Clinician Language Choices:
An Analysis of Agency in Patient-Provider Interaction through Uncertainty Management Framework

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Introduction

Though there has been substantial research in the relatively new field of uncertainty management theory, very little analysis has been done with respect to the patient-provider relationship that is fundamental to the field of health communication. Perhaps the most common binary relationship in healthcare, it is remarkable that uncertainty management theory has been mainly focused on other social fronts: romantic partnerships and family decision making processes.

The goal of this paper is to explore the rationale behind altering agency choices in patient-provider interactions. Notably, this is distinct from previous applications insofar as the information provider will be the focus of discussion as opposed to the information seeker, historically the more common source of analysis in uncertainty management research. Ultimately, the Theory of Motivated Information Management (TMIM),[1] and subsequent adaptations that integrate appraisal theory,[2] will be adapted to explain altering the source of agency in delivering primarily negative diagnoses or news to a patient.

Ultimately, the paper will define four categories in which agency can be shifted from the provider to other sources as mechanisms. Through an examination of these categories and specific examples of each, shifts in agency will be concluded to have one of two goals: (1) preserve provider safety/distance from liability and (2) manipulate or coerce the patient into a making a decision favorable to the provider.

Patient-Provider Interaction Overview

To premise, it is important to understand the complexity of the patient-provider relationship as distinct from other binaries. The relationship between a patient and provider is necessarily asymmetrical, that is, it is controlled by the physician, typically through asking questions.[3] Resultantly, the flow of information between provider and patient is also controlled by the physician. Doctors can restrict the flow of information to patients, often withholding critical facts about their diagnosis and treatment.[4] Additionally, the medical interview is shaped by the context in which it takes place; cultural assumptions about the patient, the logic of differential diagnosis, and the demands of bureaucratic organizations combine to constraint doctor-patient communications.[5] Notably, this would include legal liability and malpractice, to be discussed in greater detail later on in the paper, as well

as assumptions about a patient based on appearance that may make deflecting agency to another source easier (for example, an overweight patient).

Regarding the actual medical interview, it inherently subordinates the patient's concerns, beliefs, and life world to the demands of medical discourse.[6] It can thus become a form of repressive communication that ultimately and severely compromises the quality of patient care.[7] The structure of the medical interview is likely one such cause of these results. Roter and Hall suggest that there are five parts that take place in each medical visit: opening, history, the physical exam, patient education and counseling, and a closing. Notably, patients are most verbally active in the history section where communication is almost equivocal between provider and patient (52% in favor of physician). However, physicians are very quick to redirect patients from presenting the entirety of their concerns in the history segment of their visit, which has the effect of limiting the full disclosure of all of the patient's concerns.[8] Many times interruptions are made to redirect patients to closed-ended questions, possibly to facilitate transition to the later segments of the medical encounter.

Negative talk is rare from physicians during the medical encounter. Physicians often find other, indirect ways to express displeasure. Reprimands may be expressed as forceful counseling or imperatives on the need to follow recommendations better.[9] One such example is a deflection of agency, where the provider distances themselves from the patient and replaces another agent in place of him/herself. Notably, this would not be considered negative talk, instead, a way to communicate a message indirectly to the patient.

Defining Agency in Medical Encounters

First, I provide a definition of agency, "an autonomous organization that adaptively regulates its coupling with its environment and contributes to sustaining itself as a consequence."[10] Importantly, there is an active component to the definition provided, making inanimate objects incapable of functioning as an agent. By this logic, neither procedures nor technology can present as permissible agents in medical encounters.

It is important to provide an explanation for how to locate agency, and how it exists in medical interactions. For the sake of this paper, two criteria will be required in order to determine the source of actual agency in any given relationship:

The system must define its own individuality, and

It must be the active source of activity in its environment.[11]

To clarify, I provide an example of finding the source of agency in a typical (and perhaps, ideal) medical scenario in which a patient visits a provider for an annual, regular physical examination. The system is necessarily *individualized*, the patient and his/her scenario and relationship to the provider is unique. The *active source of activity* is that of the physician conducting the actual physical examination on the patient. Thus, the agent in this interaction can be concluded to be the physician.

Often times the agency in certain interactions can be convoluted. However, in a medical discourse, there are necessarily two parties and therefore an agent is by definition present in the provider that is delivering the message. Yet there are examples of physicians skirting around being the agent in delivering diagnoses, particularly in delivering news of chronic or terminal illness or other potentially detrimental news.

Context and Types of Agency Deflection

This section of the paper will focus on defining four categories in which agency can be deflected to another party or object through language and patient delivery. Through application and several examples, the alternative agent presented will be examined and analyzed for permissibility as an agent per the previous definition.

The four types of agency deflection to be examined are not mutu-

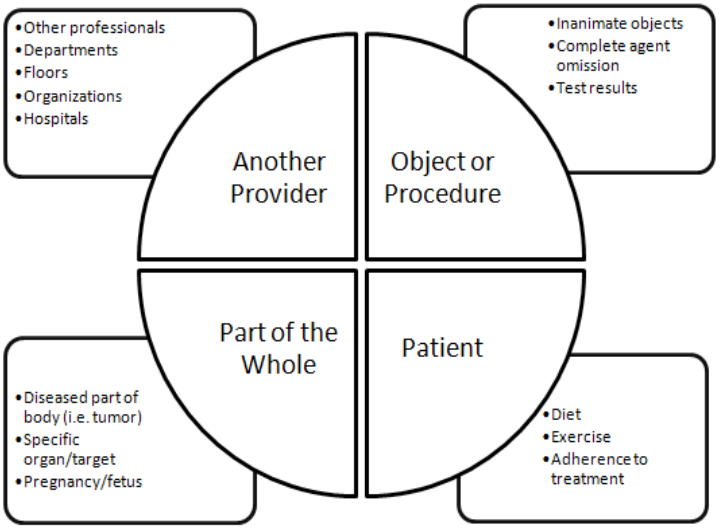

Figure 1. Proposed mechanisms of agency deflection and examples

ally exclusive yet most examples can be located in one of the four strata (Figure 1).

Deflection of Agency to Another Healthcare Provider

There are several ways in which a provider can deflect agency to another provider or organization. The first and perhaps most common is a deflection to a specific healthcare provider. This is frequently accompanied by language choices from a nurse saying, "the doctor will be with you shortly," or as a physician, "the radiologist will be in with your results." This often results in a vicious cycle of several cascades of agency shifts. The nurse can shift to the physician, the physician to the diagnostic test interpreter, the interpreter to a surgeon and so on. This can lead to compounding anxiety about test results, confusion for the patient, and a delay in patient care. Though each of these people is a viable source of agency according to the proposed criteria, a deflection of agency nonetheless occurs.

An alternative to deflecting agency to an individual provider is a deflection to an organization, department, floor, or another hospital. I provide an example to clarify: a newborn girl was transferred from a community hospital to a city hospital to rule out a GI bleed with the goal of increasing her quality of care received. Several days into her treatment, a nurse noted an IV slough with a darkened area at her IV site. The patient was subsequently transferred to the ICU and the parents came to visit. Alarmed by the extent of the injury, they consulted several floor clinicians and received a multitude of different responses, some of which claimed the problem originated in the community hospital, others blamed the general medical floor nurses where she was first admitted, and only one physician assumed accountability for the complication and admitted something should have been done sooner.[12] Significant it is that the quality of patient care was in fact compromised in failing to immediately transfer the patient to the ICU for fear of repercussion. Additionally, while a nurse can serve as the agent responsible for the complication, shifting agency to the entire community hospital or the medical floor in which the patient was transferred is not justified, as neither can

qualify as active agents and instead serve as overly generalized safety nets employed by the information providers.

Deflection of Agency to Objects or Procedures

Another mechanism in which providers are able to deflect and distance themselves from personal involvement is through utilizing an object or procedure as a faux agent. As previously discussed, neither fits the criterion for admissible agency. These types of language choices are common both in written and spoken language. For example, in a review of several physician case presentations, Renee Anspach cites several examples where either a process, test result, or machine is utilized as the source of action in case presentations:[13]

i. "Auscultation of the head revealed… and angiography showed…" [processes]
ii. "Follow-up CT-scans have showed…" [object/machine]
iii. "The arteriogram showed that this AVM was fed…" [process]
iv. "The EEG showed…" [test result]
v. "The path revealed…" [test result]

Notably, in each of these examples, the agent is entirely omitted. None of these processes can be performed without a human presence; for example, auscultation requires human interpretation of sounds. In personifying a process as a machine, procedure, or results of a test, a provider effectively distances themselves from the patient. Should blame or guilt be a resultant effect of the information provided, perhaps the hope is that the patient will exert their frustrations on the machine/object rather than the provider.

Additionally, the verb choice in each of these examples appears redundant, frequenting neutral verbs such as "revealed" or "showed" that are purely technological in nature. Anspach notes that in these choices of verbs, a provider takes an active human process and converts it to a mechanic, fail-proof method, limiting any room for human error.[14] The usage of the agentless voice can be particularly significant when the decisions are controversial, problematic, or questionable, she notes. Citing an example of a newborn baby who did not receive betamethasone, a drug that could have helped alleviate or prolong the child's life, the physician notes on an official record that "No betamethasone was given," a sharp contrast to adopting responsibility for their actions, perhaps more accurately stated as "The doctors at St. Mary's did not give betamethasone.[15] This is certainly an example of how in retrospect, language can be used as a defensive mechanism to protect doctors.

Arguably, omission of the agent and failure to acknowledge the true source of agency can also be detrimental to the quality of care received throughout the treatment of a patient as well. "Dr. Smith noted a lesion on an X-Ray," as opposed to "an X-ray revealed a lesion" would allow the party charged with patient care, or reading the patient's chart easier access to contacting the diagnosing physician if uncertainty or complications should arise.

Deflection of Agency to a Part of the Whole

This mechanism of agency deflection can occur in one of two ways. The first and more common is when clinicians refer to a very specific part of the patient in an attempt to dehumanize the part of the body. For instance, it occurs when clinicians narrow in on a part of the body such as a specific organ or a tumor. Often times this type of agency deflection is accompanied with overly scientific vocabulary that can easily confuse a patient. Multiple research avenues have shown health literacy and patient understanding of the complexities of their disease to be significant to their adherence and ultimately health outcome.[16] Examples of this type of mechanism may include "the tumor is growing," or "the inflammation of the liver has not reduced," in both cases the patient is ignored and loses the individuality of their illness and is generalized to the function of a part of themselves.

A second example that offers a slightly different comparison is that of a fetus of a pregnant woman. *The Business of Being Born*, a documentary on home birthing as an alternative to hospital births describes an elaborate drug cascade that women in hospitals go through in giving birth. If the patient isn't progressing through the birthing process at a fast enough pace, physicians administer a drug called Pitocin, which is designed to increase strength and rate of contractions. However, the increased strength of contraction results in significantly more pain, thus requiring administration of additional epidurals. In a contrasting manner to the way that Pitocin speeds up the contraction process, the epidural contains chemical properties that slow contraction rate. The cycle of administering Pitocin and epidurals continues, often giving cause for additional interventions such as vacuum-assisted deliveries or cesarean sections. Patients in the documentaries are quoted describing the process as a "domino effect" and physicians using delivery techniques such as claiming that "it's necessary for your baby." The physicians interviewed in the documentary describe a strong association between the induction of labor and increased cesarean deliveries, and thus this process is detrimental to the quality of care that both the mother and child receive.[18] Though the physician is necessarily the agent in this interaction, by honing in to the health of the unborn child, the interaction between mother and clinician is lost. Additionally, because the child is not yet autonomous from the mother, it is unable to be a recipient of agency.

Deflection of Agency to Fault the Patient

The final mechanism of agency deflection occurs when the provider deflects blame directly to the patient in which he/she is interacting with. This is perhaps the bluntest type of agency deflection discussed because it can turn physician fault onto the patient. As an example, a theoretical case of an elderly gentleman who unexpectedly passed away amidst a heart surgery is offered. In consoling the patient's family following the operation, the surgeon offers that due to the patient's lack of exercise and poor diet, there was a buildup of plaque in his arteries and he suffered from a sudden heart block. These types of deflections where a physician places blame on the patient in areas such as diet, habits, exercise, smoking, etc. can again be used as a defensive explanation to later provide rationale for physician error.

Previously discussed in Patient-provider interaction overview, cultural expectations and physical observations about the patient were said to shape the context of the medical interaction between a patient and provider.[19] Notably, issues such as smoking and weight/diet would be discussed here. By providing explanations in charts and patient records that "patient reports regularly smoking" or "patient unable to adhere to previously provided diet regimen," the physician is again employing defensive tactics. Notably, both of these explanations put the fault on the patient in a preemptive safety net for the clinician, which contrasts sharply with previously discussed events of physician error, such as in the administration of betamethasone provided.

Roter and Hall discuss that these areas are typically where physicians are actually inclined to express discontent with their patients.[20] Findings indicate that physicians often reprimand patients through forceful counseling or imperatives on the needs to follow recommendations better. "For the unsuccessful dieter, for instance, this could mean exhortation for the patient to do better on his diet and follow a prescribed regimen," (p. 120). The physician may also express discontent in tone of voice or by cutting the patient off in various ways.

Summary of Mechanisms

Though some of the mechanisms discussed function through providing a viable alternative agent, the detrimental effects of deflecting agency are evident in each of the provided mechanisms. Notably, patient outcome suffers in many regards: delay in receiving information or care, patient adherence to prescribed

treatment methods, patient understanding of the complexity of a diagnosis, or feeling at fault for their current state of being.
The primary effects of deflection of agency appear to be enacted for two purposes, one defensively as to protect from liability and, alternatively, to manipulate and or coerce a patient into a particular decision.

Defensive Medicine

The Congressional Office of Technology Assessment [21] provides the following definition of defensive medicine: "Defensive medicine occurs when doctors order tests, procedures, or visits, or avoid high risk patients or procedures, primarily (but not necessarily or solely) to reduce their exposure to malpractice liability." Some medical practices have become so routine that physicians are unaware that liability concerns originally motivated their use. This is evident in the training of both new and old physicians who simply follow organizational protocol.

The prevalence of defensive medicine, especially in the United States is particularly alarming. A 2007 survey of 300 physicians, 100 nurses, and 100 hospital administrators found that more than 76% of physicians responded that malpractice litigation had hurt their ability to provide quality care to a patient. Additionally, 79% of the surveyed responded that they had ordered more tests than necessary, 74% referred patients to specialists more than necessary, 51% recommended invasive procedures more than necessary, and 41% prescribed excessive medications such as antibiotics than they typically would have based on professional judgment.[22] It is clear that defensive medicine is deeply ingrained into modern medical practice, spanning well beyond the previously discussed language implications.

Defensive medicine is harming to both physicians and to their patients. Moore, Adler, and Robertson note, "There exists a direct, causal effect of the doctor-patient relationship on medical patients' treatment perceptions and malpractice claim intentions in the event of an adverse medical outcome."[23] By deflecting agency, a physician effectively distances themselves from the situation, largely in fear of liability. Physicians' anxiety about malpractice lawsuits may drive defensive medicine more than the actual risk of a lawsuit.[23] A malpractice suit is described as a personally and professionally devastating experience.[25]

Manipulative or Coercive Medicine

On the opposite end of the spectrum, physicians may employ these agency shifting tactics for self-benefit as opposed to self-preservation. Returning to the Pitocin-epidural cycle discussed earlier, a patient describes coercive techniques employed by physicians, "That's one of the great manipulative techniques that are used, is when a woman starts to question, Why do we need to do this? The first thing you turn to is, oh, it's for the good of the baby." She continues that, "It was very easy for them to do things that we hadn't really wanted them to do," and that at the end of the intervention, "Everybody says, "Thank God, we were able to do all these interventions to save your baby…the fact of the matter is, if they didn't start the cascade of interventions, none of that would have been necessary."[26]

There is also research that may support the claim made in Epstein's documentary describing the manipulative nature of OB-GYN physicians. Brown explores the relationship between time of day and rate of cesarean sections performed.[27] In his discussion of "physician demand for leisure," he notes that the most common times of day for cesareans are between 4-8p.m., and shortly before midnight. Epstein furthers this claim by suggesting that physicians tend to coerce patients into cesareans in self-interest before dinner time and so that they can have an uninterrupted night of sleep.[28]

But physician manipulation and coercion are not limited to OB-

GYN physicians. Scare tactics are often similarly implored in an attempt for patients to adopt a certain treatment regimen. This idea is so fundamentally ingrained in us that it seems almost natural; from the time we can walk a pediatrician is telling us to eat vegetables and drink lots of milk in order to grow tall and strong. Similar campaigns about smoking, drug use, and exercise are plentiful both in and out of the doctor's office.

Additionally, clinicians may employ some of the previously discussed objects as manipulative devices. For example, upon the return of blood work from a patient, a physician might suggest, "Your lab results may be an indicator that you are at risk for diabetes," in a preemptive attempt to persuade a patient into adopting healthier eating and exercise habits.

Theory of Motivated Information Management

Theory Background

The remaining segment of this paper will adapt the Theory of Motivated Information Management (TMIM) to fit the proposed mechanisms of agency deflection described.[29] Historically, TMIM has been used to evaluate social relationships. For example, prior implications have discussed the drives behind seeking sexual health information from partners,[30] discussion of listing as an organ donor among family,[31] conversations between parents and children of divorced or divorcing parents concerning relationship status[32] and discourse surrounding enrollment and options surrounding eldercare.[33]

First, it is important to qualify the patient-provider relationship as applicable to TMIM. TMIM is a theory framed within interpersonal contexts.[34] Additionally, Afifi and Weiner frame TMIM with several examples of relationships that it can encompass: employees and managers, students and instructors, romantic partners, and notably, individuals seeking health information from physicians. The theory is rooted in dyads, with "at least two communicators; intentionally orienting towards each other; as both subject and object".[35] Though there has been minimal published content that pertains to the patient-provider relationship, the interpersonal nature of the provider-patient interaction qualifies it for TMIM framing.

Historically, information sharing was minimal in medicine. Davis addressed ways in which physicians manage information with patients' families in order to "allow them to remain optimistically uncertain for a long time". He continued to note that "long after the doctor was no longer in doubt about the outcome, the perpetuation of uncertainty in doctor-to-family communication, although perhaps neither premeditated nor intended, can nonetheless best be understood in terms of its functions in the treatment systems."[37] Afifi and Weiner explain that these varying levels of uncertainty are what TMIM aims to explore. Individuals may desire to either increase or decrease their uncertainty.[38]

Theory Framework

The theory proposes a three-phase process of information management that information seekers go through in deciding a course of action to resolve an uncertainty discrepancy. The original theoretical framework proposed that this discrepancy would arise when anxiety motivated seeking of additional information.[39] Subsequently, the theory was expanded to account for a broader range of emotions rather than just anxiety through its adoption of appraisal theory.[40]

The framework begins with individuals becoming aware that they desire more or less uncertainty than they currently have, the uncertainty discrepancy.[41] Resultantly, they experience an emotion. Some of these emotions include anxiety, anger, fear, disgust, jealousy, envy and hope.[42] The realization of emotion concludes the interpretation phase of the theory.[43]

The evaluation phase is next in the framework and consists of

two assessments: outcome expectancies and efficacy.[44] Outcome expectancies reflect beliefs about the outcome of an information management strategy, essentially weighing the costs and benefits of seeking information.[45] These costs and benefits are said then to influence a set of three efficacy assessments: communication efficacy, coping efficacy, and target efficacy. Communication efficacy involves the ability to engage competently and understand the information management action. Coping efficacy evaluates whether the resources to handle the information are met. Target efficacy addresses the belief of whether the target has access to the information and is likely to be honest in their transmission of the information.[46]

The decision phase involves a selection of three information management options: seek information, avoid information, or engage in cognitive reassessments, thereby resolving or reinitiating the information management process.[47] Notably, the entire process is iterative, the evaluation phase affects the decision phase, etc.[48]

Though the above depiction of the process is typical for an information seeker (in a patient-provider relationship, the patient), the process is slightly altered for the information provider, discussed in less detail. The provider cycles only through the evaluation and decision phases that begin when they become aware of another's desire for information. While the information provider engages an identical process of outcome and efficacy evaluations, the specific content level is altered. During the evaluation phase there are three considerations made: the overall outcome of revealing the sought-after information, the importance of that outcome, and the probability that the information will yield the outcome they expect. These evaluations lead to a similar decision phase in which the information provider has identical options in conveying the information.[49]

However, the strategic decisions in this phase involve "the amount and veracity of information that the information provider choose to provide, the directness which the information is conveyed, and the preferred channel for interpersonal transmission (e.g. face-to-face, vs. e-mail). Ultimately, the information providers' feedback affects the entire process for the information seeker both at the time of the interaction and in subsequent assessments in information management strategies.[50]

Context-Theory Integration

There is strong overlap between the evaluation process described in the TMIM framework and the rationale for deflecting agency in patient-provider interactions. Specifically, the outcome and efficacy evaluations likely account for both the previously discussed intentions of defensive and manipulative medicine. The overall outcome (OE) of revealing the information is defined as the most important aspect in making a decision.[51] Thus, if a physician is aware that he/she may be liable following a decision, it will likely affect their phrasing and delivery of the message. Similarly, in considering physician leisure as a factor in manipulative medicine, language choices can be used to alter decision-making processes in the patient to better serve the needs of the physician.

In expanding on the current TMIM framework, I propose three additional criteria that are significant in consideration of the evaluation phase: conflict avoidance, a surrender of subjectivity, and mitigation of responsibility. Conflict avoidance is a frequented topic in interpersonal communication, but is more commonly discussed among romantic partners. However, proposed rationale for conflict avoidance are certainly relevant. Roloff and Wright propose that delaying discourse may stem from a desire to avoid confronting someone until a person has a clear notion of what to do.[52] This is particularly evident in cases of delayed patient care due to fear of liability and confrontation, specifically in the case of the newborn transferred from the community hospital to the city hospital where treatment was delayed in that the

adverse event at her IV site went unreported for several hours.

A surrender of subjectivity is particularly relevant to the object/procedure as an agent mechanism proposed. Leder proposes that a loss of subjectivity is a dire threat that modern medicine faces: in seeking to escape all interpretive subjectivity, medicine has threatened to expunge its primary subject—the living, experiencing patient.[53] Thus, in addition to the clauses provided concerning communication efficacy, the presentation of a message necessarily considers the objective versus the subjective. In understanding that diagnostic technology is most highly valued in medicine, followed in descending order by the physicians' observations and finally by the patients' account, the physician evaluates presentation method, particularly in that the state of medical culture that is data driven and scientific.[54]

Finally, a mitigation of responsibility is a necessary sub-clause to the outcome evaluations proposed in the current framework. As an enormous factor in provider decision making processes, mitigating responsibility allows for the minimization of the physician's role in producing findings and observations, and minimizes the physician's role in medical decision making.[55] Though the latter can be countered through manipulative medicine, both serve as factors in providing clinician security through defensive medicine.

Discussion

In contrast to the rather grim nature that constitutes the deflection of agency, it would be an interesting analysis to compare these mechanisms to those that occur in the delivery of positive news, such as a physician delivering news that a treatment method is working or a patient is now cancer free. Afifi and Morse propose that while individuals in bad moods make pessimistic outcome expectancies, those in good moods make rose-colored assessments of outcomes.[56] Does agency return to the physician in delivering good news? Does the provider take responsibility, proud of their actions?

Additional language and diction choices in patient-provider relationships have yet to be evaluated. An analysis of pronoun choice, for example, would also be appropriate for examination. Do the same criteria that drive agency choices also dictate whether the physician uses the plural "we" and credits his/her medical team or the singular "I?"

An examination of the prevalence of agency deflection would be a valuable step in future research. Specifically, do areas of the world where defensive medicine and fear of malpractice suits is minimal see less frequented shifts in sources of agency? A data-driven study could better pinpoint the roots of the issue and perhaps provide way to a mechanism of resolution.

Furthermore, a large area of research with regards to TMIM with and to agency choices is the role of emotions in the information provider's response.[57] Though several emotions have been examined in detail with regards to the information seeker, the emotions of the provider go unexamined. Notably, the emotions of the information provider do not necessarily fit the appraisal framework of requiring a negative emotion. Certainly a physician does not always feel negatively in delivering diagnosis in a similar manner that a patient does, entering the doctor's office with a particular concern. How can emotions like confidence or compassion be molded to the revised TMIM emotion-appraisal theory?

Agency choices may be subconscious considerations that physicians employ without actually cognizant thought. However, their effects on patient outcome make claim that intention effort to provide a legitimate source of agency is necessary. Through deflecting agency to other sources an uncertainty dilemma is unnecessarily prolonged. Consideration of diagnosis presentation

needs to be a priority for healthcare providers in order to avoid these subtle yet significant intricacies that appear in message delivery.

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