at providing explanations. These care providers combine their explanations with empathy and humor and use much repetition, pauses, ask tag questions, and use reinforcement. Those providers are also observed to validate the patient's understanding and to switch from the voice of medicine to the voice of the lifeworld. Patients are likely to experience a variety of emotions during a visit with their health care provider. It is essential, then, that, while communicating with the patient, the provider demonstrates empathy via her or his message. Research has suggested that demonstrating empathy helps the patient to better comprehend the situation and avoids situations where emotions take over (Ptacek & Eberhardt, 1996; Quill & Townsend, 1991). Observational studies further document the lack of communication about risk information, side-effects, and medication in most provider-patient interactions.

### The Co-Construction of Illness Explanations

The work just reviewed focused primarily on the need for illness explanations and suggestions in addressing those needs by health care providers when they explain illness to patients. The actual process, however, is of course, much more complicated than depicted. During medical interaction, illness explanations are *co-constructed*. Some physicians and researchers argue that shared decision making is really only appropriate in instances of medical uncertainty (Dominick, Frosch, & Kaplan, 1999), and others articulate various conditions under which patient preferences should be taken into account (c.f., Kassirer, 1994). In actuality, both the provider and the patient work together, implicitly or explicitly, to generate *any* explanation that is ultimately created. Even the use of the term "ultimately created," however, is misleading. That terminology implies that there is an end-point to illness explanation. As the research to be reviewed below makes clear, however, the explanation process is instead an ongoing one.

Essential to understanding the co-construction of illness explanation is an appreciation for the *process* of medical interaction. Initially, of course, the patient arrives at the medical interaction with some preconceived ideas about his or her medical problem. Self-reported patient health is determined by many variables beyond physical and mental symptoms (Singh-Manoux et al., 2006). These initial conceptions are rather tenacious and long-lasting. The preliminary conceptualization of illness must move through an interpretive process during which the patient begins to label sensations that she or he is experiencing as potential symptoms. This process involves determining which sensations a person must pay attention to—which sensations could be problems. These are interpretive decisions that are influenced by cultural ideas about vulnerability, sensation duration, and interference with activities (Hay, 2008).

Culturally plausible conceptualizations of illness are important considerations for understanding the explanation process (Garro, 2000). Indeed, it has been argued that cultural differences in explanatory models become key determinants of differences in health service

availability and subsequent mortality (Furnham & Baguna, 1999). “Suffering” is defined differently in various cultures (Shweder, 2008). Socio-demographic and ethnic differences have also been observed, in that individuals from lower-class and some ethnic backgrounds are less likely than others to define a particular sensation as a health problem (Stoeckle, Zola, & Davidson, 1963). Some studies have found that over 90% of those preselected as “healthy” individuals in research that compares healthy and unhealthy patients are not healthy at all—they, too, have diseases and conditions that are amenable to diagnosis and treatment (Stoeckle et al., 1963). Patients differ in the triggers that lead them to seek health care.

The initial interpretation, however, of the individual experiencing the “sensation” is tentative; it is frequently discussed with others to determine whether or not it should be seen as a “symptom.” Conversations help an individual decide if it should be pathologized and socially legitimated as an illness or health problem (Hay, 2008). These initial beliefs also include conceptualizations of potential harm and side effects of treatment possibilities (Aikens, Nease, & Klinkman, 2008). Many of these explanatory models are also metaphorical (Mabeck & Olesen, 1997). These initial ideas/models, called “lay ideas” (Leventhal, Meyer, & Nerenz, 1980, p. 7; see also Leventhal, Leventhal, & Cameron, 2001), help patients understand and cope with that threat.

Another depiction of patients’ explanatory models of illness is offered in Mill’s (2000, 2001) participatory action research on HIV positive Aboriginal and Ghanaian women. This work indicated that the women’s explanatory models combined both traditional and biomedical conceptualizations of illness. The women had their own views on the etiology, pathophysiology, symptomology, course of illness, and methods of treatment for their illness. Mill’s research indicated that care providers who did not take these initial explanatory models held by the patients into account were not able to treat the patients effectively. The significance of a patient’s explanatory model is also evidenced by the findings that patient health beliefs determine the degree of distress experienced by those receiving chemotherapy (Thuné-Boyle, Meyers, & Newman, 2006) and suffering from severe allergy and asthma symptoms (Knibb & Horton, 2008)

Because physicians and patients often have different perspectives on medical interactions scholars have noted that it is increasingly important to understand explanatory models of health and illness. Haidet et al. (2009) described the importance of identifying specific dimensions of explanatory models to develop an instrument to measure patients’ and physicians’ explanatory models (see Haidet et al. for The CONNECT instrument, a 19-item scale focusing on six dimensions of explanatory models).

The patient has, of course, made only a tentative decision about defining a sensation as a symptom at the time that a medical interaction begins. Some of the most promising work that focuses on what happens during the co-construction of the explanation that occurs within the medical interaction has been discourse or conversation analytic in nature (see also Robinson, this volume). Some related work, however, is based on writing by physicians or other care providers and is more “how-to.” For instance, Galland’s (2005) work on patient-centered care takes a very dyadic approach as it provides such guidelines for doctors as, “The importance of understanding the patient’s experience of his/her illness cannot be overemphasized” (p. 62).

To actualize Galland’s (2005) suggestions, care providers need to allow patients to explain their symptoms and perceptions in their own words. Doing so has been termed “patient exposition” by Orth, Stiles, Scherwitz, Hennrikus, and Vallbona (1987, p. 29), whose research indicated that patients who are allowed do this demonstrate reductions in

both systolic and diastolic blood pressure. By contrast, physician exposition of the patient's problem is associated with only lower diastolic blood pressure.

As noted above, patients enter a medical interaction with an explanatory model of which care providers are typically unaware. Research by Lang, Floyd, and Beine (2000) has identified cues that indicate such explanatory models, however. Their work indicates that (a) expression of feelings (especially concern or worry), (b) attempts to understand or explain symptoms, (c) speech clues that underscore the patient's particular concerns, (d) personal stories that link the patient with medical conditions or risks, and (e) behaviors suggestive of unresolved concerns or unmet expectations may communicate to care providers that the patient does indeed have an explanatory model in mind that should be explored because of its likely impact on subsequent treatment responses.

Patient-provider co-construction of explanations requires the examination of the messages offered by both and how each responds to the other. For instance, does each elaborate on what the other has said? Does each question try to clarify what the other has said? Is disagreement offered? Does the provider pick up on the patient's attempts at explanation and encourage elaboration? All of these indicate the co-construction process.

The patient's initial response to the physician's diagnostic statement is determined by the way in which the evidence supporting the diagnostic statement is presented by the physician. In those instances in which the evidence is verbally explicated, patients respond by then talking about the diagnosis. In situations where the physician does not verbally explicate the diagnosis, the patient does not go on to talk about the diagnosis. When patients do talk about the diagnosis, four types of responses have been observed: straight agreements, symptom descriptions, rejections of the proposed diagnosis, and actions related to the interpretation of evidence (Peräkylä, 2002). Rarely do patients explicitly disagree with a physician's diagnosis, however (Heath, 1992). Patients are more likely to remain silent or produce a minimal acknowledgment. Patients who disagree are likely to instead refer to the subjective experience of suffering or indirectly or cautiously encourage the physician to reconsider the assessment. Some patients, however, explicitly communicate agreement and occasionally disagreement with the other in co-construction.

Patient participation is encouraged by diagnoses (a) formatted as questions, (b) presented as uncertain, or (c) showing implicitly or explicitly that the doctor's view of the condition differs from what the patient expected. More thorough explication of the diagnosis through explanation also leads to more discussion of the diagnosis with the provider. The provider may need to make explicit the desire to share participation in decision making in order for it to be evident to the patient. Online commentary during an examination, may also invite co-construction.

Additionally, the dyadic nature of the explanation process is affected by patients' information seeking and verifying behavior. Patients vary on these behaviors both as individuals and in response to the behaviors of their doctors. Research by Cegala, Post, and McClure (2001), however, has indicated that patient training in information seeking and verifying behaviors can impact patient effectiveness and the amount of information that patients obtain.

Tuckett and Williams's (1984) review noted that "patients can manipulate doctors to do what they want by limiting what they tell them" (p. 571). However, lack of patient participation is also created by the structure of the medical interaction. Medical interactions operate according to a consistent pattern, which typically does not explicitly include patient co-creation of the explanation. Most medical interactions operate by following four simple steps: (a) establishing the reason for the visit; (b) gathering of additional information on the



part of the provider (history taking, physical exam); (c) deliverance of the diagnosis; and (d) suggestions for treatment recommendations. This is the pattern of interaction that providers are taught and it is the pattern with which patients are familiar. As can be seen, it leaves little room for patient participation in co-creation.

How patients respond to interruptions by the provider is a crucial part of co-creation. For instance, does the patient allow the provider to change the direction of the conversation or does that patient continue with the narrative, perhaps after answering the question? Co-creation may involve the patient drawing attention to particular symptoms or past history. Co-construction is also indicated by the mention of unasked for information and symptoms.

Just as examining what the patient brings to the interaction is foundational to the co-construction process, the predispositions that the care provider brings to the interaction are also relevant. Those care providers who are generally more open to discussions of feelings are more likely to explore patients' experience of illness, whereas those providers who perceive that medical interaction should be more rule-bound (Chapman, Duberstein, Epstein, Fiscella, & Kravitz, 2008) involve the patient less in treatment decisions. These doctors may, however, still explore patients' psycho-social and life experiences. Physicians who themselves report more anxious vulnerability also involve patients less in decision making (Chapman et al., 2008).

Part of the co-construction of the explanation is the patient's presentation of the narrative—telling the story of the reason that she/he is there (see Sharf et al., this volume). Narratives allow patients to maintain control over the content and trajectory of the talk. Telling the story may, thus, be used by the patient in preference to just answering the provider's questions. The story may include explication of what the patient has already tried to do to address the problem. The patients' communication of the narrative may invite the provider to reassure, as well. The patient may also bring in the opinions of others as part of the co-creation of the explanation (e.g., "my husband thought..." "I heard on the news that..."). The story may include such statements as "...and I thought" or "first I thought... So I tried ... and then it seemed..." The story is likely to describe the time line of the health problems and various attempts at treatment. The introduction of new details by the patient during the exam and diagnosis may indicate implicit disagreement with the provider. Similarly, patient repetition and emphasis of symptoms are frequently indications that the provider's explanation is not adequately taking into account the severity of the symptoms.

Understanding the nature of the co-construction of illness explanation requires examining the outcomes of the interaction in terms of subsequent patient perceptions of the information that was communicated and how these relate to actual recordings of the interaction as well as chart records. DiMatteo, Robinson, Heritage, Tabarrah, and Fox (2003) did just that in an analysis of 17 physicians and 77 of their patients. Their results indicated great inconsistency between patients' recollections and chart records, but better although not complete correspondence between patients' recollections and videotapes of the interactions. An understanding of the explanation process must take into account that the "explanation" that is understood by the patient may not correspond to either what actually occurred or what the care provider perceived.

The goal of the medical interaction is, in part, to name the problem (Brown, 1990). For both interactants, naming helps in sense making. The care provider wants the certainty and control which comes from naming the problem; to a certain degree, the patient also wants this certainty and control (Brown, 1990). This is an organizing process (Balint, 1957). But diagnosis is also "an arena of struggle" (Brown, 1990, p. 402). Although Brown characterized diagnosis as a "power-linguistic approach to categorization, in which patient

subjectivity is sacrificed to clinical objectivity” (p. 400), he also noted the dynamic and interactive nature of the process—“certain bits of information are sought or offered, leading to decisions to ask for other bits” (p. 400).

Going beyond what takes place in the medical interaction itself, however, it is important to note, as mentioned above, that the process of illness explanation is an ongoing one. It begins prior to the medical interaction, evolves during that interaction, but, importantly, continues well beyond the actual interaction. Perhaps the most interesting work articulating this process-oriented view of illness explanation comes from Hunt, Jordan, and Irwin (1989). Hunt et al. began their work by hypothesizing that the medical diagnosis plays a key role in determining patients’ assessments of what is wrong with them. Their longitudinal interviews with patients, however, indicated that the medical diagnosis and the opinions/explanations provided by the physicians played a relatively minor role in patients’ actual perceptions of their illness condition. The physicians’ diagnosis is only one small determinant of patients’ explanations of their illnesses. Patients constantly restructure their understandings of their illness as their lives evolve and change. Hunt et al.’s interviewees showed great fluctuation in the explanations they provided of their illness over time, and these reformulations were typically not prompted by the medical consultation. Daily circumstances and aspects of the social environment played a large role in these reformulations. Information came to patients from other doctors, popular literature, and the media (Gill & Babrow, 2007), their own interpretations of biology and psychology, and the advice and experiences of family and friends.

Stoeckle, Zola, and Davidson (1963) discussed a similar “lay referral system” (p. 975). Pharmacists are yet another source helping in the construction of the illness explanation (Schommer, 2000; Schommer et al., 2006). Varying environmental circumstances, such as a move, job change, or change in marital status, were reconstructed by patients to help explain their illness. These factors eventually came to be seen as more important than the physicians’ original diagnosis. A related example of how such change is seen as key to explaining illness may be found in the findings of Emami and Torres (2005) that health problems in Iranian immigrants who moved to Sweden late in life are perceived by the patients as more directly related to their recent move than to any other explanatory factor.

Rarely were the initial diagnoses provided by the physicians completely rejected by patients in Hunt et al.’s (1989) research. Instead, the patient’s conceptualization of his or her illness typically evolved over time so that, while it still incorporated some elements from the physician’s diagnosis, it also returned to the patient’s original view of the health care problem. Hunt et al.’s findings confirm the notion mentioned above about the tenacity of patients’ preconceptions of illness. The explanation, they found, was shaped to function usefully in the life of the patient. Some explanations were constructed to give the patients social recognition for their hardships and stress; some functioned to solicit social support. All were used to marshal resources needed by the patient.

The additional social factors that impact explanations of illness are also emphasized in such perspectives as those offered in this volume by Cline, focusing on the role of everyday health communication, and by Parrott (2004a), emphasizing the informal and less intentional communication processes relating to health. Similarly, Parrott’s (2004b) work on the impact of religious faith and spirituality in understanding the health communication process should remind us of the broader context in which explanations are constructed and the other important factors that impact them beyond the medical interaction. Parrott’s exhortation is also consistent with the findings of Schnoll, Harlow, and Brower (2000), which indicated the positive role of spirituality in adjustment to and coping with cancer.

The finding noted above that patients frequently reject care providers' explanations and, subsequently, treatment recommendations, has been studied in further detail by Sharf, Steljes, and Gordon (2005). Their findings help us interpret the conclusions of Hunt et al. (1989) that patients reconstruct the explanations provided by caregivers. Sharf et al. studied lung cancer patients who had refused the treatment recommended by their doctor; the rationales for these decisions offered by patients fit with the reconstructions noted by Hunt et al. (1989). They included such arguments as patient reports that, having heard that exercising is good for lung cancer, they were exercising instead of engaging in the doctor-recommended treatment. Another patient noted, "I just seen a spot on the X-ray. A little bitty spot and I'm a big man. It'd take a lot to pull me down" (Sharf et al., p. 639). There was much minimization of threat and focus instead on self-efficacy amongst the patients who were interviewed. Reliance on faith or fatalism was also noted. Such findings yield further light on the co-construction and re-construction of explanations. All of these patients had received explanations of their lung cancer and explicit treatment recommendations, which they had chosen not to follow. Similarly, Moore et al.'s (2004) large scale, multiethnic survey of patients who delayed treatment found associations between avoidance or delay of treatment and patients' satisfaction with the time spent with the provider, along with the respect, understanding, and listening provided by their physicians.

Explanations that are provided to patients are also influenced by care providers' expectations and cultural/racial biases (Perloff et al., 2006). Racial biases must also be understood within the context of literacy level, however. Controlling for literacy levels does help moderate disparities in health function based on race (Sentel & Halpin, 2006). Similarly, the gender of both the explainer and the subject of the explanation influence explanations and attributions that are offered (Benrud & Reddy, 1998). The importance of the patients' perception of an illness, regardless of where it comes from, is indicated by data showing that such perceptions are key determinants of adjustment and coping (Dorian et al., 2009).

### **Future Directions**

Health care providers, patients, and families are faced with a unique challenge in medical interactions. The move from a paternalistic model of patient care to a more patient-centered approach that considers communication suggests several avenues for future research. Scholars have long demonstrated that communication is purposeful and have described theoretical frameworks that help to elucidate the complexities of communicative interactions. Theories of multiple goals, in particular, have been useful in highlighting the importance of both content and form of messages. A multiple goals perspective is a principled way of identifying message features that are likely to be effective in explaining illness. Because individuals may have different needs during the interaction, there are almost certain to be various goals present when creating illness explanations; messages that address multiple goals should be more effective. Various theories of multiple goals have demonstrated worth in communication literature (e.g., Clark & Delia, 1979; Goldsmith, 2004; O'Keefe, 1990). Clark and Delia (1979) discussed goals in terms of relational, identity, and task goals. One of these goals may be the predominant feature of a message or multiple goals may be negotiated within the co-creation of messages. Another theory suggested that messages are constructed using different design logics (O'Keefe, 1990). Most recently, Goldsmith (2004) suggested that rather than thinking in terms of "goals," perhaps communication scholarship should consider the multiple purposes that a message needs to address in order to be considered effective. For example, when health care providers are faced with an instrumental

goal of explaining illness (i.e., comprehension) and, say, the task of delivering bad news within the same interaction sequence (a task that is reportedly one of the most difficult a medical professional faces), health care providers must consider the amount of information the patient already has in addition to how that message should be communicated to attend to relational and identity goals.

As scholars have suggested elsewhere (Thompson, 2000; Whaley, 2000) explaining illness needs to be examined at content and relational levels. It is essential to communicate information that meets patients' needs while maintaining a sense of their emotional capacity for integrating that information into decision making. This chapter provides further evidence that improving illness explanations and the relationship between providers and patients requires attention to the multitude of factors present in each health care interaction.

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