Health Communication: Toward a Phenomenological Perspective

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HEALTH COMMUNICATION: TOWARD A PHENOMENOLOGICAL PERSPECTIVE

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By

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HEALTH COMMUNICATION: TOWARD A PHENOMENOLOGICAL PERSPECTIVE

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ABSTRACT

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December 2012

Dissertation Supervised by Janie M. Harden Fritz, Ph.D.

This dissertation examines implications for health communication as a rhetorical and philosophical practice by focusing on the various topics in the health communication field today, identifying areas that have been examined qualitatively and/or phenomenologically and hermeneutically. Currently, health communication scholarship tends toward qualitative and quantitative research from the methodological perspective of social science. Bringing these approaches into conversation with current phenomenological studies in the health care field, particularly those in the area of nursing, offers the potential to transform health communication scholarship, giving birth to a rhetorically and philosophically grounded praxis in this field.
DEDICATION

I dedicate this dissertation to my daughters Samantha and Jacqueline as both of you so beautifully continue to bring light in my heart and fill each day with pride, joy and laughter. Your passion and a zest for life have forever changed my world.
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January 2, 2001 I joined the professional staff at Meadowcroft Rockshelter and Historic Village. It was here, surrounded by 16,000 years of history, my journey began, and I witnessed firsthand how infinitely rippling the sharing of stories and traditions shape the minds of future generations. My passion for teaching was ignited as I archived the life papers of one of the greatest educators and talented story tellers, Albert Miller, who spent all of his adult life recording and documenting history, as he built a museum literally with his bare hands. Growing up on his family farm, Albert Miller immersed himself in a 16,000 year living textbook. Today, the fruits of his labor are found vibrantly alive at Meadowcroft Museum, a true testimony of Albert Miller’s philosophy of pedagogy.

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Introduction

This dissertation examines implications for health communication as a rhetorical and philosophical practice by focusing on the various topics in the health communication field today, identifying areas that have been examined qualitatively and/or phenomenologically and hermeneutically. Currently, health communication scholarship tends toward qualitative and quantitative research from the methodological perspective of social science. Bringing these approaches into conversation with current phenomenological studies in the health care field, particularly those in the area of nursing, offers the potential to transform health communication scholarship, giving birth to a rhetorically and philosophically grounded praxis in this field.

Inviting current health communication research to consider examining their domain of investigation through the lens of constructive hermeneutics and phenomenology promotes a grounding theme with a focus on future possibilities, not present shortcomings, with an overall outcome of bringing people and ideas together and protecting and promoting a given good (Arnett, Fritz, & Bell, 2009) by a focus on the dimension of human meaning in the health care context (p. 191). This dissertation points to the work of Heidegger, Buber, and Gadamer, reviewing their unique philosophical approaches to health communication scholarship to resuscitate our understanding of a part of the human experience that seeks meaning and responsiveness in the face of the frailty and resilience of the human condition. This work is a starting point for that endeavor. It reviews the profession of health communication as a field, examines extant research, sifts through that research for qualitative, phenomenological and hermeneutic work, and offers exemplars from the field of nursing, a leader in phenomenological
studies in the field of medicine, as a way to enrich health communication scholarship. Finally, the scholarship of three philosophers—Heidegger, Buber, and Gadamer—is reviewed and the work of Elisabeth Kübler-Ross offered as an example of implicit phenomenological work for praxis application in the health communication field.

**Defining Health Communication**

Health communication aims to improve the health status of both individuals and populations by informing, influencing, and motivating the public about important health issues, as well as ensuring that key health concerns are on the public agenda (Nutbeam, 1998, p. 355-356). One broad definition of health communication identifies the field as emerging that involves an act of health promotion and prevention through active communication (Hershfield & Rootman 1994, p. 70). The apparent simplicity of this definition does not do justice to a complex process ranging from dissemination of health information through the use of various communication techniques in the public domain to interpersonal interactions at the dyadic and small group level.

Schiavo (2007) describes the health communication subfield as very complex and multidisciplinary:

“Health Communication is a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging, and supporting individuals, communities, health professionals, special groups, policymakers and the public to champion, introduce, adopt, or sustain a behavior, practice or policy that will ultimately improve health outcomes” (p. 7).
The Centers for Disease Control and Prevention, reflecting a strategic understanding of communication, define health communication as “the study and use of communication strategies to inform and influence individual and community decisions that enhance health” (2001; U.S. Department of Health and Human Services, 2005, cited in Schiavo, 2007, p. 8). Hence, the focus of health communication in the twenty-first century is about improving health outcomes by encouraging behavior modification and social change through utilizing a comprehensive approach that relies on the full understanding and involvement of its target audiences (Schiavo, 2004, p. 7).

Communication scholars contend that health and illness provide a fundamental framework within which to study the nature and importance of communication: communication in health and illness constitutes the most “vital” of human experiences (Brasher & Babrow, 1996, p. 243). Health and illness connect our basic elemental experiences and confront us with our physical limitations through the communicative interweaving of body, mind, and society (Brashers & Babrow, 1996, p. 243). Health communication is a rich and fruitful context for understanding the nature of communication as meaningful action in human experience and needs a methodology for research that captures its complexity.

The Current Status of Health Communication

Although the field of health communication is relatively young, questions of health communication have accompanied the human condition either explicitly or implicitly throughout history. One of the first figures to gain recognition in this area is Hippocrates (b460, B.C.), the first figure to separate medicine from philosophy and to challenge the assumption that disease was a punishment for sin. Hulkower considers the Oath of
Hippocrates as historically representing the physicians commitment to the Hippocratic traditions based on scientific investigation, patient oriented care and seeing each patient as an individual (43). Since that time, the profession of health care has played a significant role throughout history, taking particular forms in various cultures. In the United States, for instance, medicine is one of the four great traditional professions reflecting the “true professional ideal” in America (Kimball, 1995, p. 5).

The field of health communication continues to grow and diversify. The research conducted by Wright, Sparks and O’Hair (2008) looked to the work of Thompson, Dorsey, Miller, and Parrott (2003) who found “an analysis of the topics that appeared in the Journal of Health Communication between 1998 and 2003, over 20% of the articles have dealt with provider patient interaction, followed by health campaigns (13.4%), risk communication (11.8%), health and aging (8.4%), language and health (7%), media (5.9%), and social support and health (4.3%). Many of the prominent theories that are used in the area of health communication have their origins in communication, social psychology, and anthropology” (p. 8), disciplines with a particular methodological orientation rooted in the quantitative social sciences. This orientation toward quantitative methodology is reflected in much of the research in health communication reviewed here.

**Phenomenological Implications**

The rich historical foundation of health communication praxis and the growth and development of this emerging field bring health communication scholarship to a significant crossroads, creating a need to develop a praxis model for performing health communication research and application rooted in rhetorical and philosophical ground.
Rhetoric and philosophy of communication expressing itself in phenomenology and hermeneutics provides the basis for a fitting response for this postmodern movement, opening a doorway of opportunity for “making practical judgments in an inherently contingent world” (Arneson, 2007, p.128). An approach to health communication grounded in rhetoric and philosophy of communication recognizes the uncertainty inherent in the human condition and enters the conversation with existential humility, seeking pragmatic wisdom for human responsiveness in this area of life (Arnett, Fritz, & Bell, 2009).

This dissertation seeks to reframe the area of health communication from a rhetorical and philosophical perspective, with a particular focus on phenomenological perspectives. A phenomenological perspective on health communication offers a way to understand health experience as a learning journey guided by communication praxis. The application of hermeneutics and phenomenology invites the interplay of theory with action to open up lived experience textured with theoretical and personal communicative insight. Through the lens of constructive hermeneutics and phenomenology, a grounding theme emerges, serving as the touchstone for health communication scholarship with a focus on protecting and promoting a given good (Arnett et al., 2009), specifically, the dimension of meaning in the health care context.

**Rhetorical Theory and Health Communication**

Health communication, although often approached from a post-positivist quantitative or qualitative social science approach, can be grounded in rhetorical and philosophical perspectives emphasizing human meaning. The human condition, according to Kenneth Burke’s rhetorical philosophy, is fundamentally about creating a
sense of identification shared or common meaning and the constitution of community out of the multiplicity of voices, selves and experiences that make up our individuality (Burke, 1969, p. 57). Such identification must lead to action in order to qualify as praxis. Babrow and Mattson see that “health communication is nourished by the application of rhetorical theory as it offers resources for bridging theory and practice” (cited in Thompson et. al, 2003, p. 48). Rhetorical theory contributes to the creation of a change in the style of health communication research and also to profound changes in the substance of communication and care (Babrow & Mattson, 1996, cited in Thompson et. al 2003, p. 48). Grounding health communication rhetorically and philosophically provides a new approach for traditional areas of health communication scholarship and opens new avenues for application of research findings to the context of health care communication practice.

**Interpersonal Communication, Phenomenology, and Health Communication**

The importance of interpersonal communication in the health care setting has been acknowledged over the years by researchers in the field of health communication as a channel for the operation of the health communication process. According Wright et. al. (2008) interpersonal health communication scholars tend to focus on relationships, such as those between providers and patients, or they study how everyday relationships (i.e., family members, co-workers and friends) influence our health (Wright, 2008, p. 6). The exploration of everyday interpersonal communication and health typically finds its theoretical framework in social influence. The role of interpersonal interaction, according to Cline (1996), “helps to clarify the potentially powerful and often neglected influence of everyday interaction on health and provides road signs for future research and
practice” (cited in Thompson, 2003, p. 285). Health communication scholars investigate interpersonal communication in the health care context through qualitative research methodology by communicating directly with research subjects either “in person, through others, or through a document such as a questionnaire” (Joppe, 2006, cited in Schiavo, 2007, p. 273). Qualitative social science research methodology begins to move closer to an interpretive understanding of human experience. Other approaches, however, may offer richer avenues for understanding the experience of health and illness as human meaning.

**Framing Health Communication Scholarship Phenomenologically**

The area of health communication invites alternative methodologies and perspectives that focus on human meaning. Many approaches from philosophy of communication provide fruitful framings of health communication. Health communication could be understood philosophically through, for example, a dialogic perspective. Health communication scholars have also elaborated basic human communication concepts such as “intrapersonal communication which tends to focus on people’s attitudes, beliefs, values and feelings about health related concepts” (Wright et al. 2008, p.6); this focus provides an opportunity for a focus on phenomenology. Phenomenology opens up our understanding of human experience and invites a deeper understanding of human meaning.

Until recently, according to the research conducted by Babrow and Mattson “phenomenological approaches to health communication have been rare” (for exceptions, Orbe & King 2000; Peterson 1987; also see Mattson, 2000, as cited in Thompson, 2003, p. 49). However, the scant research that exists to date in this area has
opened the way to a holistic conception of health as a state of being in the world
(Babrow & Mattson, 1996, as cited in Thompson, 2003, p. 49). Babrow and Mattson
(1996) turn to Zook (1994) to view “our experience of the world arises first and foremost
with the pre-reflective unity of body and self in lived experience” (as cited in Thompson,
2003, p. 49). Phenomenology is the identification of the experience itself, in which a
deeper understanding of the meaning of that experience is sought. This identification
occurs through layered reflection by the use of rich descriptive language. Babrow and
Mattson look to the philosophy of Craig (1999) to identify ways that phenomenology
appeals to the common sense of everyday discourse and the need for human contact:
“We should treat others as persons, respect differences and seek common ground, and
challenge other common beliefs (e.g., communication is skill; the word is not the thing;
facts are objective and values subjective” (Babrow and Mattson, cited in Thompson,
2003, p. 50). These assumptions resonate with the focus of health care communication
over the millennia. Therefore, phenomenology is an appropriate framework for studying
health communication.

**Phenomenology and Hermeneutics**

A phenomenological perspective invites a hermeneutic approach, which adds
important texture to seeking meaning in the health communication context. The value of
approaching health communication from the lens of hermeneutics adds an interpretive
element to the understanding of health experience (Ajjawi and Higgs, 2007, p. 619). A
philosophical framework permits an understanding of the health communication process
as a human phenomenon of lived experiences common to all. The over-arching theme of
this project embraces the notion that health communication scholarship is first and
foremost about concrete practices in the world, and as Babrow and Mattson point out, health communication theory is meaningless if it does not influence practices related to health and illness (Babrow, Mattson, 1996, also see Craig, 1989, 1999, as cited in Thompson, 2003, p. 37). A rhetorical and philosophical approach to health communication scholarship grounded in phenomenology and hermeneutics focuses on the experience of concrete practices—their interpretation as meaningful human activity.

Health communication is a broad area of study, witnessing in its relatively recent history an evolution giving rise to several new fields of study, including health psychology, medical sociology, biomedical communication, behavioral medicine, behavioral health and medical communication. Health communication is the keystone for these areas of study; therefore, a rich variety for phenomenological exploration exists within this area. Furthermore, all of these emerging disciplines are building on the groundwork laid by professional disciplines such as nursing, social work psychology, sociology, medicine and public health, resulting in contributions to the development of theory in these fields and others as research findings emerges, suggesting implications for a phenomenology of professional health communication practice. As Friedman and DiMatteo explain (1979), information and knowledge is central and this can apply to health communication research contributing to the development of theory in these other fields, and research findings emerging from these fields contribute to the development of theory in health communication. These intersections offer additional facets of the phenomenological experience for investigation, leading to new insights and meaning for health care communication research (p. 18).
Many health professions such as nursing, physical therapy and psychology are incorporating rhetorical and philosophical approaches in their research. Ajjawi and Higgs (2007) turn to the work of Max van Manen to understand “the underpinnings of both hermeneutics and phenomenology” (p. 616). Ajjawi and Higgs (2007) find an understanding to research methodology through the work of Smith who views hermeneutic phenomenological methods are “aimed at producing rich textural descriptions of the experiences of selected phenomena in the life world of individuals that are able to connect with the experience of all of us collectively” (Smith, 1997, as cited in Ajjawi and Higgs, 2007, p. 616). This approach offers the health care communication field a way of investigating the lived experience of health, illness, and associated communicative interactions between and among people. Smith’s (1997) grounding in hermeneutically based research “provides a model for the identification of the experience of phenomena, such that a deeper understanding of the meaning of that experience is sought” (as cited in Ajjawi and Higgs, 2007, p. 616) which offers a point from which health communication research can “push off” and move in new directions. This understanding can occur through increasingly deeper and layered reflections by the use of rich descriptive language (Ajjawi and Higgs, 2007, p. 616), which taps the experience of feelings related to health care. As Ajjawi and Higgs (2007) note, “Because phenomenology is concerned with lived experience it is thus ideal for investigating personal learning journeys. Therefore, the main focus of phenomenology is with pre-reflective experiences and feelings (the essence of a phenomenon)” (p. 616).

Current Phenomenological Scholarship in the Health Care Field
Currently health communication scholarship tends to focus on qualitative and quantitative approaches from a social science methodology with an application grounded in health communication praxis and process. The present project brings these approaches into conversation with current phenomenological studies in the health care field, primarily in the area of nursing scholarship, transforming health communication scholarship through a rhetorically and philosophically grounded praxis. In recent years, the medical community, particularly the field of nursing, is shifting its research approach to the area of phenomenology. For example, Patricia Munhall (2007), a registered nurse and author of the book *Nursing Research: A qualitative perspective*, writes exclusively from the phenomenological perspective, offering a unique approach to finding meaning in human experiences through a post-modern interpretation of the study of being. Munhall offers a reason for a phenomenological approach to health care as a “human understanding comes from conscious, knowing, contemplation and commitment. In keeping with the ultimate aim of phenomenology to become more fully human” (Munhall, 2007, p.217).

The work of scholars such as Patricia Munhall offers a web of ideas that freely crosses disciplines reaching beyond the descriptive experience of medical practitioners to enlarge the scope of health communication praxis. Through the scholarship of Patricia Munhall, the health field recognizes the need to address traditional research methods from a phenomenological approach offering a way of understanding such human experiences captured through language and in context. Each of the research projects cited in this dissertation addresses specifically how researchers in the health care field have found the phenomenological approach helpful for connecting ideas and theories in
human science, opening up a gateway to new discovery. Each research project identifies socially constructed and experienced phenomena that occurred in real workplaces and professional interactions.

**The Voices of Three Philosophers**

Three significant voices in the phenomenological tradition are Buber, Gadamer, and Heidegger, whose theoretical ground offers the health communication conversation an opportunity to embrace unique philosophical approaches that offer renewal to our understanding of a part of the human experience that demands thoughtful, constructive engagement of the field. This project will be enriched by the voices and of ideas from these three philosophers yielding the potential to extend the general body of scholarship about health communication. Their philosophical contributions provide an opportunity to embrace meaningful, rich interpretive and experiential approaches to health communication scholarship to assist our understanding of health care by adding a different dimension to health care interactions and relationships. Inviting Martin Buber’s “unity of contraries” philosophical perspective as a future direction for this conversation provides a road map of alternatives for dialogic clarity and direction through the acknowledgment of probability, rather than truth, as the general rule, and that positions have to be readjusted continually in the light of “new evidence,” an interpretation that rests with a both/and rather than an either/or. Buber’s view of “otherness” provides us with clarity and direction and an explanation of the historical and contemporary significance of rhetoric and philosophy of communication in application to health communication by suggesting a dialogic road map as a way to interpret the “other.”
Buber’s major theme is that human existence may be defined by the way in which we engage in dialogue with each other, with the world, and with God (Arnett, 1980, p. 89).

The scholarship of health communication has the potential to take a new direction when viewed from the perspective of Hans-Georg Gadamer’s hermeneutic phenomenology. Scott McLemme recognizes that, for Gadamer, one never approaches the world with a blank slate as he sees “process of understanding always begins with some established understanding and a prejudice is already in place” (Arneson, 2007, p. 11). Arneson finds “Gadamer’s hermeneutic is a phenomenological one, which is to say that he adopts Edmund Husserl’s starting point in experience, understood as the interaction between noesis, a directedness toward some aspect of the world, including the actor (agent) who is always already part of that world), and noema (some aspect of the actor’s life world, i.e., of the actual cultural scene toward which the actor is directed)” (Arneson, 2007, p. 53).

It is through the phenomenological investigations of Martin Heidegger that we seek to ask specific questions of health communication praxis and theory by exploring the relationship between being and language. In Patricia Arneson’s book, *Perspectives on Philosophy of Communication*, she turns to the views of Michael Hyde who reflects on the work of Heidegger and observed the “essence of language” opens us to the disclosure of what the world presents for comprehension and what, in turn can be represented by us in a meaningful manner (Michael J. Hyde, 2007, as cited in Arneson, 2007, p. 23). It is through Heidegger’s “call of conscience” …that we find responsiveness to thought and action that enables us even in the most distressful situations to take charge of our lives as we assume the responsibility for affirming our
freedom through resolute choice and become involved in the creation of a meaningful existence” (Arneson, 2007, p. 32).

Dr. Elisabeth Kübler-Ross and Health Communication Research

A pioneer in the methods of support and counseling of personal trauma, grief, and grieving associated with death and dying, Dr. Elisabeth Kübler-Ross provides health communication scholars with an in depth understanding of relationships associated with bereavement and hospice care. Her ideas on the five stages of grief model is actually a change model for helping to understand and deal with (and counsel) personal reaction to trauma. Embracing the application of Dr. Kübler-Ross’s theories and practices relating to death and bereavement provides this dissertation with a unique phenomenological ground and praxis that has direct and compelling application in health communication scholarship, providing real life engagement into the other person’s perspective, a perspective that may differ from our own, whether we are the one in need or the one helping another to deal with traumatic upset (Kübler-Ross, 1981).

The purpose of this dissertation is to provide a potential entrance for the phenomenological and hermeneutic components in health communication research by examining the health communication literature and exploring the work of Elisabeth Kübler-Ross for potential phenomenological contributions to this area. The work of Elisabeth Kübler-Ross provides a case study as a starting point to begin a new venture in the field of health communication, one that points the way to rhetorical and philosophical ground for the area of health communication.

Conclusion and Chapter Outline
The significance of the whole of this work is threefold. First, it provides a grounding definition of health communication in the twenty-first century and provides an historical connection to the field. Second, it reviews the important work of the health communication field as manifested in the flagship *Journal of Health Communication* to reveal the contours of scholarship in this area. It introduces the study of health communication to current phenomenological studies done by scholars in the health care field. Thirdly, and finally, the work of Elizabeth Kübler-Ross offers an entrance through which the scholarship and praxis of health communication can enrich its contributions to the larger field of communication by attending to the work of philosophers Heidegger, Buber and Gadamer as an effort to draw connections between existing health communication research and phenomenological theories and praxis, interweaving these approaches and communication contributions in the hopes of generating new ideas and practices propelling the field of health communication into a deeper dimension of communication scholarship, one grounded in rhetoric and philosophy of communication, that moves toward improved individual and public health outcomes.

The following is an outline of each chapter’s engagement with the domain of health communication. The goal of this project is to explore how the interlacement of hermeneutics and phenomenology reconstructs and puts into action the praxis of health communication. Each chapter of this dissertation surfaces unique components of the health communication process examined through a hermeneutic and phenomenological lens, moving from an exploration of health communication as field through topics, frameworks, and issues in the literature to qualitative and phenomenological work already extant in current research, to philosophers who provide phenomenological and
hermeneutic ground for expanded treatment of the field, to an examination of the work of Elisabeth Kübler-Ross as an exemplar of (implicit) phenomenological and hermeneutic understanding of health communication in a focus on death and dying.

The current chapter, chapter one, acts as a health communication road map, identifying starting points and landmarks of the scholarship and praxis of the field and highlighting the variety of routes that health care professionals can travel as they explore health communication. The task of this chapter was to identify key areas of research in the field of health communication and explore the relevance of a hermetrical, phenomenological approach to the health communication process for this area. Targeted in this beginning chapter is a rationale for scholars to integrate philosophy of communication into the field of health communication by identifying the scholarship of each of the master philosophers chosen for this project, culminating in a general framework for “lessons from the field” of rhetoric and philosophy of communication for health communication scholarship.

Chapter two begins the journey of exploration into the field of health communication with a systematic, orderly account of the history of the scholarship and praxis of health communication. This account is a clear indication of the massive movement in health communication scholarship that has emerged over the decades, beginning with a focus on the early broad functions of communication in health care. Although these functions are still apparent in health communication research, concerns are now moving into more complex multidisciplinary directions. This work seeks to understand the history of the health communication area through the past and contemporary significance of key ideas, figures and events.
Chapter three chronicles the trends of health communication praxis from the analysis of what Babrow and Mattson (1996) noted as the praxis shifted from “exchange” and “transmission” to one that emphasizes the social constructive approach to illness and well-being (Thompson, 2003, p. 8). The move to a social constructionist framework was a significant move toward an interpretive, philosophical framework, bringing the field a step closer to a phenomenological approach. This turn also indicated a broadening of the methodology of health communication paralleling a move toward a appreciating multiple methodologies and approaches to inquiry emerging in the organizational communication field (e.g., Corman & Poole, 2000; May & Mumby, 2005).

The fourth chapter of this dissertation introduces the reader to some of the theoretical issues that are currently engaging health communication scholarship. Several important frameworks are used to guide an understanding of the theory in the discipline and the variety of themes and tensions that have characterized in health communication scholarship. This analysis serves to define and place scholarship into a disciplinary health communication matrix. This chapter’s focus on theoretical issues provides a topical or content focus on the field in preparation for a consideration of a phenomenological approach to health communication.

Chapter five describes the qualitative research published in the Journal of Health Communication over the last thirteen years, grounding the potential for phenomenological praxis in the field of health communication, and chronicles examples of JOHC scholarship by examining research conducted by means of interviews, case studies, and patient observations. This chapter identifies researchers who are moving in a qualitative direction without the aid of experiments and studies with numbers but
embraces the investigations of people's experiences, stories, and similar research. The JOHC provides an excellent historical record for health communication scholarship acting as window and a mirror of reflection, targeting research gaps in health related topics and methodologies and suggesting openings for phenomenological investigation.

Chapter six presents an interpretive paradigm investigating the research strategies of health practitioners using hermeneutic phenomenology as the underpinnings of clinical reasoning, designing research and professional practice enhancing the value of hermeneutic phenomenology as a credible rigorous research approach to investigate the practicing of communication in the health profession. Each research findings highlighted in this dissertation embodies a unique philosophical framework using practical methodology and strategies that derive meaning from and give attention to the connection between hermeneutic phenomenology and health communication outcomes.

Chapter seven considers the ideas of Heidegger, Buber and Gadamer, offering contributions and communicative inquiry and insight as an extension of the general body of scholarship that connects human communication to the health field. Arneson (2007) examines the insight into the lives of communication scholars in her book, *Perspectives on Philosophy of Communication*; she states, “The philosophy of communication serves to enrich our understanding of the life process, enabling us to better understand the relationship between communication content and action” (p. 10). Philosophy of communication as the background for phenomenological inquiry situates the approach of the current project.

Chapter eight examines the phenomenological and hermeneutical applications of Elizabeth Kübler-Ross’s research as conveyed in the dialogues and real-life scenarios of
patients explaining their reactions to loss as she explores the process of grieving and its natural and necessary connection to healing and one’s acceptance of one’s illness. The hermeneutic approach teaches scholars to be descriptive and to interpret the near-death event always aware of the multiplicity of understandings that stem from past and present experiences. The engagement of real life voices deeply enriches our understanding of health care and clearly identifies a new pathway for health communication research to explore a qualitative direction through the investigations of people's experiences.

Chapter nine concludes this project by reflecting on the implications, practices, and goals of hermeneutic phenomenological research in the field health communication. By illuminating investigative opportunities for engaging the practice of health communication in rich, dense descriptions of human actions, behaviors, intentions, and experiences, we meet them in the “life world” of lived experience. Through a hermeneutic phenomenological approach to health communication, practitioners in the health field can extract meaning and invite understanding of the “Other” and of the experience of health in the human condition. Whether among researcher, clinician, and patient, between a health care team and a family, or among those coping with grief and loss in response to the inevitable, a phenomenological approach to health communication offers insights appropriate for human meaning-making. Chapter 9 revisits selected research from chapters two through four and offers suggestions for an approach to those topics grounded in phenomenological hermeneutics.

The goal of this dissertation project is to provide an alternative framework for health professionals and health communication researchers. Approaching health communication from a philosophical approach grounded in phenomenology invites an
exchange between the “common language” of the human experience of health and illness
and the scholarship of health communication. This exchange holds promise for the
theory, study, and practice of health care communication as it continues its productive
trajectory as a key area of focus in the field of communication.
Chapter 2: Health Communication Scholarship: A First Look

This chapter begins the journey of exploration into the field of health communication with a systematic, orderly account of the history of the scholarship and praxis of health communication. This account reflects the massive movement in scholarship that has occurred since an original focus on the early broad functions of communication in health care. Although these functions are still apparent in health communication research, concerns are now moving into more complex multidisciplinary directions. This work seeks to understand the history of the health communication field through an examination of the flagship journals in the field of health communication, the Health Communication Journal and the Journal of Health Communication, along with other selected scholarly publications. This examination will trace the development of contemporary ideas, figures, and events as a foundation for exploring the potential for phenomenological work in health communication.

Introduction

Over the last 25 years health communication has developed into an exciting field of study, utilizing many behavioral science research methods to examine and solve health care and health promotion problems (Kreps, 1989, p. 14). This growth has occurred not only in the United States, but is seen in the work of researchers internationally, attracting scholars from all over the world. In the Health Communication Journal’s inaugural issue, Jon Nussbaum (1989) commented, “Health communication as a legitimate field of inquiry has finally arrived” (p. 35).

Today, many leading health communication scholars view the study of health communication inquiry as a sub-field of communication that utilizes a wide spectrum of
research approaches. In the book *Health Communication in the 21st Century*, Wright, Sparks and O’Hair (2010) identified a number of areas relevant to health communication. Specifically, intrapersonal and interpersonal communication, organizational communication, intercultural health communication, mass media, health campaigns and technology are the major research concentrations for health communication scholars of the 21st century (Wright, et. al, 2010, p.6). Health communication maintains a focus on application; as noted by Wright, et.al (2010), The research in health communication has “the ability to address significant real-world problems” (p.14). Health communication researchers are dealing with current health issues and “confront these issues and ultimately make improvements to the healthcare system and health outcomes” (p. 14).

There are several defining features that characterize health communication in the 21st century, which according to Schiavo (2007), focuses primarily on “sharing meanings or information, influencing individuals or communities, informing and motivating target audiences and exchanging information and changing behaviors” to encouraging behavior modification and social change (p. 7). As Schiavo (2007) notes, the key to this process is a clear understanding and involvement of its target audiences (p.7). Schiavo views the role of health communication as an opportunity to inform individuals and communities to change behaviors by increasing knowledge and ultimately empowering people about health problems and interventions (pp. 8-9).

**EARLY DEVELOPMENT OF HEALTH COMMUNICATION SCHOLARSHIP**

Health communication is deeply rooted in the scholarship of anthropology, medical psychiatry, psychology, and sociology. A growing interest in health care captured the attention of communication scholars, and concentrated research efforts in
health communication inquiry were undertaken to understand how health promotion impacted health knowledge, attitudes, and behaviors (Kreps, Query, & Bonaguro, 1998, p. 8-9).

Researchers in the field of health communication trace the origins of the scholarship to the early 20th century, when health care campaigns became an important concern as hygiene, vaccines, and antibiotics contributed to the doubling of the human lifespan (Sparks, 2010, p. 3). According to Kreps, et al. (1998), a review of the early literature relating to health communication written during this period focused mainly on “adopting theories and methods from these social sciences”, and the move towards adopting the health care context as a topic of study was a natural disciplinary trend” (p. 8)

**Theoretical Foundations**

**Humanistic Psychology**

In the 1950s, many communication scholars were intrigued by the humanistic psychology movement “pioneered by scholars such as Carl Ruesch and Gregory Bateson, who stressed the importance of therapeutic communication in promoting psychological health” (Kreps, 1998, p. 7). Humanistic psychology is largely concerned with the quality of human experience and can be defined as “…primarily an orientation toward the whole of psychology rather than a distinct area or school…concerned with topics having little place in existing theories and systems: e.g., love, creativity, growth, self-actualization, peak experience, courage, and related topics” (Misiak & Sexton, 1966, p. 454, cited in Froh 2004, p. 19). Kreps, et. al, (1998) views much of the early work found in the humanistic psychology literature as influential in igniting communication researchers’ ideas in areas such as provider/ consumer relations, therapeutic
communication and the provision of social support, paving the way into the development of health communication (p.6). It is interesting to note that much of the early developmental stages found in humanistic psychology had roots in the philosophy of phenomenology and existentialism, coming full circle and providing a rich fertile ground for the growth and development of health communication.

**Phenomenology and Existentialism**

Misiak and Sexton (1973) found the philosophical perspectives of phenomenology and existentialism had a significant impact on the development and growth of humanistic psychology (Misiak & Sexton, 1966, 1973, as cited in Froh, 2004, p. 19). William James, America’s first positive psychologist (Taylor, 2001, as cited in Froh, 2004, p. 18), maintained that “good science must also employ methods grounded in phenomenology” (Misiak & Sexton, 1966, as cited in Froh, 2004, p. 18). James saw a need to combine both objective and subjective research methodology because “objectivity is based on intense subjectivity” (Gilky, 1990 as cited in Rathunde, 2001, as cited in Froh, 2004 p. 18-19). Clinicians began to rethink the foundations of medicine and psychology and apply phenomenological perspectives. According to Schneider and Bugental & Pierson (2001), it was Medard Boss, a Swiss psychiatrist, who offered a holistic definition of health, framing it as “the total haleness and wholeness of the human,” making the concept of phenomenology critical for health care professionals to understand because, “health is characterized by an openness and flexible responsiveness to the world” (p. 12).

Today, as health care professionals begin to awaken the philosophies of phenomenology that are so deeply embedded in the foundation of health communication
theories and practice of the present, the notion of “health” as described by Medard Boss can be conceptualized by medical professionals and patients as community response and exchange that embraces each individual’s understanding of “health” as part of the human condition. The communicative nature of the health care environment becomes a vehicle for shared understanding of this ontological component of human existence.

Medical Sociology

The field of medical sociology can be recognized as one of the research pioneer fields in the development of health communication as many in this disciplinary area examined the social structure of health care delivery systems. In 1963, Irving K. Zola published, in the Journal of Medical Education, “Problems of Communication, Diagnosis and Patient Care: The Interplay of Patient, Physician and Clinic Organization.” This article examines several key factors that have a significant impact on the effectiveness of communication between the physician and the patient.

Zola (1963) turns to non-medical factors, and views ethnic background, the physician’s specialty, and the clinic’s spatial design as influences that impact the communication process in this relationship and “each of these areas operate to prevent or limit communication between doctor and patient, ultimately affecting the diagnosis and treatment” (p. 829) Zola states, “There has been little speculation about the effect of social background on the treatment and diagnosis of patients and their physical disorders” (p. 829). In a large study, Zola found that there were basic differences between the way specific ethnic groups presented their chief complaints and illnesses, provoking specific reactions as to the way physicians treated the patient. This study was one of the first that examined cultural communication and its effect on health care.
In 1972, health communication reached a major milestone when social science researchers Barbara Korsch and Vida Francis Negrete published “Doctor-Patient Communication” in *Scientific American*. This foundational article in the field of health communication examined factors that either enhanced or compromised effective communication between physicians and their patients (Thompson, et al. 2007; cited in Wright, Sparks, & O’Hair, 2008, p. 7), stressing the importance of therapeutic communication in promoting psychological health; it was most influential in the development of the health care delivery perspective to health communication inquiry (Kreps, 1998). It was this research that ignited the 1980s Kleinmans’ (1980) book, *Patients and Healers in the Context of Culture*, a publication that further reinforced the importance of recognizing cultural influences on doctor-patient interactions and encouraging additional work on culture and health communication (Kreps & Kunimoto, 1994, cited in Kreps et. al, 1998, p. 8).

**“Turning Point” Scholarship**

**Martin Buber and Carl Rogers**

Martin Buber’s philosophy of interpersonal communication profoundly impacted the American humanistic philosophy of the 1950s. *The Handbook of Humanistic Psychology* highlights a classic 1957 dialogue between Buber and Carl Rogers that pinpoints commonalities of Buber’s philosophy and humanistic views, especially the emphasis on healing through a meeting of two persons, despite their differing emphasis on the dialogue and self-actualization, thus binding health communication to many psychological and philosophical perspectives (Moss, 2001, cited in Schneider, Bugental & Pierson, 2001, p. 13). It is important to note that there is considerable confusion when
attempting to merge the psychogized views of Rogers with those of Buber, which emphasized the relationship of dialogue rooted in phenomenology.

Arnett (1981), in *Toward a Phenomenological Dialogue*, makes a clear distinction between the two viewpoints and draws from an essay written by Richard Johannesen that first introduced dialogic communication to speech communication scholars in 1971. Johannesen’s essay emphasized the emerging importance of dialogue; it also introduced a fundamental confusion when it presented dialogue which is rooted in phenomenology as synonymous with a psychologized view of dialogue. Martin Buber's and Carl Rogers' works are cited together, despite the fact that Rogers' emphasis on the psyche, “internal locus of control,” “congruence between self and organism,” and “the innate goodness of the organism” is incompatible with the fundamental dialogical notion of the “between.” Each of these concepts is based in an internal understanding of communication. The meaning of communication remains inside the person, not “between” persons (Arnett, 1981, pp. 202–203). A phenomenological perspective focuses attention not on the internal cognitions of persons, but on lived, meaningful experience encountered in the “between” of human meeting (Arnett, 1981). This phenomenological understanding corresponds to a rich understanding of human health as a facet of human communicative experience.

**Watzlawick, Beavin, and Jackson**

In 1967, Watzlawick, Beavin and Jackson linked humanistic psychology and human communication and published *The Pragmatics of Human Communication*. The authors presented the basic characteristics of human communication and discussed the particular importance of paradox in human communication, both pathological and
therapeutic (Kreps, Bonaguro, E. L., Query, J. L. Jr. 1998, p.7). Health communication scholar Gary Kreps sees this book as the springboard in the development of the field of health communication, clearly illustrating the significance of provider/consumer relations, therapeutic communication, and the provision of social support (Kreps et al, 1998, p. 7). One implication of work of Watzlawick, Beavin, and Jackson rests in its attention not on the ‘internal” psychological states of persons, but on patterns of human interaction.

**Parvanta**

The medical community, during this period, began to recognize health communication praxis as an opportunity to enhance optimum health care delivery and health promotion. Parvanta’s book, *The Essentials of Public Health Communication* chronicles the evolution and history of health communication and how early connections to interpersonal communication and the utilization of therapeutic methods from a variety of disciplines helped to shape the development of health care delivery and health promotion:

Interpersonal and group communication influenced health care delivery (including) the provider/consumer relationship, therapeutic communication, health care teams, health care decision making, and the provision of social support. In contrast the health promotion branch grew out of the communication field’s long-time focus on media in communication and was concerned with “the development, implementation and evaluation of persuasive health
communication campaigns to prevent major health risks
and promote public health” (Parvanta, 2010, p.7).

A collaborative study done in the early 1970s between cardiologist Jack Farquhar and communication scholar Nathan Maccoby clearly illustrates the significant impact that melding a variety of disciplines had on the development of health communication. This study, according to the research of Gary Kreps (1998) demonstrated the powerful influence that communication campaigns had on health promotion and was a longitudinal field experimental evaluation of a multi-city health promotion intervention program (Kreps, Bonaguro, Query, 1998, p. 8).

Through a historical reflection of the field of health communication, we are drawn into a deeper understanding of how multidisciplinary influences shaped the ongoing course of scholarship. Despite its multidisciplinary roots, however, the field of health communication did coalesce into an area of its own. The next section addresses the professional disciplinary identity of the field of health communication.

Development of Professional Identity of the Area of Health Communication

As the history of health communication developed, it is clear to see how multidisciplinary roots shaped the field. Eventually, scholars actively engaged in health communication research, found it necessary to establish a core professional identity and become recognized as an unique academic field of scholarship. According to Woyseth and Michl (2001), the status of a discipline depends on multiple factors, including “a community of interest, a network of communications, a tradition, a particular set of values and beliefs, a domain, a mode of inquiry, and a conceptual structure”(p. 8).
Melissa Tombro (2008) examines the significance of developing a disciplinary identity through the work of Steven Mailloux (2006), who explores the varying identities of rhetoric as it found homes in English, composition, and communication studies (p.199). For the issue of health, as for rhetoric, the particular disciplinary homes in which an area finds traction gives that body of knowledge and practice an entrance into the world with a particular orientation. This orientation permits an area to contribute to the larger human condition in unique ways. At the same time, a distinct disciplinary home provides a standpoint from which scholars working in that area can articulate understandings of the area that will serve as a road map to assist scholars in other disciplines. Professional associations provide public locations for disciplinary identities to represent themselves to themselves and to other communities (e.g., Greenwood, Suddaby, & Hinings, 2002, p. 58).

**Professional Health Communication Organizations**

The two significant communication groups, the International Communication Association (ICA) and the National Communication Association (NCA), were host to specific interest areas that were formed as a result of these early health communication publications. A rise in health communication publications and journals prompted the formation of the interest group Therapeutic Communication in 1972 within the International Communication Association. The emergence of this professional group, according to Kreps et.al, (1998) was of the most influential moments in the genesis of health communication, providing a public forum to showcase scholarship specifically devoted to health communication (Kreps, 1998). This group or interest area was renamed The Health Communication Division in 1975. The Health Communication Commission
of NCA became the Health Communication Division. These divisions are now one of the largest at both ICA and NCA (Thompson et al., cited in Wright, Sparks, & O’Hair, 2008, p.7).

In addition to professional associations, professional journals are important markers of disciplinary identity (e.g., Goggin, 2000; Leonard, 2012). Not only do journals serve as public repositories of knowledge claimed by a discipline, but they serve as gatekeepers for a discipline and a locus for disciplinary power (Goggin, 2000, p. xv). The journals of the field of health communication, therefore, are key to this examination.

**Health Communication Journals**

Numerous communication conferences focused on health communication research, inspiring two major health communications journals. The launching of *Health Communication* was a momentous occasion for the field of health communication. The quarterly publication’s founding editor, Teresa Thompson, encouraged scholars to publish exclusively in health communication inquiry through this peer-reviewed journal (Wright, Sparks & O’Hair, 2008). The first issue of *Health Communication*, published in 1989, highlighted essays written by communication scholars advising the professional community at large of the need for a focused direction in this new and exciting field of study. “That issue marked an important point in the academic maturation of the field of health communication inquiry, and over the years the journal has provided the field with a respected outlet for health communication research” (Kreps et al, 1998, p. 11).

Some of the leading health communication scholars such as Barbara Korsch, Gary Kreps, David Smith, Paul Arntson and Jon Nussbaum wrote essays in this inaugural issue. Charged with developing sophisticated and influential health communication
research agendas, this first issue reviewed such topics as doctor-patient communication and examined the future of the discipline by contributing to scholarship and calling for future essays. Kreps (1998) describes the articles found in this first issue as focusing on theory-building, theory-testing, discipline building, praising the benefits of rigorous and relevant health communication inquiry. Paul Arntson, in an article in that same issue, argued for a focus on developing citizens’ health competencies in future health communication research, empowering citizens to make active and enlightened health care decisions (Kreps, 1998, p. 11).

The first international health communication journal, edited by Scott Ratzan, was published in 1996. The Journal of Health Communication took on a new approach to the field by encouraging a focus on the international scene, adding another dimension to the intensity of the scholarship. Kreps (1998) sees each publication as complementing each other “and provides important scholarly outlets for health communication scholarship, indicative of the growth and maturation of this field of study” (p. 5). The focus of the Journal of Health Communication: International Perspectives was on “presenting timely research into and evaluations of the use of communication to prevent disease and promote good health” (Ratzan, 1996, p. vii). It is through the scholarship found in this publication that the field of health communication continues to grow and develop by presenting the latest developments in the field of research, bridging the gap between research and praxis and seeking to achieve higher levels of health related standards of practice through communication.

Institutionalization
The multidisciplinary nature of health communication began to threaten the loss of the true root of the field and it became difficult to discern whether the identity of research in the area stemmed from health communication inquiry or from another discipline. *Journal of Health Communication: International Perspectives*, was introduced. The Journal of Health Communication (JOHC) stated its mission as “presenting timely research into and evaluations of the use of communication to prevent disease and promote good health” (Ratzan, 1996, p. vii). Scott C. Ratzan, editor, envisioned an international scope of scholarship outlining objectives for this new endeavor as, “Expanding the realm of health communication to include…advocacy, marketing, media, persuasion, and global communication,…fostering a shared understanding of community ideals to…begin to eliminate the current bureaucratic maze, simplify medical and behavioral jargon, and nurture supportive personal, family, work and community environments” (Ratzan, 1996, pp. v-vii).

Scholars engaging in health communication research found it necessary to situate this field of study in the academic environment in a way that emphasized the communicative elements of this discipline. Health communication scholars were driven to pursue innovative and cutting edge research, nurturing the discipline and ensuring outstanding graduates in the field of health communication. This concern for disciplinary identity reflects concerns of professionalization of disciplines in various areas in the American university (Veysey, 1965). The development of curricula specific to health communication is a marker of institutionalization of health communication as a field.
Health communication majors began to appear at several universities across the country in the mid-1990s (Kreps, et al., 1998, p. 13). It was during that time Emerson College began to offer a Master of Science in health communication. Kreps, et al. (1998) notes that the expansion of the discipline into undergraduate and graduate communication programs broadened the horizons in research and theory (Kreps, et. al, 1998, p. 13). Today, most communication programs offer formal health communication programs (Kreps, et al., 1998, p. 13). Students studying the field are researching health communication topics that examine connecting points to the larger communication field—for example, advertising, public relations, survey research methods and technical writing. The discipline of health communication has made inroads into medical schools, and public health programs providing health care professionals with courses that specifically focus on health communication related topics (Kreps, et. al, 1998, p.13).

**Health Communication: A Multidisciplinary Approach**

Health communication has gained significant traction as a field of study over the last 30 to 40 years. One of the leading specialists in the field, Barbara Schiavo, sees health communication as “a multifaceted and multidisciplinary approach to reach different audiences and share health-related information with the goal of influencing, engaging and supporting individuals, communities, health professionals, special groups, policy makers and the public to champion, introduce, adopt, or sustain a behavior, practice or policy that will ultimately improve health outcomes” (Schiavo, 2007, p. 7). It is evident today health communication scholars and the professional medical communities embrace the role of health communication inquiry. It is an essential component in the contemporary health care system.
Placing communication strategically within the overarching goals of the health care professions permits a trans-disciplinary science to emerge. Stokols (1992) notes, “health and health promotion should address the multidimensional and complex nature of human environments. Environments can be described in terms of their physical and social components, but they can also be characterized in terms of their subjective and objective qualities and their scale or immediacy to individuals or groups” (p. 7). It is through the exchange of knowledge and resources exploring a variety of research methods and approaches we gain a depth of understanding that is necessary in understanding the complexity of health communication. It is impossible to perceive the scholarship from a unidisciplinary investigation when the discipline was built on collaboration among a vast array of research approaches. Health communication scholarship needs the mustered, combined strength of a varied disciplinary community because its content affects every aspect of life. The discipline over the years has been trying to establish a singular identity despite the multidisciplinary nature of the scholarship. This important field of study has finally embraced its defining interdisciplinary characteristics, elements that set health communication apart from other communication subfields. In this sense, ironically, its interdisciplinarity is a defining feature of its disciplinary identity.

HEALTH COMMUNICATION SCHOLARSHIP CONTINUES

Emerging Research in Health Communication Scholarship

As health communication scholarship continues its trajectory, it responds to questions of the historical moment facing it (Arnett & Arneson, 1999). Two significant questions arising for research health communication are technology and cultural
diversity. Although questions of technology and diversity have always been present, they have become more salient during the last decade. Issues of technology are multifaceted, affecting public, mediated, interpersonal, and professional spheres of health communication. Health communication faces human diversity as difference emerges as a significant facet of human experience shaping responses to health care (e.g., Arnett, Fritz, & Bell, 2009).

**Health Communication and Technology**

Health care professionals recognize the significance of technology in disseminating health information to the public. In a recent article written in the Coalition for Health Communication (2012), the multifaceted nature of technology in relation to health communication surfaces:

“The impact of health and technology on health communication cannot be overstated. At every turn in the medical arena, technology is changing the delivery of health care services. Monitoring of chronic illness through cell phone text messaging, using social network websites to disseminate health information, integrating into nursing home care, establishing tele-health networks in rural areas, and converting patient health files into electronic medical records provide some examples of areas ripe for further study as they impact communication processes and health outcomes.”
Internet technology is transforming the health care environment, and its impact presents a layering of challenges that are being recognized and examined by health communication scholars. The public has infinite ways of receiving health information and health care professionals no longer rely on the traditional face to face delivery of health messages, and interventions. Healthy People, a national science based organization, examines the changing role of health communication health internet technology which will require multidisciplinary collaboration and careful monitoring of the quality of health care is an essential role of health communication research (http://www.healthypeople.gov/2020/about/default.aspx).

**Health Communication and Cultural Diversity**

The racial, ethnic, and cultural face of the United States is changing. In 50 years, the traditional English-speaking majority once recognized as the majority will give way to a population of diverse cultures and languages. This new cultural landscape is already transforming health care (Kreps, 1996). Health care analysts point to the growing need for providers to adjust to the nation’s changing demographics by developing and updating their health communication skills (Kreps, 1996). Health communication inquiry is increasingly concerned with the role of culture on health and health care. Communication scholars will work to end the prejudicial treatment of marginalized cultural groups within the modern health care system, such as prejudicial treatment of people with AIDS, the poor, minorities, women, and the elderly (Kreps, 1996, p. 103-104).
Health communication scholars see the need to view health communication in a more global context, and this new image has made significant inroads over the last few years. Diversity is likely to intersect with technological sophistication. It is reasonable to assume that the use of text messages and twitter will surpass traditional media messaging methods to provide opportunities to target specific health missions, gathering supporters who are dedicated to the goal of bringing health information to new heights internationally.

Wright, Sparks and O’Hair (2008) note that because our nation has become a culturally diverse population, health care providers are now faced with the challenges that this diversity brings to the health care system” (p. 102). Wright, Sparks, and O’Hair go on to note challenges related to language differences: Today there are large numbers of patients and health care providers who have difficulty speaking the various languages as many patients have trouble speaking the English language; they do not have access to adequate health care providers and there are various levels of education, income and housing statuses, ultimately creating complex challenges that impact the overall effectiveness of the health care system (p. 102). In addition to issues of language, cultural practices related to health care are likely to vary, requiring responsiveness on the part of health care providers to multiplicity of meanings in the medical context (e.g., Galanti, 2008).

**Future of Health Communication**

Wright, Sparks and O’Hair (2008) see the three key areas of focus emerging; health literacy, research on breaking bad news to patients in an appropriate way, and older adult health care. These challenges, according to Wright, Sparks and O’Hair, are
reflective of our changing needs within the confines of our society. However there are many scholars studying a variety of vital health communication issues and the field continues “to evolve and discover issues that influence our health and well-being” (Wright, Sparks, O’Hair, 2008, p. 307).

The key role, according to Schiavo (2007), for health communication scholarship is to seek to find health communication research opportunities that impact the public and the health care system. Schiavo places significance on areas that raise awareness of health issues, increasing health services, demonstrating health skills, improving patient-physician relationships, as opportunities to create new standards of care, treatment and disease prevention. The scholarship of health communication “should not work in a vacuum independent from other larger public health or marketing interventions” (p. 27).

Communities can achieve goals to solve a multitude of health issues. Martin, Ray & Sharf (2003) see a multitude of benefits by naming the capabilities associated with common health complexities and steer clear of focusing on the deficits: “At the macro level of health advocacy, individual citizen’s work together to formulate strategies to include the development of interpersonal and organizational networks to build leadership and affect policy decisions” (p. 350). Addressing the public health needs from a more intimate approach has the capability of increasing understanding the needs of each individual within these communities, and changing public health policies will serve a diverse population going beyond the national level, grabbing the attention of global institutions to prompt coordinated efforts that will impact public health policies worldwide.
Health communication scholarship has grown over the last thirty years and, according to Wright, Sparks and O’Hair (2008), many of the prominent issues are still being explored today. The exciting vibrancy about the development of health communication is the diversity and complexity of real-world health-related issues that are currently explored. Many of the prominent theories are still used, which is a reflection of how the various contexts of health communication research have developed over the years (p. 8).

Health communication researchers Gergen (1999) & Pearce (1995) continue to draw from the humanistic psychological roots of the scholarship as they view “our understanding of the world and our experiences of illness and health are heavily influenced by our day-to-day communication with others. Some communication scholars have argued that people create reality through communication” (cited in Wright, Sparks, O’Hair 2008, p.103). It is through our interactions with others and our perception of past experiences we come to develop an understanding of our personal reality. Galanti (2008) and Lupton (1994) as well as Wright, Sparks, & O’Hair (2008) see each culture as having specific beliefs about illness and health and this is passed down to each generation (cited in Wright, Sparks, & O’Hair, 2008, p. 103). Kreps believes “the field of health communication is moving toward a sophisticated multidimensional agenda for applied health communication research that will examine the role of communication in health care at multiple communication levels in multiple communication contexts, evaluate the use of multiple communication channels, and assess the influences of communication on multiple health outcomes” (Kreps et. al., 1998, p. 14).

Conclusion
This chapter provides a reflective opportunity to explore, from a standpoint temporally situated in the present and from the phenomenological distance of an observer, decades of time, events, and people, tracking the successes and the failures, the opportunities and challenges, that shaped the present day scholarship of health communication. The depth and dimension of the scholarship has developed into an organized, highly respected field that addresses contemporary health issues that impact the world. The multidisciplinary roots of health communication provide research opportunities to stretch out and explore, and even challenge, every minute detail of health related topics from a rhetorical, phenomenological perspective. In chapter 3, I develop a deeper and richer understanding of the details of health communication by sifting through the trends of health communication praxis from the perspective of Babrow and Mattson (1996) to discover major influences shaping and defining scholarship in this area.
Chapter 3: Health Communication Scholarship: Toward Communicative Praxis

Chapter three chronicles the trends of health communication praxis from the analysis of what Babrow and Mattson (1996) noted as a praxis shift from “exchange” and “transmission” to one that emphasizes the constitutive role of communication in (re)creating social reality (Thompson, 2003, p. 8). A significant body of valuable research now exists within the field of health communication. The rich scholarship engaging health communication provides a backdrop of theoretical trends that developed over the last fifty years. By examining various research trends, a framework for analysis has emerged emphasizing a body of theoretical knowledge within the health communication field that embraces the shift from exchange and transmission to one of social construction in other words, communication as constitutive.

Introduction

This chapter traces the trends of health communication praxis, addressing some key findings that are the building blocks within this body of scholarship, revealing many of the research challenges and solutions over the years. I take a developmental approach to the history of research methods and trends in the field. I begin with an examination of some of the historical foundations that led to Babrow and Mattson’s (1996) framework, from some early evidence of incipient change through social psychological behavioral models and educational research. The section following turns back to review selected areas of health communication scholarship through this new lens, focusing particularly on specific issues of methodology, exploring qualitative research and the scholarship of health communication praxis. The study of doctor/patient communication provides a
theoretical and applied “point of inflexion” in the field of health communication scholarship, highlighting the importance of this area, which was followed by a focus on improved research methods. The final two sections address issues of newly recognized accountability for scholarship—both in terms of theory and methodology and in terms of responsibility to society. Throughout this history, the key changes involved a move from a set of relatively scattered research topics at a very general level, with little depth, to a more focused, refined approach to scholarship. The development of this area was spurred by concerned scholarly voices calling the field to action—to refinement of theory, method, and topical focus. The final section notes the move of health communication scholarship toward the global arena, a responsive move paralleling society’s trends and needs.

**The Earliest Evidence of Change**

During the 1950s, health communication scholarship was in its developmental infancy. Chapter 2 recognized the humanistic psychology movement of the 1950s and 1960s and identified the influence it had in development of health communication, stressing and promoting therapeutic communication. *The Pragmatics of Human Communication*, by Watzlawick, Beavin, and Jackson, was published in 1967, highlighting the need to examine ways to merge human communication and psychology to improve the quality of therapeutic and pathological outcomes (Kreps, Query & Bonaguro, 2008, p. 7).

In the early years, a social science research approach influenced a large body of communication theory, generating successful results in areas of organizational and mass communication (Hurwitz, 1995, p. 4-5). Scholarship in health communication relied
heavily on borrowed theories and methods from psychology and social psychology in an attempt to jump-start research projects (Hurwitz, 1995, p. vi). At this time, research was primarily focused on social influence and persuasion, providing a broad theoretical ground for the application of health care promotion (Kreps, Query & Bonaguro, 1998, p. 7). Much of the early research was undertaken from a quantitative social science perspective.

During the mid-1960s, health communication researchers began to explore the field of medical sociology, following a growing interest in the social structure of the health care system as it relates to the doctor-patient relationship and the influence of culture on health communication. In 1980 Kleinman published *Patients and Healers in the Context of Culture*, shedding light on the significant impact culture has on doctor-patient interactions (Kreps, Query & Bonaguro, 1998, p. 7). This book provided a foundation for health communication scholars. Today, many of the ideas initiated in Kleinman’s book are still addressed. Deborah Lupton continued the conversation in an essay in 1994 with an exploration of the application of a critical cultural approach and political theory to health communication inquiry and practice. Lupton adopted a critical health communication approach to health and illness and focused on the use of discourse as a means to shape a cultural response to health, disease and treatment issues. Lupton’s (1994) research called for a “sophisticated understanding of the use of discourse to shape social responses to illness and disease, viewing health communicators as advocates to improve the conditions of health practice” (Lupton, 1994, p.63). The importance of this shift towards the use of a critical cultural approach using discourse provides health communication scholars a toolbox of philosophical approaches in constructing a concrete
foundation for communication praxis in the health care environment. It is through the exploration of discourse from a cultural perspective that many health communication scholars began to explore health issues through a phenomenological lens.

**Influence of Social Psychological Behavior Models**

The early progression of research and practice in health communication reveals the significant use of social psychological behavior models. It is interesting to note that many of the same social approaches and research models were utilized in the field of education. Over the years, researchers in the field of education have been studying the construction of knowledge and the process of change within a classroom environment. The social constructivist approach to knowledge is achieved through the use of language as individuals are able to share ideas and seek clarification until understanding is achieved. The emphasis is placed on a communication-rich environment, and as David Palmer notes, individuals are given opportunities to interact with peers in order to negotiate meaning (Palmer, 2005, 1855). Palmer examined a social constructive approach to improve the understanding of the dynamics of science education learning, viewing the role of teachers as central in providing guidance and support to learners. This confluence of methods in health communication and education is not surprising, given the role of both medicine and education as "architectonic" professions (Kimball, 1995) in America during the last three centuries.

**Health Communication and the Field of Education**

Research conducted in the field of education embraces several methods that provide health communication scholarship with a spring board from which to launch new studies, by appropriating the literature and models found in constructivist-informed
learning. Many of the motivational strategies found in learning have an application to a general sense of health and well-being, which can be understood in the context of self-determination theory, with a focus “on three innate psychological needs—competence, autonomy and relatedness, which when satisfied yield enhanced self-motivation, mental health and well-being which greatly impacts the psychological needs of the health care domain” (Ryan & Deci, 2000, p.68). The emphasis on these basic needs can be used to frame the health communication process, ultimately stimulating a connection to a variety of communication theories.

The social construction approach is deeply rooted in historical and contemporary communication theories. In the *Handbook of Health Communication*, Sharf & Vanderford (2003) discusses the evolution of social construction, highlighting the tension between commonly accepted knowledge and personal understanding. She states, “Social constructions of reality are mediated through linguistic expression articulated among people and communities, shaped and recorded as history” (cited in Thompson et al, 2003, p. 10).

A Social Constructive Approach to Health Communication

Sharf and Vanderford turn to the work of Robert Craig (1999) who differentiated between a transmission concept, in which communication is understood to transfers messages from one individual to another, and a constitutive approach that sees communication as a “process that produces and reproduces shared meaning” (Sharf & Vanderford, 2003, cited in Thompson et al, 2008, p.11). Sharf and Vanderford see the ideas of Craig (1999) provid a relevant application to a “practical life world” in which communication is already a richly meaningful term (p. 119). Craig strengthens this notion
as he makes a case for using the constitutive or social construction perspective as a meta-model encompassing all the various particular theories that attempt to explain how communication works (cited in Thompson, 2003, p. 11).

In 1996, Austin Babrow and Marifran Mattson explored the theoretical map of health communication research developed by Robert Craig. Babrow and Mattson (2003) considered the shift in communication research as the concept of “exchange” and “transmission” (Thompson, 2003, p. 8). Babrow and Mattson considered themes and tensions that characterize health communication scholarship, such as the interplay of the body and communication, science and humanism, idiosyncracy and commonality, and issues of constraints and uncertainty, serving to ground health communication (Thompson, 2003, p. 8). Their exploration yielded a visual disciplinary communication matrix that provides a heuristic tool for examining health communication scholarship.

Looking at health communication praxis through the theoretical framework described by Craig reveals a meta-discourse that intersects with and potentially informs the ongoing practical meta discourse in society. Babrow and Mattson (2003) frame health communication using this theoretical concept, and it was noted in the *Handbook of Health Communication* that “there is a pronounced tension between scientific and humanistic assumptions, values and aspirations, and limitations” (Thompson, 2003, p. 42). Babrow and Mattson further explain that historically, this tension has developed between researchers who examine health care with a biomedical model and researchers who use the bio psychosocial model, a more humanistic model, to examine health communication.

**The Interplay of Qualitative Research Methods**
Ellingson (2002) examines the praxis of health communication research and turns to the work of several scholars who “traditionally quantitative and positivist in its orientation” (e.g., du Pre, 1999; Vanderford, Jenks, & Sharf, 1997 cited in Ellingson, 2002, p.4). Ellingson reflects on health communication research historically, thru the lens of scholars in the field who have biomedical perspective that privileges the physicians’ perspectives and puts physicians’ (not patients’) concerns at the center of the research” (Sharf, 1993; Thompson, 1994, cited in Ellingson, 2002, p. 4). This biomedical research concentration focused on the practice of health communication. Health communication theorists specifically contributed very little conceptually, and many adopted and/or practiced within a parent discipline such as, for instance, interpersonal communication. Although much work remains quantitative with its emphasis on controlling and predicting behavior, researchers of health care teams have begun to integrate a range of theoretical and methodological approaches into their work (Ellington, 2002, p. 4).

In these early years of health communication Mokros found that particularly in psychiatry, communication was the tool used to diagnosis patients which was found to be a traditional health-related activity, which he suggested was one of the functions served by communication in a health provider-patient interaction (Mokros, 1993, cited in Schement, J. R., & Ruben, 1993 p.66). In some sense it is not surprising that minimal theoretical attention has been directed to the topic of diagnosis, given the emphasis was on identifying deficits and the primary evaluation was based on the interview, observations of the patient, interpersonal communication competence and promoting more effective communication skills to remediate such deficits in the interaction between

Similar themes and tensions outlined by Babrow and Mattson (2003) can be identified early in theoretical development of the field. In 1979, Costello and Pettegrew wrote that “if one is to be on the leading edge of research and theory in health communication, emphasis must be given to the organization in which formal health care takes place” (cited in Rootman and Hershfield, 1994, p.36). Many years later Rootman and Hershfield (1994) opened up this conversation, adding to Costello and Pettegrew’s dialogue, by encouraging the study of communication processes and outcomes with respect to health in other settings and involving people other than health care professionals. In 1989, through the work of Arntson, we began to consider the value of expanding health communication into an applied environment that took additional features of the interactive and institutional context into account. Arntson emphasized the importance of improving citizens’ health competencies in his article and noted that “systematic research has been done on health communication in family, peer, work or social settings” (Arntson, 1989, p. 29). This theoretical approach enabled people to increase control over and improve their health (WHO, 1986) and inform consumerism (Rootman & Hershfield, 1994, p. 69), framing this theme and tension outside of the scope of the healthcare setting.

**Defining the Scholarship of Health Communication Praxis**
The onset of an official *Health Communication Journal* sparked concern for a broader field of research, which was mapped out by Jon Nussbaum (1989), and in the inaugural issue of *Health Communication*, he directs researchers “who wish to investigate the communication process within the health setting” (p. 35) by pointing out the need for scholars in the field of communication to contribute to health communication research. Nussbaum focused on the issues of constraint and uncertainty in the field of health communication, noting that much of the early research was interdisciplinary, done by scholars who did not have an advanced degree in communication (p. 35). At the time of that publication, most researchers in the field were interested in seeing theoretical plurality within health communication that would lead to a more methodologically diverse scholarship. Nussbaum notes that many communication researchers have stated that they accept both quantitative and qualitative methodologies, but the public record does not indicate that this diversity exists. He stressed that a thick description of the health care environment was needed and those methodologies that provide such descriptions should be utilized (p. 35).

Gary Kreps (1989) used that first issue of a scholarly health communication journal to develop a clear set of primary goals for health communication research, which he identified as “not to break out in print but to generate health communication knowledge for directing health care policy, practice and intervention” (pp. 14–15). Kreps reminded readers of the diversification of the discipline and encouraged a unification of health communication scholarship and research while embracing a more dialectic approach towards the larger field of communication. His comments pointed to the need for continued integration of health communication theory and practice.
Barbara Korsch (1989) also contributed to this inaugural issue of Health Communication Journal, reinforcing the view later to be articulated by Babrow and Mattson (1996) to consider the characteristics of science and humanism as frameworks guiding studies, encouraging scholars to ground health communication in all communication theories, providing added integration with the health communication field. Korsch (1989) highlighted many of the early developmental incentives for health communication research and praxis, noting that most physicians had a romantic image of their communication practices. The need for a more scientific approach to health communication was precipitated by increased demands on the physicians and the advent of increased technology, which made it easier for physicians to prescribe medical treatment without carefully interviewing the patient (p. 5).

The publication of that scholarly journal made an indelible mark on the field of health communication. An agenda was set for the future of this important subfield of the communication discipline, representing a paradigmatic shift away from the traditional medical model of communication, where emphasis has been placed on the physician as active and the patient as passive, to one that provides for patient participation in health care. The challenge that David Smith (1989) outlines in an essay for the rapidly emerging blooming field of health communication is to work on the problems and applications associated with a participatory model of health care (p. 20).

During the early 1990s, much health communication research was dominated by social psychological models of behavior and theoretical perspectives informed by the stimulus-response school of communication (Lupton, 1994). In 1994, Deborah Lupton published an essay titled “Toward the Development of a Critical Health Communication
Praxis.” Lupton invited readers to engage with the taken-for-granted assumptions that circulate in the dominant ideology of health communication, drawing attention to the interplay of power and control in the formulating health problems and in developing of solutions (cited in Dutta, 2010, 534).

In her landmark essay, Lupton (1994) presented a new challenge in the field of research and practice generally incorporated under the rubric of health communication. The field, according to Lupton, needed to incorporate critical cultural and political theory into its scholarly inquiry and informed practice. As the theoretical scholarship continued to expand over the years, the field realized that the relevance and utility of the communication discipline as a whole is linked to an enhanced dimension of society that commands a great deal of public attention and economic investment (p. 55). Lupton finds social inequity is being reinforced rather than challenged by the current health communication practices and she offers the promotion of health advocacy activities that steer clear of individualism in health communication (p. 55).

The issues of constraints and uncertainty within the field of health communication sparked the attention of Sharf and Vanderford (2003), who embraced the dawning of the 21st century, seeing this new age as an opportunity to reexamine the goals of health communication scholars, a time to change the state of affairs. According to Sharf, the health communication field needed to reexamine role of scholarship and elevate the status of expertise, setting high research expectations and developing scholarship that truly made an impact in the field; it was time to make a difference, whether in educating health professionals, preparing a health-competent citizenry, or impacting health care policy. Sharf and Vanderford outlined the scholarship for the future by using the three Cs—
contextualization, complexity, and consequences. She stressed that driving this agenda was the quest to contribute to theory building with implications for public health and clinical practice directed toward practical, health-related outcomes (Sharf and Vanderford, 2003, cited in Thompson, 2003 et al, p. 29). Others in the field added to her agenda, seeing that the scope of health communication needed to be expanded to account for personal, social, and societal well-being, in addition to biological survival, the human quest for meaningful existence (Zook, 1994), and spiritual concerns (Gonzalez, 1994).

Once again, framing theoretical praxis by using Babrow’s themes and tensions follows a parallel with the growing trends in the field at this critical period in the development of new theories and practices in health communication. It becomes clear that the most meaningful frameworks from which to approach research data, rather than the most convenient, were required—and also needed to acknowledge the political, cultural, and economic implications emerging within the health communication field. Sharf and Vanderford (2003) looked to the variety of growing interdisciplinary readerships, outlets and expansion, seeing a need to include a wide range of health care practitioners, researchers, and the public at large. Health communication scholarship needed to be both theoretically engaged and practically useful.

**Traditional Doctor Patient Communication as a Point of Inflection**

One of the most prominent reoccurring themes in the history of health communication centers on concerns regarding traditional doctor-patient communication. These issues remained problematic even in the later part of the 20th century. Roter, Stewart, Putnam, Lipkin, Stiles, and Inui (1997) described some work done at that time and a few solutions; they determined that recent studies confirmed that the traditional
approach to doctor–patient communication and attitudes about power were still present in medical encounters, although they were changing (Roter et al., 1997, p. 356). The work of Waitzkin and colleagues (Waitzkin, 1989; Waitzkin & Britt, 1989) illustrate their point well. They note that in medical discourse, undertones reflecting a variety of social issue rise to the surface of the conversation. Typically, problems associated with work or family life or problems that connect to drug or alcohol addiction may be revealed. These personal stories told by patient are difficult for doctors to deal with as it takes the doctor out of his clinical comfort zone to help the patient deal with these personal health related issues. For this reason, Waitzkin and Britt (1989) note, physicians have not traditionally paid much attention to the personal context of patients’ lives. However, such issues matter—for example, many scientists and physicians have come to recognize the mind–body connection in the study of psycho neuroimmunology, which investigates relationships between psychological conditions and the immune system (Ader, Felten, & Cohen, 1991).

In the past the traditional model of doctor–patient communication focused on biomedical issues, physician control of interview topics, dominance of closed-ended questions, physician-determined diagnosis and treatment plan, expected patient compliance, an assumption of patient passivity, and an imbalance of power between physician and patient (Haan, 1979; D. H. Smith & Pettegrew, 1986). Over the years there have been alternative approaches to patient-provider interaction, which fell under the heading of the biopsychosocial model (Engel, 1977). Other approaches include the patient-centered approach (R. Smith & Hoppe, 1991), the deliberative model (Emanuel &
Emanuel, 1992), the COAST model (Ratzan, 1993), and the persuasion model (Smith & Pettegrew, 1986).

These emerging alternatives all seem to share, to varying degrees, a number of qualities and characteristics, including a shared doctor–patient agenda for the medical interview, the incorporation of patients’ understandings and expectations concerning health and illness, the inclusion of psychosocial issues and information, shared decision making about treatment options and management, expectations of empathy, and the development of trust and mutuality. Due to the development of many of these newer models and approaches to doctor–patient communication, the overall outcome is a more require sharing of power in medical interactions (Roter, Stewart, Putnam, Lipkin, Stiles, & Inui, 1997, p.356).

As continued research in this area revealed more positive and successful outcomes in physician-patient communication, most medical schools saw the need to incorporate communication training into their curricula. In the early 21st century, more than 80% of medical schools were incorporating interviewing techniques into introductory courses, including topics such as taking a medical history, communicating empathy, enhancing interpersonal communication, and developing the doctor–patient relationship (Novack, Volk, Drossman, & Lipkin, 1993). However, course directors revealed wide variations in topics, feedback, and methods used to teach communication competency, which resulted in many medical schools not fully preparing students to address critical communication skills needed by health care providers in practice (Novack, Volk, Drossman & Lipkin, 1993, p. 2105).
It was also difficult to determine how many practicing physicians sought to continue to find ways to focus on improving their communication skills and practices with continuing education. “The extent to which established clinicians avail themselves of ongoing professional development in this area is uncertain” (Thompson, 1994, p.725). Therefore, many scholars who focused on this issue over the years sought to integrate communication skills training into continued medical education for practicing physicians. The education centered around patients’ increased expectations concerning physician communication skills (Thompson, 1994), as most of the research findings linked patient satisfaction to high-quality doctor–patient relationships (Feeser & Thompson, 1993; Howell-Koren & Tinsely, 1990; Molzahn & Northcott, 1989; Roter, 1989; Street, 1989; Street & Wiemann, 1987).

Through the health communication research scholars in the field, that focus on the traditional model of doctor–patient communication provide much needed insight into the effects determined by a diagnosis and treatment plans, and expected patient compliance, and the assumption of patient passivity.

Improving Research Methods in Health Communication

Another interesting finding that follows the concept of framing health communication praxis based on themes and tensions is the evaluation of the predominant type of research methodology used over the years. Thompson, editor of Health Communication Journal, wrote in 2010 that the emphasis was on quantitative rather than qualitative methods. “We don’t ultimately publish as many qualitative submissions as we might desire, simply because it is more difficult to do qualitative research well. There are fairly straightforward standards for quantitative research.” At this point in the continued
development of scholarly submissions in major health communication publications, editors were to encourage authors to submit qualitative work. “We see the important contributions made by qualitative work to the study of health communication and we welcome it” (Thompson, 2010, p. 483).

Following this call to increase qualitative research appears to be a focus on developing research and publish topics related to critical/cultural work. Although there was an increase in the number of published works that fell into this category and there appeared to be more articles submitted that focused on culturally related topics, there was a zealous interest in this research agenda. The significance of this perspective in the field of health communication had a tremendous impact on the interrelationships between communication in both health and health care delivery (Thompson, 2010, p. 483).

A Major Turning Point in the Field of Health Communication

As the field of health communication continued to refine and develop in scholarship, attention then turned to the conceptualization of a communicative process that provided a more sophisticated method of training in the field of communication rather than in other disciplinary areas. Thompson (2010) noted the interdisciplinary nature of the field of authors who were publishing in the Communication Journal: “This fact does not mean, however, that the research that is published in the journal is not inter- or transdisciplinary. There is much interdisciplinary collaboration and research from scholars without a background in the field of communication, as well” (p. 484).

Thompson went on the explain that the journal’s tendency to publish a preponderance of work by scholars trained in the disciplinary area of communication than by those in other (allied) fields was related to the differences in the ways that scholars in different areas
were trained to do research. For example, at this time, the field of communication placed strong emphasis on establishing a theoretical foundation for research (p. 484). The focus for this particular health communication journal was to publish sophisticated, methodologically appropriate, and theoretically based research that illuminates the interrelationships between communication and health/healthcare delivery with the emphasis on communication (Thompson, 2010).

In 1999, Sharf called all communication scholars to action embracing the social approaches of Babrow and Mattson (1996) regarding illness and wellbeing, by proposing a scholarly movement toward conducting research that addresses explicitly the implications it will have on public health and clinical practice for practical health-related outcomes. Sharf (1999) noted, “It is not enough to conduct research only because it is of interest to us or even because it continues to add to theory building” (p 196). She gave credit to the many health communication scholars who addressed tough social health problems by exploring new communication practices with the likelihood of improving improve health education and promotion. At this time in the history of health communication, Sharf (1999) noted the need to expand the entire scope of the field to account for personal, social, and societal well-being, in addition to biologic survival, the human quest for meaningful existence (Zook, 1999), and spiritual concerns (Gozalez, 1994, cited in Sharf, 1999, p. 196).

Sharf (1999) recommended that the field move toward national prominence and discussed three major connecting points to achieve this monumental strategic plan. It is through the assessment of the rhetorical strategies and impact of public communication arguments about such medical social issues such as managed health care, bioethical
issues, and medical activism. It is seen through her plea to communication scholars to reevaluate research considering these issues paradigmatic case studies for analyses of the impact of grass roots rhetoric on health care issues. Communication scholars using a variety of qualitative and quantitative approaches can answer a variety of socially responsible questions. These studies necessitate the diminution of boundaries between categorical dichotomies on which we often rely: interpersonal and mass media and clinical care and public health (Sharf, 1999, p.195).

The Development of Health Communication Internationally

It is interesting to follow the chronology of health communication trends and watch the evolution of the scholarship of the discipline unfold as many of the research themes and tensions provided a necessary stimulus and catalyst for growth. As leading scholars in the field strived to push research agendas to new levels the goal at the turn of the century was to achieve national prominence, it seems only natural an international spotlight would not be far on the horizons. In 2004, a European journal devoted to research and development in the field of health communication was launched titled Communication & Medicine, published by Equinox. Its editor, Srikant Sarangi, worked at Cardiff University in the United Kingdom. The publication was committed to the linguistic analysis of health communication and named as its aim to “consolidate different traditions of discourse and communication research in its commitment to an understanding of psychosocial, cultural and ethical aspects of healthcare in contemporary societies” (Schulz & Hartung, 2010, p. 548).

The inaugural issue of Communication and Medicine found it necessary in the development of the health communication scholarship to continue to strive to raise
awareness on an international level. Many European universities were establishing professorships in health communication. In Munich and also at the Communication Department at the University of Amsterdam, professorial positions situated in or affiliated with communication departments were strengthening a communication and social science approach to health communication and complemented by the traditional linguistic approach to the field in Europe (Schultz & Hartung, 2010, p. 548).

According to the essay written by Schultz and Hartung (2010), there are three major factors that will contribute to the further establishment of the field as an academic discipline in Europe. First, the area of the study of the media as well as campaigns and their effects will find increasing attention, within academia and outside of it. No matter whether the effects of the mass media or of health campaigns are considered, one is certainly no longer inclined to leave one’s design to the fantasy and creativity of agencies, as was often done in the past. It is rather to be hoped and expected that the field of social marketing will be professionalized, which can only happen if knowledge in health sciences and theories of media effects are spread. Second, an increasing interest in the study of social networks in health care and the use of high-tech communication tools and e-consultations can be observed. Finally, it can be expected that the field of medical communication will considerably gain in importance in the future. Some indicators point to that. For once, it is exactly the area where the much-debated “missing link” between health and communication can be found (Pettegrew, 1988).

The field of health communication needs to consider research agendas that focus on a more global merging of studies that address doctor–patient conversation to open up a wide field of researching particularly driven by positive outcomes of effective
communication. Such communication is, for instance, ascribed a crucial clinical function: Not only does the lion’s share of diagnostic information come from these talks, but the patient’s satisfaction and his or her adherence to therapy are contingent on the doctor’s interpersonal skills, which thus also affect health outcomes in patients.

Finally, in Europe there is growing discontent with the medical profession and its representatives is, at least in part, triggered by deficiencies in clinical communication. Due to the availability of a large amount of medical information, studies on the exchange and the perception of the value of this information will become increasingly important. And not only this, but also (and maybe primarily so) the demands on physicians’ communication skills and thus studies on the outcomes of doctor–patient communication will become increasingly important.

According to Schultz & Hartung (2010) “medical faculties in different European countries have recently begun to include communication skills in the training programs for physicians, on both undergraduate and graduate levels. In regard to the German-speaking countries, such inter- and intrapersonal skills—teamwork, personal, and professional development, or dealing with uncertainty—have even been defined as core competencies for medical-school graduates” (Kiessling et al., 2010) (p. 550). In defining which communication skills are to be included in the training of young physicians, decisions are informed by publications such as the Toronto Consensus Statement (Simpson et al., 1991) and the Kalamazoo Consensus Statement I (Makoul et al., in Schultz & Hartung, 2010 p. 550).

Conclusion
Thompson (2003) reminds us that health communication researchers are engaged in a vast, varied, and dynamic enterprise, and she frames the research done in the area as consisting of a number of tensions reflected in the work of Baxter and Montgomery (1996). She suggests that one new approach for the health communication field is to identify dialectical tensions reflected in the various topic areas in the field. Her suggestion is applicable to the tensions between quantitative and qualitative scholarship, between theory and practice, between traditional areas of scholarship and new areas, all of which were identified in this chapter. This way of framing health communication may do justice to what is distinctive and significant about health communication. Thompson is convinced that if other areas of communication theory and research are also interested in these tensions, health communication theories that grapple with these characteristics will contribute substantially to the entire field (Babrow & Mattson, 1996, cited in Thompson, 2003, p. 53).

The trends for health communication research will depend on future researchers. As for future research trends in areas in health communication, most researchers would like to see specific academic programs incorporated into the scholarship of health communication at universities that are offering health communication as part of the communication discipline. The number one research focus is risk communication with crisis communication/ bioterrorism ranking second (Edgar & Hyde, 2005, p. 21).

The next chapter explores qualitative research in the field of health communication, focusing on one “pole” of the dialectical tension of quantitative/qualitative methodology. As this exploration of the health communication field continues, the various tensions between theory and practice, qualitative and
quantitative methods, and old and new research areas will continue to be highlighted, with an eventual turn to phenomenological approaches in health communication. As will be evident, the field needs all of these areas to flourish—and to contribute to the flourishing of the larger area of communication to which it belongs.
Chapter 4: Theoretical Issues in Health Communication

The fourth chapter of this dissertation introduces the reader to some of the theoretical issues that currently engage health communication scholarship. Several important frameworks are used to guide an understanding of the theory in the discipline and the variety of themes and tensions that have characterized health communication scholarship. The work of Renata Schiavo, one of the leading health communication scholars in the discipline, offers a comprehensive guide to the major theoretical issues of the scholarship, which provides a roadmap that orients much of the research that is currently engaging health communication scholarship. This chapter frames those issues and connects many of the theoretical issues with current real world scholarship that is being conducted in the field today. This analysis serves to define and place scholarship into a disciplinary health communication matrix. The final section offers an initial look at an issue framed from a phenomenological perspective as a transition to the next chapter.

Health communication research has the capability of addressing a multidimensional spectrum of world health issues with an overarching theme of addressing “the real life health issues” that confront “real people” (Schiavo, 2007). Communication scholars find that behavioral and social science theories provide the necessary guidelines to analyze and explain how change occurs at the individual, community or social levels (Schiavo, 2007). The basis of many of the behavioral and social science theories emphasizes a mutual dependence of individual and external influences (Schiavo, 2007, p. 32). Schiavo specifically addresses many of the issues that influence the practice of health communication. The topics address very specific topics relating to a variety of political, environmental, health issues to broad health topics that
affect large populations. The case studies in this chapter address several of the issues and implications for health communication that Schiavo (2007) lists in her book, *Health Communication, from Theory to Practice*.

**The Issue of Patient Empowerment**

The issue of patient empowerment provides a backdrop for those seeking to analyze and explain change, particularly how change occurs in individuals and the community. Patient empowerment focuses on bringing together health care professionals and patients to work together as a team treating to prevent disease on the micro level. In this era of the empowered patient, physicians are now focused on empowering their patients and changing the way they inform and instruct to communicate shared values, shared language and mutual respect to help each patient become better utilizers of health care resources (Schiavo, 2007, p. 58).

In 1998, a team of health care professionals Stone, Bronkesh, Gerbarg, & Wood, 1998, examined ways to improve patient compliance from a behavioral and social scientific approach. According to their findings, the key issue is the need to influence patients to become adherents of good self-care as managed care organizations are increasingly focused on empowering their members with information and self-care skills (Stone et al., 1998). Today the concept of patient empowerment is important in modern medicine and one of the central pillars of health communication strategies, which improves patient awareness about a disease and its treatment (Schiavo, 2007, p. 58). Through this concept, patients are better equipped to engage in informed discussions with their health care providers and therefore participate in treatment and prevention decisions (Schiavo, 2007, pp. 58–59).

**The Issue of Technology (Internet) and Health Communication**

As more and more health care professionals endorse a patient empowerment paradigm, Schiavo (2007) turns to the research conducted by Eysenbach (2001) who
considers the concepts of “self-management” and “self-responsibility” as an opportunity to open up possibilities for much larger health communication interventions through the use of the Internet and related technologies. For example, Eysenbach (2001) views e-health has emerged as “a field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies” (cited in Schiavo, p. 61). In health communication, the increasing reliance on the Internet by consumers and professionals has opened the way to the use of interactive health communication tools, which are often designed as part of larger health communication interventions. Schiavo (2007) noted that because of rise and dependence on technology, it has also prompted several initiatives and research studies that attempt to analyze the impact of the Internet on health beliefs, behaviors, outcomes and policies as well as health-related encounters and communications such as patient-provider interactions (p. 61).

By extending the outreach of health communication programs, the rising use of the Internet and other new technologies provides health communication practitioners with an opportunity to contribute to public awareness and policy efforts that can expand access to this new channel for health information in addition to limiting the potential harm to individual and public health that may derive from inaccurate internet-based sources (Schiavo, 2007, p. 61). According to) findings, internet and related technologies have significantly extended the scope of health care beyond its traditional boundaries and consequently affected the practice of health communication(cited in Schiavo, 2007, p.61) Increasingly, patients, health care professionals, the general public, and the overall health care community rely on the Internet for a variety of services and communications, which
include advice on health issues, virtual pharmacies, distance learning for practitioners, medical public health information systems, and health records, to name a few applications (Eysenbach, 2001; Gantenbein, 2001, cited in Schiavo, 2007, p. 61).

**Blogging as a Health Communication Medium**

People might utilize various sources when searching for health information, including blogs. One such study, conducted by Lorraine Buis and Serena Carpenter, published their research findings in the *Health Communication Journal* in 2009, in an article that described the nature of non-personal journal health and medical blog posts and the frequency of interactive blog feature use within these blogs. A quantitative content analysis was performed on 398 blog posts from a constructed one week sample of posts in WebMD, Yahoo Health Expert Blogs, and independently hosted blogs (p.703). The research of (Buis and Carpenter 2009) revealed that the majority of health and medical blog posts “highlighted and provided commentary pertaining to medical issues found in external media such as books, television, websites, magazines, and newspapers, whereas only 16 percent contained actual health or medical information”. In addition, distinct differences in patterns of content were evident between credentialed and non-credentialed bloggers, as well as different blog hosts (p. 703).

**Email and Health Communication**

Despite the ubiquity of technology and its promises for patient empowerment, the concern for human interaction in the health care context remains a salient issue in the research based on this review of literature of health communication scholarship. For example, the ability for technology to mimic face to face health communication was challenged as Roter and Larson (2008) explored the extent to which e-mail messages
between patients and physicians mimic the communication dynamics of traditional medical dialogue and its fulfillment of communication functions. This study examined a large group of patients who volunteered to shared very personal medical dialogues that they had with their physicians (p. 80). The study found that physicians’ e-mails are shorter and more direct than those of patients, averaging half the number of statements. Interestingly, the electronic dialogue exchange did express elements of empathy toward the patient along with therapeutic and treatment exchanges. Roter and Larson found similarities between e-mail and face-to-face communication and concluded that e-mail accomplishes informational tasks but is also a vehicle for emotional support and partnership. Roter and Larson concluded that “the patterns of e-mail exchange appear similar to those of in-person visits and can be used by physicians in a patient-centered manner. E-mail has the potential to support the doctor–patient relationship by providing a medium through which patients can express worries and concerns and physicians can be patient-centered in response” (p.80).

Using the World Wide Web to Promote Physical Activity

The use of the internet by professionals and patients has provided the field of health communication new and challenging research opportunities that open new ways to engage health communication interventions (Schiavo, 2007, p. 61). Kelly Bonnar-Kidd (2009) evaluated physical activity websites to determine quality, accuracy, and consistency with principles of the extended parallel process model (EPPM) (p.165). This study attempted an in-depth exploration into the utility, application, and representation of physical activity online. The results of this study provided a clear snapshot of the limitless capabilities of the internet and its function in providing a forum to promote and
inform a healthy lifestyle. The results of this study suggest that health professionals have much work ahead to promote physical activity online, but that the health communication tools exist to aid in this endeavor (Bonnar-Kidd, 2009, p. 165).

**Technology as a Tool to Promote Healthy Living**

The internet has expanded the scope of traditional medical practice and stretched the boundaries of providing health information to the public (Schiavo, 2007, p. 61). The Internet has become an important topic for health communication researchers. For example, Yan Tian & Robinson, 2009 examined a recent study by Pew Internet & American Life Project suggests that about 95 million American adults have used the Internet to find information on health-related issues such as diseases, treatments, diets, and exercises (Fox, 2005, cited Yan Tian & Robinson, 2009, p. 41). Even though e-mail is still the most commonly employed use of the Internet, using the Internet for medical information has become one of the 10 most popular online activities (USC, Annenberg School Center for the Digital Future. (2005, cited in Yan Tian & Robinson, 2009, p. 41). Traditionally, people use formal channels (e.g., doctors and nurses), informal channels (e.g., friends and neighbors), and commercial/media channels (e.g., newspapers and television) for health information (Mills & Davidson, 2002; Napoli, 2000) (Yan Tian & Robinson, 2009, p. 41). Today, using the internet to find quick answers to health related questions that may help guide informed decisions about health issues is becoming very popular. However, individuals need to be aware that not all information found on the internet is reliable and it is not a substitute for seeing a doctor.

**The Mass Media and Health Information**


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The research conducted by Tian and Robinson in 2009 revealed that the occurrences of incidental health information acquisition from the Internet are positively related to overall Internet usage, active health information seeking for self and others, and incidental health information use in television, newspapers, and magazines. Yan Tian & Robinson, 2009 state “appears that like active information gain from purposeful media use, incidental information acquisition is also based on audience interest in the topic and not merely channel availability” (Tian & Robinson, 2009, p. 47-48). “People with an interest in health information are more likely to seek information about health and more likely to find health information accidentally than are their counterparts with less interest” (Tian & Robinson, 2009, p.47).

This study confirms the complementarities of health information use on a nonpurposive information use level and extends the notion of media complementarity to incidental media and education. Incidental Internet health information use was positively and predicted by incidental health information usage in traditional media (newspaper/magazine), overall Internet usage, active self health information usage and active other health information usage. Incidental health information usage gained from television was also positively related to incidental health information use on the Internet, but the relationship was not significant (Tian & Robinson, 2009, p. 48).

Tian and Robinson (2009) note that future research will be needed to improve understanding of these information-gathering behaviors and further the development of media complementarity theory. They suggest attribution theory as one framework to explain how audience members assign causes their own health information-seeking behavior. Future researchers investigating health information seeking—purposeful and
inadvertent information seeking—may want to consider this issue when measuring health information seeking (Tian & Robinson, 2009, p. 49). People who are seeking purposeful health information via the internet are gaining knowledge about a health issue that is a positive approach and is stepping away from our traditional methods of acquiring health information. This demonstrates an ideal of responsibility and taking control of personal health issues and not depending on the medical community alone to provide medical information. This “outside” source is a valuable tool for people to take ownership of their body and provides knowledge support from outside the traditional medical personnel.

Last, attribution theory may be useful for providing an increased level of specificity in Dutta-Bergman’s (2004a; 2004b) theory of media complementarity. Perhaps individuals do indeed use the various channels of the media in a complementary fashion, as he suggests. If complementary usage is based on need or information salience, as Dutta-Bergman suggests, it may well be that the enhanced desire increases individuals’ belief that they are more in control of their informational quest—particularly when the channel is more easily shaped to fit this conception of reality (Yan Tian & Robinson, 2009, p. 41). This research area may prove particularly fruitful for phenomenological approaches to health communication, given the nature of information seeking as a “turning toward” particular elements of the lifeworld. Knowledge becomes internal when phenomenology is considered through the lens of attribution theory. Phenomenology blends our “lived” experiences with acquired knowledge to increase understanding, discover new insights, challenge old views, and make constructive decisions that will enhance all aspects of health and well-being.
E-health also expanded into delivering messages via multimedia technologies to include using YouTube. Kyongseok Kim (2010) published an article in Health Communication Journal that examined the prevalence of using YouTube as a beneficial health communication tool. This study provided valuable information that exposed a variety of health risk behaviors and was the spotlight for social marketing (p.97). Kim advised health communication researchers and practitioners to “examine the beneficial and detrimental impact of YouTube, or similar kinds of user-generated, video-sharing websites, on various health behaviors” (Kim, 2009, p. 104). This study represents a small but important step to urge more research related to how online resources can promote healthy behavior. The valuable role that health communication research plays in future research and provides necessary tools for preventing or reducing harmful health behaviors (Kim, Lynn & Paek, 2009).

The Issue of Health Disparities and Cultural Competency

The field of cultural competence has recently emerged as part of a strategy to reduce disparities in access to and quality of health care (Betancourt, Green & Carrillo, 2002, v). Because this is an emerging field, efforts to define and implement the principles of cultural competence are still ongoing. To provide a framework for discussion and examples of practical approaches to cultural competence, researchers Betancourt, Green & Carrillo (2002) published a field report in October 2002, after evaluating current definitions of cultural competence and identifying benefits to the health care system by reviewing the medical literature and interviewing health care experts in government, managed care, academia, and community health care delivery. This study identified models of culturally competent care as a way to determine key
components of cultural competence and develop recommendations to implement culturally competent interventions and improve the quality of health care. Cultural competence, according to Betancourt et al. (2002) in health care describes the ability of systems to provide care to patients with diverse values, beliefs, and behaviors, including tailoring delivery to meet patients’ social, cultural, and linguistic needs that patients and market share (Betancourt et al, 2002, p.2). Key health information should reflect the appropriate level of health literacy, language proficiency, and cultural norms for the populations being served. This includes signage, specific programs for health promotion and disease prevention, health education materials, pre- and post-procedure instructions, informed consent forms, and advanced directives, among other materials (Betancourt et al., 2002, p. 5).

The Issue of Health Literacy

The Issue of Health Literacy as a Concept

Schaivo (2007) look to the work of Zagaria (2004) to describe the massive use of the Internet, one of the most important issues in health communication today concerns low health literacy, which is the inability to read, understand, and act on health information (p. 63.) Also, thousands of people who have access to the Internet many lack computer skills, because of their inability to read. For Schiavo (2007) states that “no matter how accurate, compelling, or graphically appealing information appears to be, the overall purpose of any materials or verbal communication is defeated if people cannot understand it” (Schiavo, 2007, p. 63). Low health literacy affects all age groups and ethnic backgrounds. Nearly half of all American adults—90 million people—have difficulty understanding and acting upon health information (Institute of Medicine, 2004,
The U.S. Department of Health and Human Services, 2006a views “the increasing role of the Internet as a key source of health information has been creating a divide between those who cannot understand it” (cited in Schiavo, 2007, p. 63).

Schiavo (2007) turns to Healthy People 2010 to describe “health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions”. (U. S. Department of Health and Human Services, 2005, cited in Schiavo, 2007, p. 63). Health communication can help break down the barriers to the understanding of health-related issues by using culturally relevant messages, materials, and activities that reflect the language capability and preferences of target audiences (Schiavo, 2007, p. 63).

One way that health communication scholars are combating the issue of low health literacy is to examine it through a critical-cultural approach that involves health campaigns. Dutta and Souza (2008) discuss the manner in which the critical-cultural approach interrogates modernist assumptions and provides an alternative paradigm for approaching the theory and practice of health campaigns by suggesting the necessity for reflexivity. Specifically, this perspective interrogates the role of the media in development, the significance of culture, the locus of health responsibility, the impact of structural conditions, and the politics of knowledge, providing examples of campaigns that illustrate this reflexivity (p. 326).

**Health Literacy and Culture**

The significant impact of culture on health literacy is clearly identified in an essay published in the *Health Communication Journal* 2011 by Helene A. Shugart (2011) as
she assesses the narrative of obesity as articulated in representative contemporary mainstream media fare—namely, *The Oprah Winfrey Show, The Biggest Loser,* and *Big Medicine.* Her work examines the emergent narrative of obesity across these programs, signaling a shift from the historically received narrative in light of its intersection with the concurrent culturally resonant narratives of addiction and self-actualization (Shugart, 2011, p.37). The medical community is looking at new solutions to the problem of obesity, focusing on the underlying issues so commonly associated with obesity that are symptoms of much larger socially induced problems (Shugart, 2011). This investigation suggests novel cultural understandings, practices, and policies regarding the mounting “obesity epidemic.” Shugart goes on to note, “In any event, it stands to reason that the intersection of master narratives that, by definition, reflect dominant ideological perspectives would recalibrate in such a way to maintain them to the extent possible. But such recalibration also demonstrates the fragility and fluidity of narratives as well as the necessity of responding to cultural shifts in sensibilities and attendant challenges posed by those shifts” (p. 37).

In terms of implications for praxis, this analysis confirms that attention to “expressions of discourse” (Lupton, 1994, p. 60) around health is vital to a comprehensive awareness of broader cultural understandings, beliefs, attitudes, and practices, as well as of the assumptions and implications that follow from them. This is particularly salient as relevant to strategic efforts designed to ameliorate health “epidemics” and “crises,” as is the case with obesity (Shugart, 2011, p. 47). According to Shugart (2011), “Audiences that accept or resonate with the narrative of obesity described earlier may find public health campaigns and initiatives that operate on a
biomedical model of obesity less than compelling, if not downright irrelevant” (p. 50). This study also suggests that intervention into master narratives is possible, and accordingly, strategic interventions—especially in tandem with broader shifts in cultural sensibilities—may be a productive avenue for health communication practitioners. Certainly, awareness of and responsiveness to the resonance of cultural narratives around health are vital to the study and practice of health communication in a contemporary, heavily mediated age (Shugart, 2011, p. 47).

The Issue of Managed Care

Schiavo (2007) turns to the issues of “managed care in the United States which had an overall impact on provider-patient relationships, as well as the way health care may be perceived by the media, the general public and health care providers” (Schiavo, 2007, p. 64). One study, conducted by Dalsey and Parks (2009), investigated both smoking and nonsmoking undergraduates’ reactions to an organization implementing a policy that either mandated or recommended that employees quit smoking. The findings showed that organizational attraction was affected by the level of organizational assistance but not by the level of severity (p.71). These and other findings concerning individuals’ perceived severity, perceived organizational support, smoking sensitivity, and employer control are presented in detail (71).

Organizational polices, according to Highhouse, Lievens & Sinar (2003), may be implemented for the purpose of making employees healthier and reducing health care costs. Such policies have the capacity to strengthen or weaken employees’ and job applicants’ relationships with the organization (as cited in Daley and Parks, 2009, p. 71) The research conducted by Daley and Parks (2009) specifically examines the extent to
which organizational attraction of undergraduates, posing as job applicants, is affected by two main factors: how severely a smoke-free policy affects one’s employability and how supportive the organizational assistance is for employed smokers. In addition, individual differences, such as smoking sensitivity, beliefs regarding employer control, and smoking cessation self-efficacy are examined.

This study addressed how organizational attraction would be affected by a policy aimed at promoting a smoke-free workforce. Further research in this area is needed to investigate both individual and organizational characteristics that may moderate the relationship between a smoke-free policy and organizational attraction. With increases in health promotion programs in the workplace and smoking restrictions, it is crucial to understand how both job applicants and existing employees evaluate organizational messages concerning these topics. services to patients (Dalsey & Parks, 2009, p. 71).

Health communication scholars Martin and Bell (2009) documented how the care the holistic providers offer represents the high-quality communication that patients often do not receive from their biomedical providers (p.631). This research explores the perceptions of holistic providers in Costa Rica about their communication with their patients. The results reveal two practices of communication—“authenticating and integrating as central to providers’ communication with patients in the provision of holistic health care” (p. 631). Providers describe their communication as an exploration of an anatomy of pain/suffering, including investigating the location, timing, length, intensity, and overall rhythm of the patient’s condition and sense making that leads them to seek the care of a holistic provider (Martin & Bell, 2009, p. 631).

**The Issue of Communicable Diseases**
Schiavo (2007) see “the reemergence of many infectious diseases that had started to decline or disappear has influenced health communication in two different but related ways. Due to the rising incidence of several reemerging diseases such as cholera and tuberculosis (Centers for Disease Control, 1994a), many authors and organizations have pointed out the need to raise awareness of the ongoing risk for communicable diseases by using the health communication approach” (Freimuth, Cole, and Kirby, 2000 as cited in Schiavo, 2007, p. 65). “Health communication has traditionally used strategies that raise awareness of disease severity and risk among interested groups and populations, so that people can relate to this risk and learn how to minimize it. Now, a more systematic approach to risk communications has been dictated by new attitudes toward disease prevention that have led to the reemergence of many infectious diseases” (Schiavo, 2007, p.65).

Cameron, Rintamaki, Kamanda-Kosseh, Noski, Baker, Makoul (2009) studied a group of African American seniors (65 and older) and the results showed they are less likely to be vaccinated against influenza than are non-Hispanic white seniors. There is a clear need for targeted messages and interventions to address this disparity. According to this research conducted, Cameron et.al (2009) found that some participants saw influenza as a minor nuisance; others viewed it as threatening and potentially deadly. “Participants discussed issues related or antecedent to self-efficacy, including vaccine accessibility and affordability. Regarding response efficacy, some participants had confidence in the vaccine, some questioned its preventive ability or believed that the vaccine caused influenza, and others noted expected side effects” (Cameron et al., 2009, p. 316). This
study clearly identifies the need for health communication scholarship to continue to explore patients’ responsiveness to preventive treatment.

**The Issues of Bioterrorism and Crisis Intervention**

Schiavo views “the threat of bioterrorism has forced public health officials, governments, and key community leaders and organizations to revisit their communication strategy in the light of a possible emergency situation” (Shiavo, 2007). A few general principles about the key characteristics of communications efforts aimed at averting a potential public health disaster have emerged from the lessons learned from 2001 anthrax-by mail bioterrorist attacks in the United States (Schiavo, 2007, p. 66).

A recent study conducted by Taylor-Clark, Viswanath, Blendon (2010) examined the effects of low socioeconomic positions (SEP) and social networks among Black Hurricane Katrina victims about access to and processing of evacuation orders, and abilities to evacuate before the storm hit. Taylor-Clark, Viswanath, Blendon (2010) “evaluated the effectiveness of the evacuation orders by targeting how the storm’s severity was perceived and the initial compliance with evacuation orders. This study provides implications for targeted public health emergency campaigns and future research to understand the effects of socio demographic influences on communication inequalities and public health preparedness” (p. 221). In this study, Taylor-Clark et al. found that exposure to communication messages seems to play the strongest role in affecting these hurricane victims’ abilities to evacuate before the storm hit, after controlling for other variables. Furthermore, many infrastructure logistics hindered the disaster responsiveness and delayed evacuation to the underserved communities. Taylor-Clark et al.’s findings urged emergency prepared teams to search for ways to better serve
these vulnerable communities by implementing an emergency communication plan to provide effective emergency evacuation (p. 227). The role of scholarship of health communication, according to Schiavo (2007), is to find ways to intervene socially and politically and assist in developing a public awareness that sheds light on many of the issues faced by underdeveloped countries during times of disaster (p. 67-68).

According to Clarke, Viswanith, & Blendon, 2010 “understanding mass media behaviors before and during public health disasters is also of import to future research (Katayama, 1992). Specifically, understanding the role of ethnic media in signaling public health threats will be an important area of inquiry as disaster research increases in this area” (Beady & Bolin, 1985 p. 228). For Clarke et al, (2010) view the act of information delivery needs to be aware of the negative implications that communication dissemination and researchers should “pay attention to media and other forms of information delivery, inequalities in communication that could potentially work to the disadvantage of the already vulnerable must be taken into account” (Clarke, Viswanith, & Blendon, 2010, p.228).

**The Global Issue of HIV**

The research conducted by Rimal, Böse, Brown, Mkandawire, & Folda, (2009) researched the world statistics of disease and global issues to find “Sub-Saharan Africa represents only 10% of the world’s population, but it is home to 60% of all people living with HIV/AIDS (UNAIDS/WHO [United Nations Joint Programme on HIV/AIDS/World Health Organization], 2004). Malawi is a country in this region that has been hit particularly hard by the epidemic. Approximately 14% of the adult population is infected with HIV (Malawi National AIDS Commission, 2003), and 84,000 deaths in Malawi
were attributed to AIDS in 2003” (UNAIDS/UNICEF [United Nations Children’s Fund] /WHO, 2004, cited in Rimal et al. 2009, p. 1533). According to Rimal et al, (2009) large percentages of sexually transmitted disease were related to heterosexual activity according to their research findings found from Government of Malawi, (2004), and the goal is to encourage programs and education that promoted safe sexual practices in this country. The research conducted by Rimal et al, (2009) found “behavior-change interventions have become an integral national strategy in combating AIDS in Malawi. This article reports the results from research that was conducted as part of the Johns Hopkins International access to essential drugs” (Rimal, Böse, Brown, Mkandawire, & Folda, 2009, p. 1533).

The findings from the research conducted by Rimal et al, (2009) found “the HIV/AIDS crisis in Africa and other developing regions have the high incidence of AIDS which has been threatening not only lives but also the regions’ economic and social development, has dramatically pointed to the importance of equal access to lifesaving medications” (UN Millennium Project, 2005, as cited in Rimal et al., 2009, p. 1532). The research team of Rimal et al concluded that “it would certainly be a failure of modern medicine if treatment could not be delivered to those most in need of it. The overall point is that health communication together with other kinds of interventions can help advance this debate by creating consensus and raising awareness about adequate strategies, lessons learned from previous experiences as well as the importance of a cohesive approach where different stakeholders would assume their share of responsibility” (Rimal et al., 2009, p. 1532).
Peterson (2010) explored the social support challenges of women living with HIV using a grounded theory approach. Peterson interviewed 45 women and noted that due to limited resources and the stigma associated with HIV, these women had very little social support. Peterson explored the social support challenges of women living with HIV or AIDS and developed a model of support that provided women living with HIV effective services and interventions that increased the quality of the life and in the future will provide them with much needed support from medical clinicians (Peterson, 2010, p. 470).

The field of health communication continues to lead the way in strengthening and refining the scholarship that utilize the theories of hermeneutics and phenomenology to understand and give ownership to each individual health experience.

**Toward Phenomenology and Hermeneutics: The Issue of Patient Empowerment**

Rebecca Souza examines the strategies of patient empowerment and sees a “new public health” emerging, which she finds compelling because it uses the discourse of empowerment and participatory methodologies to promote health citizenship. In an article published in *Health Communication*, 2011, Souza examines the uses of the interpretive approach to health communication to understand how debates regarding rights and responsibilities inherent in the new public health are appropriated by six employees at two community-based organizations that provide support to HIV-positive (HIV+) people in South India” (p. 25). It is through an interpretive lens that is so deeply rooted in the traditional theories of hermeneutics and phenomenology researchers “seek to understand how meaning is constituted and contested through interaction” (Zollar & Dutta, 2008, p. 6).
Souza (2011) begins by posing the question: How is the term “empowerment” understood by these individuals? (25) What was brought to light conceptualized three important positive effects of self-empowerment; power from self-acceptance and inner strength, power from family and society, and power from self-reliance. The research conducted by Souza found “the participants had the opportunity to explore the health care environment and developed a clear understanding of their role within the health care setting. They examined the responsibilities of everyone involved in shaping a health care environment and reframed the “rights, duties and responsibilities of all citizens in relationship to health and illness” (p. 25). This study lays the groundwork for future research and exploration and adds a new dimension to the responsibilities inherent to public health issues that focus on HIV/AIDS. According to Souza (2011), power resides in the self, in the social world, and in the physical world and is interactive among these three realms. The World Health Organization views regarding empowerment do not depend solely on an individual’s ability to make choices and impose them on the world; rather, external forces such as structural and cultural factors may severely limit people’s ability to “to take ownership and control of their own endeavors and destinies” (WHO, 1986, cited in Souza, 2011, p. 35).

It is through interpretive engagement health communication constructs meaning through documenting detailed descriptions of health meanings related to health and medicine. Paul Haidet, (2010) a practicing physician, examines the meaning and value of patient rights, as he recounts Health Communication Journal, important moments during his wife’s pregnancies and deliveries in which they learned the importance of being an active patient participant. As a result of these experiences, Haidet has devoted the past10
years to teaching his patients to be more active communicators. He believes the most important lessons he learned from this work is that fostering more active patient participation is more than filling a knowledge deficit or even convincing patients to speak up. For all the talk about how the medical field acculturates doctors to be controlling and unapproachable, the dirty little secret is that it also acculturates patients to be passive and “compliant” (Haidet, 2010, p. 197). It is through this article told as a “story” and the experiences shared by Haidet, there emerges a clear “demonstration of the value of narrative and the role of stories in relating health and illness experiences” (Zoller & Dutta, 2008, p. 6).

In an article written in *Patient Education and Counseling*, Anderson and Funnell (2005) examine patient empowerment through a unique paradigm involving strength in collaboration between the health professionals and the patient, focusing on beliefs learned during professional education and exert a “deep hold” on the student’s (health professional’s) mind. This essay chronicles insights and experiences over the last 16 years while introducing and promoting the patient empowerment approach to diabetes care. It represents knowledge acquired phenomenologically, rather than empirically, which is consistent with Thomas Kuhn’s assertion that paradigm shifts occur as “Ah ha!” moments rather than through logic or empirical study (Anderson & Funnell, 2004, p. 153).

Anderson and Funnell’s (2004) study specifically evaluated the acute-care system, finding most patients surrender varying amounts of control to health care professionals in order to gain the expertise, technology, and compassion available from health care professionals. In this acute-care paradigm, health care providers take responsibility for
solving their patients’ problems. This feeling of responsibility leaves many health care professionals feeling frustrated when their patients with diabetes do not follow their self-care recommendations (p. 155).

This research revealed that health care workers learned what it ‘‘means’’ to be a health care professional without ever considering the fact that alternative definitions for the roles and responsibilities of health care professionals can and do exist. Their paradigm becomes part of their professional (and often personal) identity. Once in practice they do not see their paradigm at work but rather see their work through the paradigm. Once adopted, a paradigm can have such a deep hold that it acts like a psychological ‘‘eye’’ with which we see the world but which we cannot see. The acute-care paradigm is not only embedded in the minds of individual health care professionals, but is also the basis for most of the policies and procedures of health care organizations and third-party payers (Anderson & Funnell, 2004, p, 155).

**Conclusion**

The health communication issues that are highlighted in this chapter have been ones that Reneta Schiavo outlined in *Health Communication; From Theory to Practice.* This chapter is a collaborative walk in which Schiavo takes us on a guided exploration of each issue to uncover key research examples that demonstrate methodologies used by health communication scholars addressing the issues she has so clearly identified in her book. Schiavo walks reflectively alongside of this work, and the research teams noted in this chapter expose new perspectives to each issue and offer solutions through scholarship and praxis.
The issues and research examples used in this chapter provide a backdrop of scholarship as chapter five presents research from a qualitative perspective that has developed over the years in the field of health communication. Chapter 3 pointed out the need for scholars in the field of communication to contribute to health communication research and publish work in the professional journals, calling out for more researchers in the field of communication to focus on issues in the field of health communication. The scholarship needed diversity in research methodologies, with a focus on approaches that contained a “thick description” of the health care environment (Nussbaum, 1989, p. 35). It is also evident in chapters 2 and 3 that the multidisciplinary roots of health communication are grounded in constructive humanistic philosophies and several of the key figures instrumental in the development of the field were engaging in phenomenological approaches to many health related research agendas. The next chapter, chapter 5, explores the research strategies used and guided by a phenomenological perspective incorporating a qualitative method to explore many of the health communication issues that demands critical attention in the field.
Chapter 5: Qualitative Research in the Field of Health Communication

Chapter five describes the qualitative research published in the *Journal of Health Communication* (JOHC) over the last 13 years, grounding phenomenological praxis in the field of health communication and chronicling the JOHC scholarship by examining interviews, case studies, and patient observations. This chapter identifies researchers who are moving in a qualitative direction without the aid of experiments and studies with numbers but embrace the investigating of people's experiences and stories. The JOHC provides an excellent historical record for health communication scholarship in its targeting of research gaps in health-related topics and methodologies. The health communication journals provide scholars in the field a public record that engages and ignites scholarship. I begin by addressing Gary Kreps’s work with the first journal to address health communication as a defined area of study—the *Health Communication Journal*. This journal was focused on practical issues in the United States. The *Journal of Health Communication* emerged as a call to respond to the need for rigorous theory and scholarly investigation and a more global outreach—without losing an applied focus.

**Background**

The first scholarly journal in the field of health communication was the *Health Communication Journal*. Gary Kreps used the first issue to develop a clear set of primary goals for health communication research, which he identified as “not to break out in print but to generate health communication knowledge for directing health care policy, practice and intervention” (Kreps, 1989, pp. 14–15). Kreps reminded readers of the diversification of the discipline and encouraged a unification of health communication scholarship and research. Kreps also encouraged a more dialectical approach reflecting new theoretical
perspectives in the larger field of communication. His comments pointed to the need for continued integration of health communication theory and practice, as well (Kreps, 1989, pp. 14–15).

In 1996 the *Journal of Health Communication* launched its inaugural issue, which was driven by a dedicated group of communication scholars who were offering to the field of health communication practical and heuristic insights into the reciprocally beneficial relationship between optimal health and effective communication (Ratzan, 1996, p. v-vii). The editor, Scott Ratzan, mapped out a strategic plan for this publication, bringing together a group of multidisciplinary scholars who were devoted to the mission of “preserving a fundamental natural resource—the health of a global population” (Ratzan, 1996, p. v-vii). Ratzan set an ambitious agenda for the Journal of Health Communication that focused on “expanding the realm of health communication to include . . . advocacy, marketing, media, persuasion, and global communication, . . . fostering a shared understanding of community ideals to . . . begin to eliminate the current bureaucratic maze, simplify medical and behavioral jargon, and nurture supportive personal, family, work, and community environments” (Ratzan, 1996, pp. v–vii).

Freimuth, Massett, and Meltzer (2006) published an article celebrating the 10 year anniversary of *Journal of Health Communication*. Their study evaluated publications in *The Journal of Health Communication* appearing during its first ten years. The authors reviewed 321 articles using a unique coding system that profiled a typical article published in the journal (p. 11).
Freimuth et al.’s (2006) analysis revealed that most of the articles were published by scholars from the United States. Freimuth et al. noted that over the ten year publication span, more quantitative than qualitative research was conducted. They also noted that less than half of the research published was framed theoretically—“that is, not driven by any primary theory” (Massett, Meltzer & Freimuth, 2006, p. 11)—which they found problematic. The two most common theories used were the Social Cognitive Theory and the Health Belief Model.

Freimuth et al. (2006) noted that most of the articles were empirical studies, and only 4% of the articles in that time period were rhetorical studies (Freimuth, Massett & Meltzer 2006, 17). They found it surprising that there were few discourse analyses, and very few articles published by the journal in the first 10 years of publication used qualitative data, despite the increasing trend for that type of research in health communication (Massett, Meltzer & Freimuth, 2006, p.17). There was also very little research describing scale development and few meta-analyses. Qualitative approaches were increasing, but over the first decade of the journal’s history there were very few qualitative research articles published. Those qualitative studies that were conducted were empirical, employing in-depth interviews (p. 20).

Freimuth et al.’s (2006) careful work on this descriptive qualitative content analysis examining past decades provides insights for scholars seeking direction for future health communication scholarship. As Freimuth et al. note, during those first 10 years, JOHC published an impressive body of research and clearly contributed to a growing maturity both in theory and practice. For example, their review suggests that over the years, the scholarship of health communication has grown sufficiently to provide
the scholarly based for an academic field. However, their work also revealed a lack of theoretical grounding for much of the research and called for more theory development in health communication research, a necessary step to enhance future research in the discipline (p. 20). Of particular interest to the current project is the report of growing numbers of qualitative studies.

**The Importance of Qualitative Research**

In the past, medical science, with its strong tradition of biomedical research, traditionally used conventional, quantitative, and often experimental methods (Mays & Pope, 2000). This reputation existed even into the 1990s as the status and acceptability of qualitative research within medical and health services was often criticized for lacking scientific rigor. There was a perception that medical research placed quantitative evidence much higher up the hierarchy of evidence than qualitative research. This is because questions about the effectiveness of an intervention or treatment are much better addressed by quantitative methods (Mays & Pope, 2000, p. 50). It is argued that qualitative research lacks reproducibility and the researcher is so subjective that there is no guarantee that different researchers would not come to radically different conclusions; and, finally, qualitative research is criticized for lacking generalized reliability. It is said that qualitative methods tend to generate large amounts of detailed information about a small number of settings (Mays & Pope, 2000, p.50).

The application of quantitative measures enables statistical methods to be employed and quantitative questions to be answered. However, these are not the only questions that matter. The contributions of qualitative research can be illustrated by examining the outputs of qualitative research, the combination of qualitative and
quantitative research, and the synthesis of qualitative research (Mays & Pope, 2000, p.50).

In recent years, qualitative methods are becoming more common place in many areas of research where it was traditionally unacceptable because the quality of qualitative research was in question. Mays and Pope (2000) framed this issue in an article examining research applications for qualitative methods, noting that “there is considerable debate over the nature of the knowledge produced by such methods and how such research should be judged” (p. 52). Mays and Pope’s work explored the quality of qualitative research methodology in the health services, which has gained considerable attention over the years. Their work reflected on questions posed relating to the relevance of the research, the clarity of the research question, and the appropriate research design (p. 52). To be done well and credibly, qualitative research must follow accepted procedures, and it takes ability and careful attention to method. As Dingwall et al conclude, “Qualitative research requires real skill, a combination of thought and practice and not a little patience” (cited in Mays and Pope, 2000, p. 52).

In an article written in *Family Practice*, 2010, M. Kelly (2010) examines different approaches to qualitative research, such as grounded theory and discourse analysis. Her work offers practical guidance to researchers using a qualitative methodology, stressing the importance of theory as a driving force that steers the design, analysis and quality of the research (p.285). Researchers use qualitative approaches to explore behaviors, perspectives, feelings, and experiences which aids in the understanding of human challenges that exist as we come to terms with each human experience. The next section addresses discourse analysis.
Qualitative Discourse Analysis

Discourse analysis can be applied to a variety of interpretive based research questions that are socially relevant and calling out for interpretations emerging from (Gadamer, 1993) views of being in the world … and the rhythm of life which is a permanent process in which equilibrium re-establishes itself (cited in Svenaeus, 2001, p.94). This reflection can apply to the researcher’s world view and participants’ lived experience as articulated in verbal utterances. Julianne Cheek (2004) explored the topic of discourse analysis and examined the possible applications for this qualitative research approach. Cheek raises questions about the confinement of discourse analysis within the parameters of qualitative methodology (Cheek, 2004, p.1140). Wodak and Meyer (2009) define critical discourse analysis as “language use in speech and writing as a form of social practice” (2009, p. 5).

Kulich, Berggren, and Hallberg (2003) published an article that demonstrates the use of discourse analysis in qualitative research to analyze how dentists interact with their patients. In a Swedish clinic that specialized in treating patients who were dental phobic, interviews were conducted and transcribed using the principles of grounded theory (p. 171). The study identified several core categories, including “Holistic perception and understanding of the patient,” “The dentist’s positive outlook on people,” and “the dentist’s positive view of patient contact,” and six further subcategories. Kulich et al. concluded that their findings supported previous models of patient-centered medicine and contributed to a better understanding of how patient-centered dentists interact with dentalphobic patients (p. 171). A closer examination of their study provides insights into
the value of discourse analysis as a research method for health communication researchers.

Kulich et al. (2003) approached dentist-patient interactions from a theory-generating qualitative perspective, based on the principles of Grounded Theory (Strauss & Corbin, 1990). The aim of data collection and analysis was to study dentists’ perceptions of how they thought and felt, and what they did during the actual consultation. The patients that participated agreed to a video recorded interview. The questions in this study focused on what constitutes a patient-centered consultation and on the characteristics of a patient-oriented dentist.

The results of this study demonstrated the value of qualitative research using a discourse base approach and demonstrated the applicability of results to the practice of dentistry as an area of health communication. Furthermore, Kulich et al. (2003) argued that their findings extended beyond the specific context—that is, dentistry. Although their findings were applicable to dentists who are working primarily with “fearful dental phobic” patients, Kulich et al. believe that their findings may be applicable to other health-focused contexts. They also suggest that their findings may be heuristically provocative by generating interest in other types of medical situations involving patients who are fearful about medical treatment in general (p. 185).

Kulich et al. ’s (2003) recommendation for future research is to focus on the entire consultation process, targeting very specific areas of how the health professional performs while taking patient histories and paying very close attention to the patient’s understanding of his/her dental phobia as this is felt to have a significant impact on the consultation process (Kulich Berggren, Hallberg, 2003, p. 186). This study demonstrates
just one example of discourse analysis representing one basic medical application using qualitative research. The next section explores phenomenology as qualitative research.

**Phenomenology as Qualitative Research**

Phenomenology as qualitative research is explored by Christina Goulding (2003). Although her work focused on marketing and economics, it is relevant to research in health communication because it targets a specific academic area from which application of phenomenological method can be generalized. Goulding highlights the “understanding” element of phenomenology, noting that “phenomenology, as both a philosophy and a methodology has been used in organizational and consumer research in order to develop an understanding of complex issues that may not be immediately implicit in surface responses” (Goulding, 2003, p. 301). She turned to Joplings’s (1996) views to discover a richer understanding of the phenomenological contributions to qualitative research, in particular, its focus on conscious experience. According to Joplings (1996), “Phenomenology therefore is a critical reflection on conscious experience, rather than subconscious motivation, and is designed to uncover the essential invariant features of that experience” (p. 304). Phenomenology demands intense reflection as an integral part of the process, but above all, the primacy of the subjective experience is felt to be crucial (Goulding, 2003, p. 304).

The application of phenomenological methodology to consumer health related research is noted in the work of Ancker, Chan and Kukafka (2009). Ancker, Chan and Kakafka found that traditional quantitative research methods would not provide them with the guidance they needed for their research design. Instead, they applied qualitative methodologies to explore consumer preferences for different interactive graphics. In this
study, consumer interpretations were examined to determine how they used the product and what they saw (p. 463). The overarching goal was to explore how technology interacted with human interpretation and meaning to create a user centered product (p. 463).

The results of this research provided an opportunity to move research from a laboratory setting to a “real world” environment by applying consumer interactions to explore consumer health communication. Ancker, Chan and Kukafka see this a future application their work, because “interactive graphics may be a new medium for conveying comprehensible, credible, and motivational health and health promotion information, which may help improve health-related decision-making and outcomes” (Ancker, Chan, Kukafka, 2009, p. 463).

This study also applies the practice of phenomenological methodology by using language to construct legitimate data and apply this approach to qualitative inquiry.

There is a need for more rigorous qualitative methodologies in order to develop theory in the field of health communication. For example, researchers from Boston University confronted the challenges that exist when trying to build patient centered relationships. This study conducted by Duggan, Bradshaw, Carroll and Rattigan (2009) titled, What can I learn from this interaction? A qualitative analysis of medical student self-reflection and learning in a standardized patient exercise about disability, examined how medical students learned about disability. Patients with disabilities face a variety of obstacles when placed in a health care environment and are especially “vulnerable to adverse health care experiences, including time constraints to address complex issues,
sensory and cognitive communication barriers, limited financial resources, and physically inaccessible care sites” (Duggan et. al, 2009, pp. 798–799).

Medical students were videotaped during interview sessions. The analysis revealed the emergence of three qualitative descriptive themes that reflected on “the ways in which medical students indicate learning to integrate reflective practice and disability, and how reflective practice about patients with disability promoted relationship-centered care” (Duggan et al, 2009, p. 800). This unique project provided valuable evidence of the ways examining disability can serve as a cornerstone for building relationship-centered patient care and encouraging reflective practice overall. Achieving relationship-centered communication demands open communication between patients and physicians, but challenges exist in reaching this goal for both the general population and for many population subgroups (Duggan & Bradshaw, 2009, p798-99).

This project opens up the unique conversation that physicians may become integrated into a “culture of disability” (Eddey & Robey, 2005, p. 706) for which a particular set of competencies are required to acknowledge patients’ values and needs, encourage self-advocacy, and emphasize interdependence between patient experience and physician expertise. Identified learning areas suggest that the boundaries between inexperience with disability and general medical inexperience are blurred, and that learning about patients with disabilities can indeed serve as a cornerstone for relationship-centered care. The current analysis also identifies examples to build core constructs for evidence-based theory to explain reflective practice and relationship-
centered health care, each of which could be explored from a phenomenological perspective.

The next section explores how qualitative and quantitative methods may work together to provide insights into health communication. More than one epistemological framework may be useful for understanding phenomena in the area of health communication. As researchers in the field of organizational communication note, the “common ground” of inquiry is the subject of study, which can be approached from multiple perspectives (Corman & Poole, 2000).

**Qualitative and Quantitative Blending**

In recent years the movement in health-related research is the collaboration of both qualitative and quantitative methods. For many researchers outside the field of health communication who traditionally use a quantitative approach, a blending of the two methods can be very fruitful. Health communication, like research in many areas of the communication field, requires significant effort employing multiple methodologies, including longitudinal research, which captures health-related phenomena over time (Casebeer & Verhoef, 1997).

Public health scholars Casebeer and Verhoef (1997) found a need for urgent change in the current research that focused strictly on “either/ or” method of defining research strategies. Casebeer and Verhoef discussed some of the underlying reasons health researchers have historically had difficulty working collaboratively across qualitative and quantitative research paradigms but have now understood the need to move beyond a rigid adherence to one methodological framework. They suggest that productive health communication research—their example is health research on
managing health-related conditions—lies in both qualitative and quantitative research perspectives, methods, and tools. This section offer examples of research in the health communication scholarship that employs both methods.

In 2009, Veyth, Steenhuis, Mallant, Brug, and Mol from the Vrije Universiteit (VU) University of Amsterdam teamed up with researchers Temminghoff, Feunekes, Jansen, and Verhagen from the Netherlands and Belgium to perform a quantitative and qualitative process evaluation. Their work resulted in a 2009 article published in the JOHC. Their project focused on an evaluation of the use of the Choices logo, which was a front-of-pack nutrition logo found on products with a favorable product composition, adopted by many food producers, retail, and food service organizations and conditionally endorsed by the Dutch government, validated by scientists, and in the process of international dissemination (Veyth et al., 2009, p. 632).

Veyth et al.’s (2009) research employed a quantitative process of evaluation by examining the perception of the nutritional facts panel found on the back of the product. A major Choices logo campaign was initiated and evaluated within a year. An online questionnaire was completed four months after the Choices logo was introduced, which included qualitative elements. The qualitative data indicated that the authority supporting the logo was not totally clear to consumers, resulting in mixed feelings regarding the logo’s trustworthiness.

The qualitative research blended into this project provided greater insight into the depth of consumer perception of the logo. Through a series of interviews and questions, a deeper level of public awareness was detected than would have been possible using only traditional quantitative methods (Veyth et al., 2009, p. 632). Veyth et al.’s (2009) study
highlights the usefulness of quantitative and qualitative methods for evaluating the outcome of a public health message through quantitative and qualitative methods. The key issue to be noted from this study is that through this research using both qualitative and quantitative methods, the ability to evaluate the type of logo that motivates a favorable dietary choice was achieved. Evaluating the Choice logo message through qualitative methods is an example of how consumer perception can be tapped fruitfully in ways other than quantitative analysis—and how qualitative and quantitative analysis can work together. This nutritional education campaign is one of many employing mixed methods that can be used as a benchmark for future research and discussion.

The combination of both quantitative and qualitative methodology not only provides initial insights into the perception of the Choices nutrition logo among consumers, but also provides an illustration of how a mixed methods study can take advantage of the strengths of both research processes and for one approach to confirm the insights of another. For example, the Choice logo qualitative findings that habitual purchasing behavior and time pressure play a role in whether or not consumers are paying attention to the logo are in agreement with other studies (Croft et al., 2002; Grunert & Wills, 2007; Harper et al., 2007; Signal et al., 2008). Furthermore, these findings are heuristic, providing insights and impetus for further research regarding the Choices logo (Veyth et al., 2009, p. 632) and similar health communication campaigns. These findings also have applied value; they can be used to formulate useful recommendations for communication [campaigns] regarding the logo (Veyth et al., 2009, p. 643).

**Diffusion Research: An Example of Blending Quantitative and Qualitative Research**
Diffusion of innovations research has been one research framework used in healthcare settings. This theoretical framework examines how messages about change travel through a social system through time through particular channels (Rogers, 1995). This section addresses one researcher’s attempt to shift diffusion research into a qualitative direction as an illustration of

Diffusion research is typically characterized by the collection of quantitative data about one innovation gathered from adopters at a single point in time after widespread diffusion has occurred (Meyer, 2004). Meyer (2004) explored traditional quantitative approaches to diffusion research, focusing specifically on its strengths and weaknesses. His hope was to encourage innovation—that is, use of alternative methodologies—to increase understanding of diffusion processes.

In 2004, Gary Meyer looked closely at a variety of research methodologies, including communication and public health, which have been mainly driven by diffusion research. According to Meyer, “this approach is characterized by the collection of quantitative data about one innovation gathered from adopters at a single point in time after widespread diffusion has occurred” (p. 59). The primary goal of this project was to examine the diffusion research approach and consider the strides made over the years utilizing this methodology in comparison to other similar research approaches (p. 59).

Meyer (2004) notes that over the last thirty years, many researchers have been dissatisfied with the field of diffusion research. Meyer discusses the “pro-innovation bias” (p. 63), which assumes that innovations should be universally adopted quickly and with no thought to the particularities of the individual adopter’s needs. The result of such a bias is blaming the end-user of the innovation: “This bias places blame for societal
problems with individuals within the social system rather than with the social system itself” (Meyer, 2004, p. 63). Meyer notes that one remedy for the shortcomings of the diffusion approach is to apply qualitatively oriented research methods.

Meyer (2004) suggests that quantitative quasi-field experiments are not likely to yield data sufficiently rich to permit a researcher to get “close enough” (p. 67) to the diffusion process to provide an in-depth explanation for the occurrence of events of interest to the researcher. He suggests that “qualitatively oriented research methods that are focused on the continuous investigation of the diffusion process over time, as it unfolds, could help” (p. 67) is to collect data that would allow information to flow freely from participants—for example, through journals and tape recorded conversations. Such techniques can yield qualitative data to complement useful quantitative data (Meyer, 2004, p. 67) and would permit a focus on human meaning essential to the nature of health and illness as part of the human condition (Arnett, Fritz, & Bell, 2009).

In sum, both quasi-experimental field studies and the integration of qualitative methods hold much promise for advancing the state of knowledge in diffusion literature. Each accounts for the important dimension of time in ways that have not been emphasized previously, and as a result, each potentially enables the investigator to more fully account for the sequence of events that leads to diffusion outcomes. These methods, however, will challenge investigators to think about diffusion research in new ways. In the case of quasi-experimental studies, investigators will need to strategically control more of the diffusion process, while in the case of qualitative methods, to strategically control less of the diffusion process, hoping in both cases to better understand the phenomenon of interest, the diffusion of innovations (Meyer, 2004, p.67).
Conclusion

The introduction of phenomenological approaches as a significant qualitative research approach in health communication begins with the implementation of a “real life” understanding individuals needs and understanding of the world. According to Thompson and Zahavi, phenomenology grows out of the recognition that we can adopt, in our own first-person case, different mental attitudes or stances towards the world, life, and experience. In everyday life we are usually straightforwardly immersed in various situations and projects, whether as specialists in one or another form of scientific, technical, or practical knowledge, or as colleagues, friends, and members of families and communities (p. 4).

For the most of the 20th century, the quantitative research methods were predominantly employed in most health related research. It was during the 1980s that the qualitative paradigm came of age as an alternative to the quantitative approaches. Qualitative research could be framed as the opposite of quantitative research in its approach to knowledge and methods for securing that knowledge. Through this exploration into the methods used in the research of health communication, we see a move from methodological approaches that seem to reflect much of the methods and approaches found in early social behavioral research to a blend of approaches. The current trend of blending both qualitative and quantitative methods promises new insights into health communication scholarship.

Casebeer and Verhoef (1997) note that the research methods employed in the future for scholars studying health communication can make a difference through multi-method studies. There is an intuitive appeal to combining research approaches, but the barriers separating researchers’ different world views, different training, and simple lack of contact and understanding all conspire to make collaboration difficult (Casebeer &
Verhoef, 1997). Cassbeer and Verhoef point to the issue of studying chronic disease as a paradigm case for the usefulness of blended methods. They note that if research can be improved by linking quantitative and qualitative approaches in the study of managing chronic disease, then such collaborations should be encouraged and supported. Casebeer and Verhoef (1997) give voice to the sense that surely all health communication researchers would articulate: people living with long-term illnesses surely deserve the best efforts of the research community (Casebeer & Verhoef, 1997, p. 18). It stands to reason that these approaches could be transferred to other areas in health communication research. As will be illustrated in the chapter 8, a phenomenological approach to understanding long-term, chronic, and terminal illnesses promises a focus on meaning that may provide the “best efforts” that the health communication research community can offer.

The next chapter continues the thread of examining health care communication research. Chapter 6 revisits the domain of health communication scholarship to explore a set of theoretical issues. These issues have been studied from a variety of perspectives, typically from quantitative approaches. The final issue presented in chapter 6, however, represents a move to a phenomenological methodology. This issue is an exemplar of health communication scholarship aimed at uncovering the meaning of health in the human condition.
Chapter 6: Hermeneutic Phenomenology in Health Communication

Chapter six presents an interpretive paradigm of investigation into the research strategies of health practitioners using hermeneutic phenomenology as the underpinning of clinical reasoning and professional practice to enhance the value of hermeneutic phenomenology as a credible rigorous research approach to practice communication in the health profession. Each of the research findings highlighted in this chapter embodies a unique philosophical framework; each employs applied methodology and strategies that derive meaning and give attention to the connection between hermeneutic phenomenology and health communication outcomes. The chapter begins by framing hermeneutic phenomenology, then moves to phenomenology in health communication, and then explores the phenomenological approach in the area of nursing. The next section offers selected studies from a phenomenological perspective. This set of studies provides additional avenues of research for health communication scholarship. The chapter concludes with a summary and preview of chapter 7.

Framing Hermeneutic Phenomenology

Today hermeneutic phenomenology is a credible research approach used by health care professionals that lays the groundwork for enhancing health related research designs and enhances clinical reasoning (Ajjawi & Higgs, 2007, p. 612). Ajjawi and Higgs (2007) discuss how to use hermeneutic phenomenology to explore how practitioners communicate clinical reasoning. This interpretive research paradigm is grounded in an epistemology of social construction. Hermeneutic phenomenology is attentive to the philosophies and “research methodology aimed at producing rich textual descriptions of the experiencing of selected phenomena in the life world of individuals
that are able to connect with the experience of all of us collectively” (Smith, 1997, p. 80). From an identification of the experience of phenomena, a deeper understanding of the meaning of that experience is sought (Smith, 1997). This understanding is invited through increasingly deeper and layered reflection by the use of rich descriptive language (Ajjawi, 2007, p. 613).

**Definition and Focus**

A minimalist definition of hermeneutics—that is, textual interpretation—emerges from research done in the field of nursing. Byrne (2001), for example, extracts and defines the term based on two embedded assumptions: one, that humans experience the world through language; and, two, that this language provides both understanding and knowledge (p. 73) The term hermeneutics, which was used originally to refer to a method of interpreting the Bible, was derived from two words: the Greek verb hermeneuein, meaning to interpret, and the noun hermeneia, meaning interpretation (Byrne, 2001). The definition provided by Byrne views the application of hermeneutic methodology as a way to approach data relevant to health communication; understanding emerges from the recognition that human experience is embedded in a rich socio-cultural and historic context that requires qualitative interpretation to derive meaning that may be obscure (Byrne, 2001, p. 968).

It is interesting to note that these definitions emerge from the nursing literature. Over the years the medical profession, particularly nursing, has made a phenomenological turn. Researchers in the field of nursing have applied a phenomenological approach to derive meaning from human experience—meaning that requires an understanding and knowledge emerging through personal experiences and
emotions related to health and illness. Merilyn Annells (2007) notes that the application of hermeneutic phenomenology in the field of nursing must be grounded in traditional philosophical roots; she turns to the work of Heidegger and Gadamer, who supply the origins of philosophical hermeneutics. Annells finds that the discipline of nursing can apply analysis rich ontological, epistemological and methodological perspectives that enhance an interpretivist/constructivist paradigm of inquiry (p. 223).

Van Maanen (1997) captures the essence of the phenomenological approach to research when he describes it as an open doorway. We step through this doorway to extract meaning through an understanding of a unique “lived experience,” and it is by virtue of exploration into the personal journeys of particular people through the application of a phenomenological approach that we focus pre reflectively on experience and feelings. Communication and language are intertwined and hermeneutics offers a way of understanding human experiences captured through language and in context (Ajajwi & Higgs, 2007; van Maanen, 1997). Such an approach is thus ideal for investigating personal learning journeys in the context of health communication.

It is important to note that the application of hermeneutic analysis, which focuses on texts generated by stories, interviews, participant observations, diaries, literature, letters, or other relevant documents, provides an excellent lens for research in the field of nursing, where much of the data is extracted from such sources. According to Byrne (2001), meaning is derived through a process of thematic categorization of the text to identify useful information necessary to the research project (p. 968). If this method of hermeneutic analysis applies so well to the field of nursing, it is not surprising that it would also emerge in the area of health communication, which seeks understanding of
human experience in the face of one of the most significant elements of life. The next section reviews the “method” of hermeneutic phenomenology in order to explore how it draws out human meaning from the experience of health and illness.

**Hermeneutic Phenomenological Method**

One approach to hermeneutic phenomenological investigation is the interview. In hermeneutic phenomenology the interview serves very specific purposes. First, it is used as a means for exploring and gathering of narratives (or stories) of lived experiences (van Maanen, 1997). Second, it is a vehicle by which to develop a conversational relationship with the participant about the meaning of an experience (van Maanen, 1997). This relationship may be achieved through reflection with the participant on the topic at hand (van Maanen, 1997). Interviews also allow participants to share their stories in their own words.

Phenomenology focuses on a person's lived experience and elicits commonalities and shared meanings, whereas hermeneutics refers to an interpretation of textual language (Ajjawi & Higgs, 2007, p.615). Although there is no absolute or universal definition of either term, when these concepts are used together, they usually are closely related to qualitative research methods that use words or narratives as the basis to gain understanding (Byrne, 2001, p. 74). Researchers must define these terms and link them with a particular philosophy or approach as they develop the framework for a research study (Byrne, 2001, p. 74).

Because phenomenology focuses on understanding meaning in human experience, the goal of phenomenological data analysis is to “transform lived experience into a textual expression of its essence—in such a way that the effect of the text is at once a
reflexive re-living and a reflective appropriation of something meaningful” (van Maanen, 1997, p. 36). Text may be viewed as both the data and product of phenomenological research (Smith, 1997). The aim of researchers using phenomenology is to construct an animating, evocative description (text) of human actions, behaviors, intentions, and experiences as we meet them in the” lifeworld.” Phenomenological descriptions are rich and evocative, invoking in readers the “phenomenological nod” in recognition of a phenomenon so richly described that they too may have experienced it (Ajjaawi & Higgs, 2007, p. 615; van Maanen, 1997, p. 27).

According to the research of Ajjaai & Higgs (2007), “the product of phenomenological research should be simple and straightforward, such that readers who have experienced the phenomenon can analyze their own reality with the identified themes (Swanson-Kaufman & Schonwald, 1988). Phenomenological themes may be understood as structures of experience and offer a thick description of phenomena (van Maanen, 1997). This thick description is the result of analysis and the way the researcher offers an interpretation of the data of the text” (van Maanen, 1997) (p. 622).

**The Hermeneutic Circle and Critical Hermeneutics**

Bontekoe (1996) visits the use of the hermeneutic circle metaphorically to facilitate understanding and interpretation, which is viewed as a movement between parts (data) and whole (evolving understanding of the phenomenon), each giving meaning to the other such that understanding is circular and iterative (Ajjawi & Higgs, 2007, p.630). The questions that emerge from the experience give meaning to words. As the text is interpreted, new ideas are generated, creating a question answer interplay to occur. In this sense, the questions and answers work in dialogic fashion. As Bontekoe (1996) notes,
understanding emerges in the process of dialogue between the researcher and the text of the research. The act of interpretation itself represents a gradual convergence of insight on the part of the researcher and the text (Ajjawi & Higgs, 2007, p. 630).

Byrne (2001) links critical hermeneutics with critical social theory (i.e., identification of societal contradictions, in which the purpose of critical hermeneutics is to expose hidden power imbalances and challenge the status quo, p.968). Based on Byrne’s experience, “the researcher always should clarify his or her interpretation of critical hermeneutics when asking a research question and reporting the findings. For example, a critical hermeneutics approach might be used to explore hidden power imbalances in the surgical setting by examining written transcripts of surgeon and nurse communication during surgery” (Byrne, 2001, p.968). Thus, critical hermeneutics asks the researcher to bring questions related to power to the text as an approach to inquiry.

Philosophers associated with critical hermeneutic perspectives include Paul Ricoeur, Jürgen Habermas, and Hans-Georg Gadamer. Gadamer’s hermeneutics emphasizes how language is embedded in our understanding of our world. His work helped extend philosophical hermeneutics to critical hermeneutics by stressing the importance of tradition, background, and history in our ways of understanding. Gadamer believed that understanding comes from interpretations embedded in our linguistic and cultural traditions, which contribute to our inherent prejudices (Byrne, 2001, 969).

**Gadamer and Prejudice**

It is through the inherent nature of prejudice that we find meaning in human responsiveness to the world. Gadamer defined the concept of prejudice as “prejudgment” (Gadamer, 1975). Byrne (2001) draws close to Gadamer’s definition as he notes that
prejudices are preconceived notions of phenomena (for example, events, interactions, other persons) arising from our past experience and socialization. Byrne notes that if a person were able to take an objective stance to all experiences, prejudices would disappear, but Byrne notes that Gadamer found this outcome impossible to achieve (p. 969). Byrne believed that to understand each other, we cannot and should not shed our past experiences; these experiences actually enhance our understanding. Byrne leans into the work of Gadamer, who advocated continually striving to identify our prejudices. Byrne supports the philosophies of Gadamer and explains how prejudice provides a standpoint for understanding that, ironically, may permit the possibility of a temporal transcendence of standpoint:

To be engaged in a conversation with a text is to bring one's prejudices into play. On the basis of one's prejudices' one is able to understand the content of what the text says. The reader is engaged from a definite point of view and is only able to understand the content of the text from this perspective. The very fact that we question the text suggests that we are trying to transcend our own prejudices (969).

In the medical profession, prejudice exists as a result of past experiences, and from a hermeneutic perspective the prejudice can be viewed as “good” or at least helpful—indeed, it is inevitable, part of the human condition. For it is prejudice, according to the work of Byrne (2001), following Gadamer, that adds dimension, depth, and a multiplicity of alternatives to research. This understanding of prejudice can be
applied in the clinical setting as health care professionals interact with patients and family members, who bring a spectrum of ideas to be considered from an angle not previously available. Byrne notes that it is important for us to identify our cultural traditions and recognize the way they shape us in order to acknowledge the existence of prejudice in all situations (p. 969).

Byrne (2001) look at critical hermeneutics from the perspective bias and prejudice imply the potential for power imbalances to form and endure, particularly when one considers the existence of interests (Habermas, 1979). One researcher used critical hermeneutics to analyze fundamental nursing textbooks in an effort to uncover common types of racial bias. The textbooks provided a textual data source that was analyzed for themes reflecting the portrayal of African Americans. The researcher clearly linked the philosophy of Gadamer, especially the concept of prejudice, with the research topic of racial bias. The researcher's race, background, and research assumptions were explicated in a research journal providing readers with a context for critique. The thematic findings then were compared to numerous literary sources on racial bias. Experts on African American identity and culture confirmed the findings that nursing textbooks may contribute to reinforcing racial bias. This research did not explore a lived experience and, therefore, could not be considered phenomenological. Rather, the goal was to uncover hidden bias, which is congruent with critical social theory (Byrne, 2001, p.969-970). This example serves to illustrate a contrast to phenomenological methodology.

**Phenomenology and Health Communication**

Health communication research, according to Dutta and Zollar (2008), can be categorized as falling primarily under the post positivistic paradigm (e.g., Miller, 2000)
and has primarily focused on the roles of effective messaging strategies in health communication settings (social support systems, provider-patient interactions, health campaigns, health organizations, and media systems). Dutta and Zollar identify a variety of influences in the health care environment that have influenced health outcomes. It is important for health care professionals to recognize and be able to pinpoint those factors that may influence a particular person’s interpretive experience; the focus cannot be solely on the patient as there are influences from clinicians that may shape health outcomes (p. 5).

Zollar and Kline (2008) have found that interpretive, critical and cultural studies approaches to health communication tend to be thought of as “alternative” because of the dominance of past-positivistic approaches (cited in Zollar & Dutta, 2008, p. 5). Zollar and Kline note that the term “alternative” applies to the temporal space of the current moment; scholars recognize that what is considered “alternative” at one point in time can move to a position of dominance as discursive spaces of scholarship shift terrain and as the power structures within and across institutional systems change (p. 6).

Zollar and Dutta (2008) view the interpretive approach to health communication emphasizes the construction of meanings related to health and medicine (Ellingson, 2005; Geist & Dryer, 2003; Shaft & Vandiford, 2003). “Drawing from the theoretical traditions of hermeneutics, phenomenology, ethnomethodology, and symbolic interaction, among other approaches, interpretive theorists seek to understand how meaning is constituted and contested through human communicative interaction” (p. 6). Scholars applying the interpretive approach to health communication typically engage in documenting detailed descriptions of health meanings and the process through which they are constructed and
enacted by using a variety of techniques such as in-depth interviews, focus groups, participant observations, textural and rhetorical analysis and ethnographies (Ellingson 2005; Geist and Dreyer, 1993; Sharf & Vandiford 2003). Most of these approaches are qualitative in nature, and emphasize contextually located accounts rather than generalized explanations that predict health behaviors and outcomes (p. 6).

In health and illness related research, a qualitative approach provides an all-encompassing understanding of the entire concept of health and illness relying on a narrative perspective to extract stories associated with health and illness. Qualitative approaches work collaboratively with critical approaches to enhance the entire scope of health and illness research by including the community of health care workers and the patient. The critical approach emphasizes understanding the role of health communication in construction and reinforcing dominant power relationships, and in simultaneously marginalizing certain sectors of society. Critical theorists in communication may be influenced by the same hermeneutic phenomenology and rhetorical perspectives as interpretive scholars but also draw critical concepts from a number of different sources focusing on issues of power (Zollar, & Dutta, 2008, p.5).

The next section explores the application of phenomenological method in the health field. Exploring this context of application opens up interpretive space for enhanced and broadened application in the field of health communication scholarship, which is still dominated by post-positivist, variable-analytic approaches. This material may strengthen phenomenological work that has been done in the field of health communication and encourage additional studies.

Application of Phenomenology in the Health Field
Phenomenology

The area of nursing research, as noted earlier, has embraced a meaning-centered approach to health and wellness. The phenomenological approach, for example, has gained popularity among nurse researchers as an alternative investigative method to those used in the natural sciences. As more nurse scholars and nurse researchers utilize phenomenology as a research approach, it becomes critical to examine the implications this approach may have for nursing knowledge development and for the utilization of that knowledge in practice. Carper and White (1995) offer a comparison of the results of phenomenological inquiry with the types of knowledge considered important for nursing. It is clear that phenomenology contributes to empirical, moral, aesthetic, personal, and socio-political knowledge development. Its contribution is not in developing predictive and prescriptive theory, but in revealing the nature of human experience. Although interpretive inquiry, such as hermeneutic phenomenology, does not prescribe action for use in clinical practice, it does influence a thoughtful reflective attentive practice by its revealing of the meanings of human experience (Van der Zalm, 2000, p. 211).

Hermeneutic Interpretive Phenomenology

Crist & Tanner (2000) have researched “hermeneutic interpretive phenomenology, based on Heideggerian philosophy (Allen, Benner, & Diekelmann, 1986; Heidegger, 1962; 1975), is a qualitative research methodology used when the research question asks for meanings of a phenomenon with the purpose of understanding the human experience” (p. 202). In an article written by Crist & Tanner (2000), a hermeneutic phenomenological philosophy was the underpinning for a study that explored effects of interpretive methodologies as they examined how elderly individuals
responded to home health care. The research approach provided a detailed guide to the interpretive process that clearly demonstrated the effectiveness this interactive experience (Crist & Tanner, 2003, p.202).

**Phenomenography**

Sjöström and Dahlgren (2002) explore phenomenography “is a little-known qualitative research approach that has potential for health care research, particularly when people’s understanding of their experience is the goal (Marton, 1988). Phenomenography is explained as a qualitative, nondualistic research approach that identifies and retains the discourse of research participants (Marton, 1988)” (p. 339). Sjöström and Dahlgren (2002) presented a study describing the underlying ontological and epistemological assumptions in health care and nursing research. The illustrated examples used in Sjöström and Dahlgren provide some examples of phenomengraphic studies in medical research possibilities for applying the methodology to nursing research are discussed (p. 339). The application of a phenomenographic approach to nursing research emphasizes the differences between how different patients experience their states and needs. The phenomenographic approach to understanding patients’ experiences and needs provide the medical team with practical alternatives to caring for and filling the needs of each patient. Phenomenography in a clinical setting has the potential to offer the area of qualitative health communication research an alternative methodological approach and will benefit from ongoing development and application (Sjöström & Dahlgren, 2003, p. 340).

**Issues in Interpretive Research**

Researchers working in interpretive traditions need to address three central issues: philosophy, rigor and representation (Whitehead, 2004). These issues focus on
legitimating of hermeneutics as a research process: the philosophical underpinnings of the methodology; representation, or the participation of the researcher in observing and identifying data; and rigor, or establishing the trustworthiness of the particular hermeneutic research project, an issue framed in postpositivist research as reliability (Whitehead, 2004, p. 513). According to Whitehead, (2004) researchers have ethical and professional obligations to produce research of a high standard. The research techniques and recorded can vary, which creates inconsistencies in the documentation of the patient interpretive data. Whitehead (2004) noted that some researchers fail to consider the theoretical underpinnings of the methodology chosen and the link between these and the methods employed. These need to be accessible to readers in order to assess the trustworthiness of the research.

Whitehead (2006) conducted a study on the lived experience of Chronic Fatigue Syndrome/myalgic encephalitis in order to evaluate the trustworthiness of hermeneutic phenomenological methods. This methodology focused on the approach and on the importance of recognizing the influences and the impact of generating the data. It highlighted the process and the importance of analyzing the data at a macro and micro level, acknowledging the evolution of the data over time, and ensuring that analysis does not move beyond the data and out of the hermeneutic circle. In seeking to make the decision trail clear to others, researchers must distill the philosophical principles of the methodology and set these out in a way that is accessible and open to scrutiny (Whitehead, 2006, p.1023).

**Examples of Research Employing Phenomenological Approaches**
A variety of disciplines are employing phenomenological methods, which are found to be effective at bringing to the surface experiences and perceptions of individuals from their own perspectives (Lester, 1999). Lester (1999) finds this approach adds an interpretive dimension to research, enabling it to be used as the basis for practical theory, to inform, support or challenge policy and action (p. 1).

Thomas and Pollio (2004) outline, in *Listening to Patients; a Phenomenological Approach to Nursing Research and Practice*, a variety of phenomenological methods that help nurses extract meaning from the narratives within the context of nursing practice. The exploration of phenomenological praxis is achieved through the examination of patient interviews addressing a broad scope of topics addressing the human experiences relating to body, other people, time and the world. The work of Thomas and Pollio illuminates the deeper meaning of health crisis and universal human experiences such as pain or spiritual distress (p. x).

Chapter 5 of this dissertation explored the beneficial significance of qualitative research methodology found in health communication. This chapter recognizes the field of nursing for its implementation of phenomenological approaches as a qualitative method. For example, the research conducted by McClosker, Bernard, and Gerber (2003) is a phenomenographic study incorporating both quantitative and qualitative methods to describe the experiences of women who were victims of domestic violence. The research methods found in this study were chosen to specifically quantify the “wholeness” of the experience and understand from the perspectives of and in the language used by each woman who were in abusive situations.
McClosker, Bernard and Gerber (2003) uncover implicit and explicit meanings that are embedded in the experiences of adult women’s interviewed. The phenomenographic study uncovered three relational themes and one overarching pattern from the data. The women describe a loss of self, being controlled and destruction. The narratives of their lives, and “going beyond themselves” reveals how each victim told their story, who they told, and what they wanted to happen. What emerges as a result of this research is the process of survival, and constructive pattern of expression from those who have lived experiences of violence (McClosker, Bernard, Gerber, 2003, p. 212).

A unique study conducted by Jonas-Simpson, Whyte, and Dupuis (2012) describes the phenomenological shift that health care professionals experienced after attending a performance of research based drama called “I’m Still Here.” Jonas-Simpson et al. explain a phenomenological shift as changes patterns of lived experience and the research drama was created specifically to help persons understand and relate to persons living with dementia. The research findings revealed the phenomenological shifts reflected were moved from “descriptions of ‘diminishing humanness to discerning humanness’, from 'disengaged care/mundane relating to reflexive relating in the now', and ‘terrifying portrayals of loss to awakening to hopeful possibility” (Jonas-Simpson et, al, 2012, p. 1944). Jonas-Simpson et al. (2003) supported the research findings through supportive examples of group transcripts to reveal the powerful impact drama plays to shift understandings and actions of health care professionals as they have an opportunity to experience through a live dramatic portrayal, the lived experiences, relationships and quality of life of people who have dementia (p. 1955).

**Conclusion**
Hermeneutic phenomenology provides health care workers with a credible research approach based in qualitative methodology to uncover several layers of meaning in the human response to health and illness. Through an explorative journey into the interpretive elements of hermeneutic phenomenological philosophy, researchers in the health communication and in the allied health professions, particularly nursing, engage in an interpretive research paradigm that is grounded in epistemology of social construction. A health care environment encompasses many forms of interpretive messages that mirror our “real world.” It is the acknowledgement of that outside experience as patients enter into a health care domain that needs to be accounted for by the community of health care professionals, the patient, and family members. This “matrix of meaning” is of interest to the qualitative researcher in health communication and constitutes the “text” for phenomenological investigation.

This chapter explored health and illness experiences through a hermeneutic phenomenological lens analyzing research results from the field of health communication and nursing. Current research in health communication, although leaning heavily toward the variable analytic approach, is beginning to acknowledge the trustworthiness of a phenomenological approach. Likewise, today the discipline of nursing is taking a hermeneutic phenomenological approach to examine many critical research agendas within the field. The studies used as examples near the end of this chapter focus on the grounding philosophies of Gadamer and his understanding of language and tradition to help frame much of the interpretive research obtained from the field of nursing, with the hope of extending phenomenological research in health communication.
One interesting point that was extracted from the research conducted in this dissertation chapter was Gadamer’s notion of prejudice which was then examined in a health care setting. Bias and prejudice are inevitable; we interpret experience through the lens of prejudice and, from that interpretation, extract meaning and understanding of experience. This situated-ness of observation helps define a phenomenological perspective and emerges from community “ground” within which an agent is embedded (Arnett, Fritz, & Bell, 2009). In the health care setting, the people involved in a health and illness experience bring with them their world view with which prejudice intermingles. Gadamer’s contribution rests in the philosophy of identifying key cultural or “community” traditions that may facilitate a constructive approach to prejudice through acknowledgement of bias. Once prejudice is identified, a very deep, rich interpretation of the total human experience that embraces the whole community is possible, one that invites meaning for health and illness that emerges from those receiving care in the medical contexts and those administering it.

The studies reviewed in this chapter used a hermeneutical phenomenological approach to understand and interpret in-depth patient interviews. The work was qualitative in nature, providing an understanding of health and illness from a variety of interpretive formats. The dominant ingredient in all of the studies incorporated the use of a narrative approach and the role of stories in understanding human responsiveness to health and illness. These stories can be understood as emerging from narrative “ground” on which participants in the health care context stand; community agreement on a larger “story” gives meaning to the personal stories of participants, which become foreground
information against the larger narrative interpretive background supplied by the community.

Chapter seven is a continuing exploring into the philosophy of hermeneutic phenomenology. This dissertation walks hand in hand with Heidegger, Buber, and Gadamer to explore how their philosophical contributions offer insight and dimension to health communication scholarship. Chapter seven prepares the ground for chapter eight, which explores the work of Elisabeth Kübler-Ross as an unacknowledged example of health communication scholarship from a phenomenological perspective.
Chapter 7: Contributions from Philosophers

Chapter seven considers the ideas of Heidegger, Buber and Gadamer, offering contributions and communicative inquiry and insight as an extension of the general body of scholarship that connects human communication to the health field. Patricia Arneson examines the insight into the lives of communication scholars in her book *The Philosophy of Communication*, and she states, “The philosophy of communication serves to enrich our understanding of the live process, enabling us to better understand the relationship between communication content and action” (Arneson, 2007, p. 10). The opportunity to unite medicine and philosophy through careful phenomenological and hermeneutic explication opens up a plethora of opportunities for health communication scholarship to explore and make sense of those themes long buried within western medicine. For example, Fredrik Svenaeus (2001) sees themes emerging with bold and important ontological and epistemological significance in the context of the development of physician-patient relationships, providing constructive interpretation of the prominent methods and goals of medicine (p. 8).

Phenomenology Meets Medical Science

The last three decades have witnessed what might be called a revival of the philosophy of medicine and health (Svenaeus, 2001). Through the philosophy of phenomenology, we are enriched with an interpretive language that forces us to explore our “lived experiences,” directing us to look inward and pay attention to the feelings, thoughts, and actions of the individual person living in the world. From this perspective, healthcare professionals need to evaluate the individual’s interpretation and the particular elements of a given situation and not depend strictly on a biological investigation of the
One representative study from this perspective was conducted by Scott, Scott, Miller, Stange, and Crabtree (2009).

Scott, Scott, Miller, Stange, and Crabtree (2009) observed that the practice of medicine today in the United States has a philosophical underpinning derived from a form of Cartesian reductionism that views the body as a machine and medical professionals as technicians whose job is to repair that machine (p. 5341). Scott et al. advocated an alternative philosophy of medicine based on the concept of healing relationships between clinicians and patients. In their work, Scott et al. undertook research from this perspective by exploring the ethical and philosophical work of Pellegrino and Thomas and then connecting Martin Buber's philosophical work on the nature of relationships to an empirically derived model of the medical healing relationship (p. 5341).

Scott et al. (2009) developed the Healing Relationship Model to open up understanding of the health communication encounter. The foundation of this model was established on qualitative analysis of interviews of physicians and patients. Scott et al. turn to the philosophy of Buber to understand relationships between the clinician and the patient as manifestations of the “I-Thou” relationships, encounter characterized by dialogue and mutuality, but a mutuality limited by the inherent asymmetry of the clinician-patient relationship” (p. 5341). Scott et al. explain the Healing Relationship Model by identifying three processes necessary for such relationships to develop and be sustained: valuing, appreciating power, and abiding (p. 5341). For health care professionals to develop a meaningful relationship with patients that will facilitate a understanding of the patient that illuminates the “wholeness” of the patient that focuses
on healing, health care professions need to assume roles as healers and providers of technical biomedicine, noting that healthcare should be focused on healing, with “I-Thou” relationships at its core (Scott et al., 2009).

Throughout this chapter there are several phenomenological approaches found in the work of Svenaeus, who blends the philosophical concepts of Gadamer’s social constructive analysis of health and phronesis with Heidegger’s interpretive understanding of “otherness” through storytelling. Martin Buber’s dialogic approach to communication textures this philosophical merger through the use of language to create a phenomenological understanding of health and illness that can be applied to health communication scholarship.

**Health Communication and Gadamer**

A starting point of exploration begins with Svenaeus’s (2011) phenomenological understanding of human experiences associated with health and illness, which he grounds in the philosophical writings of Gadamer. The book *The Enigma of Health* with the subtitle *The Art of Healing in a Scientific Age* (Cambridge, Polity Press 1996) is a set of essays written by Hans-Georg Gadamer on problems of health. Gadamer’s views on the topic of health surface a thick, multilayered abstraction of his understanding of disease as a human experience that disrupts an individual’s state of equilibrium.

Gadamer moves into a deep philosophical analysis, approaching disease as a foreign entity that offsets and robs the afflicted person of normal everyday social freedoms and disrupts the balance of everyday existence. Svenaeus (2011) turns to Gadamer’s views to understand illness: “Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and
in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place” (Svenaeus, 2001, as cited in Ferguson, 2012, p. 314).

Svenaeus’s (2011) work moves forward to express the goals of medicine through the Gadamerian concept of health restoration as a return to a “homelike being in the world (as cited in Ferguson, 2012 p.317). The situation of illness is characterized by Gadamer as a disruption of the normal rhythm and balance of everyday life. Gadamers use of the term “unhomelike” represents not being internally at home with the rhythm of everyday life (as cited in Ferguson, 2012, p. 317).

Svenaeus (2003) examines physician patient interaction through the practical philosophy of Aristotle, which was centrally important to Hans-Georg Gadamer and to the development of his philosophical hermeneutics. Accordingly, the concept of phronesis was viewed as central to a Gadamerian hermeneutics of medicine: “If medical practice is conceived of as an interpretative meeting between doctor and patient with the aim of restoring the health of the latter, then phronesis is the mark of the good physician, who through interpretation comes to know the best thing to do for this particular patient at this particular time” (Svenaeus, 2003, p. 407).

Svenaeus (2003) argues that the application of hermeneutic phronesis provides medical clinicians a solid ground of praxis that is embedded in the rich texture of the ancient philosophies of Aristotle, and the interpretative hermeneutics offered by Gadamer promises insightful application for physician-patient interaction as an alternative way to understand the phenomena of health and the good life as issues for
medical practice. It provides a detailed map of the terrain of a medical meeting and the acts of interpretation through which phronesis is exercised (p. 407).

**Health Communication and Heidegger**

Exploring the history of philosophy through the lens of medicine reveals the work of Heidegger, who examined the meaning of Aristotle's concept of *physis* (Noueira, 2007, p. 429). Heidegger seems to espouse the idea that the human physical body keeps inside itself a spontaneous power of healing that responds to the well-known notion of *natura medicatrix* and Heidegger’s (1927) notion of “Dasein, and existentiell, which is a person’s self-understanding, that is, an understanding of her/his own way to be or what s/he is” (p. 12). Heidegger delivered a series of philosophical seminars delivered between 1959 and 1969, and it was at these seminars, according to Passos (2007), that he made clear that health and disease are nothing less than modes of Dasein's existential ways of being-in-the-world (Passos, 2007, p. 429).

Svenaeus (2011) attempts to understand the human response to illness through a connective exploration of the phenomenological relationship of illness and the concept of “otherness,” grounding his work in the philosophical foundations of Heidegger, Being and Time. Svenaeus interprets “otherness is to be understood here as a foreignness that permeates the ill life when the lived body takes on alien qualities. A further specification of this kind of otherness can be found with the concept of unhomelike being-in-the-world found in the work of Gadamer. Health, in contrast to this frustrating unhomelikeness, is a homelike being-in-the-world in which the lived body in most cases has a transparent quality as the point of access to the world in understanding activities” (Svenaeus, 2011,
p.333). The onset of illness takes on an aura of change that alters the live experiences in which illness becomes the central focus of an individual’s world experiences.

Svenaeus (2011) embraces Heidegger’s notion of “otherness” and views the onset of illness as a marked moment in time that directly correlates to past and future experiences. Every experience leading up to the onset of an illness and every experience there-after is viewed as steps leading up to an infliction of disease and the life after a diagnosis. According to Svenaeus, illness takes on a unique identity or “otherness” that alienates all past, present and future experiences, comparing them to the way life was perceived before and after onset of the illness (p. 333). Heidegger’s perceives the onset of an illness as an experience of temporality to one’s past and present and future (Svenaeus, 2011). According to Svenaeus (2011), the philosophical underpinnings of phenomenology redirect clinical methodologies used to treat an illness and focuses on a philosophical approach to understand powerful impact illness has on individual’s relationship to “everyday life” (p. 334).

Individuals use story telling as an attempt to make sense out of the changes that are taking place in their world. Svenaeus (2011) finds value in story telling as a way to understand the change of a disease and how it alters the “lived body in its being in the world” (p. 341), vigilantly keeping the “otherness” of our silent bodies intact. Svenaeus’s reflections on storytelling detail the metaphoric qualities of a phenomenological theory of health and illness which push off a deeper understanding of the meaning of the world around us. “A story must be understood in a metaphorical sense, and an exploration of how phenomenology addresses the metaphoric quality of its conceptuality is ushered in” (p. 340).
Health Communication and Buber

Martin Buber, the renowned philosopher, developed a profound interest in dialogue. His “I-Thou” and “I-It” concepts are one well-known way of viewing many different types of relationships. Three types of dialogue were recognized by Buber: (1) genuine dialogue, in which a mutual relationship grows, (2) technical dialogue, in which there is the goal of achieving objective understanding, and (3) monologue, in which one is more interested in self than in the relationship (Buber, 1967). I-Thou relationships are dialogic, while I-It relationships are monologic. Buber acknowledged that communicators will tend to alternate between these types of interaction in everyday life (Friedman, 1956, cited in Thomplison, 1982).

A dialogic encounter, according to Thomplison (1982) assumes an essential faith in human interaction. It is not a method, but rather an attitude or orientation toward communication. In dialogic communication, Thomplison (1982) contends that each participant possesses genuine concern for one's partner instead of concern as a means to an end. Thomplison (1982) offers to characterize dialogue by trust, openness, spontaneity, caring, sensitivity, sincerity, and empathy. It is through genuine honesty in dialogue, individuals are able to experience intimate interpersonal relationships (Thomlison, 1982).

Jacobs (1989) reflects on the concept of dialogue in Gestalt therapy and turns to Buber’s philosophy of dialogue for clarity and implications for practice. Jacob notes, “In dialogue, there is a special insight or illumination in the personally experienced confirmation of oneself by another. The act of confirmation requires that one enter into the phenomenological world of the other without judgment, while still knowing one’s
own being. In the peak I-Thou moment, the underlying process culminates and spills over into the peak moment” (p. 12). This moment of encounter and confirmation describes the essence of human meeting that constitutes Buberian dialogue.

Jacobs (1989) believes that the most important therapeutic implication is that the therapy must take place within a dialogic relationship of the patient and the clinician. Jacob notes, “Patients must be afforded the chance to meet another person if they are going to know themselves. Therapy composed solely of awareness techniques, without the contractual engagement of the therapist/person with the patient/person, limits the awareness possibilities for the patient and interrupts the becoming of both people” (p. 22). Therapeutic relationships are a mutual acceptance of the roles therapist/person with the hope of building an intimate therapeutic relationship.

The work of Broadfoot and Candrian (2009) relies on Buber’s philosophy, which frames the future projections of physician/patient communication as outlined by Zerhouni as follow: “The future is going to be patient centric and proactive. It must be based on education and communication… It requires voluntary, intelligent participation, not passive acceptance. We can provide the information, but the patient has to do something for themselves … Dialogue is a process by which patients and physicians engage differently and in so doing make communication productive, creating something new together, as opposed to reproducing what either has or is” (p. 2). The dialogue that occurs between patients and physicians is a very delicate balancing act where the physician needs to gain the patients trust, demonstrate openness, spontaneity, caring, sensitivity, sincerity, and empathy towards the patient.
Martin Buber (1970) has argued that authenticity—the desire to communicate in a manner that is appropriate and genuine—lies at the core of dialogue. Similar to rhetorician Kenneth Burke’s (1969) theory of consubstantiality, authenticity is the means by which humans create a sense of self in relation to others (Billig, 1987, p.263). Health is essential human relating in responsiveness to health and illness as part of the human condition (Arnett, Fritz, & Bell, 2009).

**Medicine from a Phenomenological Approach**

Medicine’s own rich historical traditions demonstrate the need for the kind of phenomenological approach stemming from a fundamental principle found in medical practice that views the physician/patient interaction as critical to the overall treatment of patients within any given medical context (Svenaeus, 2001, p. 4). Although it is true that medicine’s centerpiece is the clinical event, Svenaeus argues, very few of those who have written about medicine focus on the encounter, the meeting of the doctor and patient, itself. What has captured the most attention are the results or outcomes of that meeting: health, compliance, satisfaction, autonomy. However interesting such matters are the fact is that medicine has only rarely been apprehended in light of the ontological and most important epistemological themes, which, more that anything else, reveal what medicine is (Svenaeus, 2001, p. 5).

Svenaeus (2001) utilizes the key notions developed by Heidegger, especially in the Sein und Zeit, to work his way through the major features of the clinical practice that values the medical encounter (p. 4). The clinical practice, whose major characteristic is not text but rather dialogue, clearly demonstrates how Gadamer’s main notions are
commensurate with Heidegger’s ontology, confirming Svenaeus’s phenomenological explication of the clinical encounter.

**Medical Practices Merge with Phenomenological and Hermeneutical Methodology**

Medical practice and the philosophy of medicine, according to Svenaeus (2001), enjoyed a rather close partnership until the emergence of modern medicine around 1800. In Ancient Greece, physician healed patients by blending the craft associated with clinical practices and the philosophical healing of the soul. Svenaeus (2001) contends that 19th century modern medicine made the decision to perform a radical philosophectomy in medicine. Philosophy was cut off as a useless and even dangerous speculative approach to questions of health and illness—questions that can only be answered through somber empirical research (p. 5).

**The Philosophical Turn**

During the first decade of this century we have seen a gradual rebirth of philosophy in medicine. Svenaeus (2001) speculates that medicine cannot solve all its problems with the help of empirical science, but rather needs a more reflective, theoretical approach, which can be provided by philosophy, as well as other disciplines in the expanding field of medical humanities (p. 7). Modern medicine believed it had performed the excision of an ancient body of medicine. The rebirth of philosophy in medicine represents the birth of a new language that focuses on a “lived” philosophy of health and medicine carrying with it new knowledge that is absorbed into the feelings and thoughts of physicians and patients. Svenaeus (2001) views articulation to be “vital because illness is not only a disease, but rather a life-form, and medicine is not only science but primarily dialogue and understanding and lacks a language for articulating
this knowledge in a systematical way (p.5). Today, the reactivation of philosophy in medicine can be found in publications such as *The Medical Dialogue Review* that encourage health care clinicians to publically converse about the unscientific medical issues to inspire healing.

Svenaeus (2001) views hermeneutics and phenomenology has a starting point in the human experience with all its lifeworld characteristics embodied in culture, sociality, history, and other phenomena (p.6). Gadamers work within the phenomenological theory of health, wrote in 1993:

So what possibilities do we really have when it comes to the question of health? Without doubt it is part of our nature as living beings that the conscious awareness of health conceals itself. Despite its hidden character, health nonetheless manifests itself in a kind of feeling of well-being. It shows itself above all where such a feeling of well-being means that we are open to new things, ready to embark on new enterprises and forgetful of ourselves, scarcely notice the demands and strains which are put upon us. This is what health is (1993, pp 143-144).

Gadamer (1993) acknowledges that the concept of health is as a condition that is taken for granted until we are faced with an affliction. A state of “healthiness” is one that is internally balanced and in sync with the world. Gadamer observes:

Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there (D-Sein), of being in the world (In-der-Welt-Sein), of being together with other people of
being taken in by an active and rewarding engagement with the things that matter in life…. It is the rhythm of life, a permanent process in which equilibrium reestablishes itself. This is something known to us all. Think of the processes of breathing, digesting and sleeping for example (Gadamer 1993, pp. 144-145 cited in Svenaeus, 2001, p. 80).

In these suggestions from Gadamer we can find similarities to other health theories we have surveyed. Health is described not as an introspective state, but rather as a pattern of action of being in the world. This understanding recalls Nordenfelt’s (2007) conception of health as an ability to act. Svenaeus (2001) sees that Gadamer is on the verge of a truly phenomenological account of health. Heidegger, on the other hand, focused on the everyday world of being and understanding. His phenomenology is accordingly what he calls a fundamental ontology--investigating different modes of what it means to be rather than what it means to know.

According to the research of Svenaeus, Heidegger (1986) never wrote anything substantial about the subject of health. There is no analysis of the structures of the healthy versus the ill existence in Sein und Zeit” (p.90). Svenaeus (2001) concludes that Heidegger analyzed the meaning of death, Heidegger never linked the “ontological interpretation of death as the finitude of human existence to an analysis of the meaning of illness and health” (p.90). Heidegger views the existential interpretation of death stems from our understanding of human existence and as Svenaeus points the way to understanding the work of Heidegger he sees his work as “the existential interpretation of death is prior to any biology or ontology of life, but he also mentioned that the medical
and biological inquiry into life that dying could be of importance in the analysis of the meaning-structure of human existence” (p. 90)

The essence of health is a mood of homelikeness that is understood as a physical balance with the world (Svenaeus, 2001). The point of the phenomenological theory provides a general characteristic of health and illness through a language that embraces a thorough understanding of an individual’s affliction. Hermeneutics is basic to clinical practice, which is the very same kind of approach that Heidegger developed as the existential of understanding being in the world in Sein und Zeit (Svenaeus, 2001).

Medical practice, according to Svenaeus (2001), is to be understood as a special form of understanding, which is identical with neither explanation in science nor interpretation in the humanities (p. 83). Hermeneutics is here an ontological and not a methodological concept; that is, hermeneutics is not taken as a method, but as a basic aspect of life (Svenaeus, 2001, p. 83). Authentic self-understanding, however, cannot only rest on an immediate experience the moment of anxiety but must also develop in interpretation through language in dialogue with others. Heidegger makes it clear in Sein und Zeit that Dasein is to be thought of primarily as a being with others (Svenaeus, 2001, p. 83).

Svenaeus (2001) recognizes that truth in Gadamer’s philosophy is primarily to be understood as openness for the other and his world and not only for one’s own world. The difference from Heidegger’s point of view would not be decisive because the world of the other is also one’s own—two persons share the same world in their being together. This otherness becomes overwhelming and uncanny in illness. The illness transcends into
a state of unhomelikness, and the illness disrupts the equilibrium of the individual in all daily experiences (2001, p. 94).

Language, in Gadamer’s philosophy, is emphasized as the key mode of this being together with others (Svenaeus, 2001, p. 94). The form of language he concentrates his analysis upon—that is, Wahrheit und Methode, is not, however, the spoken dialogue, but the reading of literature and other texts of the past. Historical texts are separated from us by a temporal distance, which makes present day understanding of the text more difficult to dismantle (Svenaeus, 2001, p. 94)

Svenaeus (2001) views medical practice as a form of meeting—a clinical encounter. A meeting takes place between persons who come to understand each other:

In science it is the scientist alone, and not his object, who understands moreover in the particular form of scientific explanation the structure of which is explicated …what characterizes a meeting, in contrast to scientific explanatory understanding, is thus mutual, shared understanding. In a medical meeting, as many have pointed out before me, is generally, despite its intimate aspects, a meeting between strangers. It is a meeting that is radically asymmetrical in the sense that the patient is the weak help-seeking party asking for aid from the expert in health matters—the doctor, nurse or some other medical personnel. The doctor must understand the patient as an understanding person, through projecting himself into the patient understand and vice versa, and what the doctor and patient say to each other must make sense for both parties” (p. 33).
The foundation of patient/physician relationship is dependent upon an honest dialogue that reflects caring and empathy as the physician strives to build an intimate professional relationship with the patient (Svenaeus, 2001).

Svenaeus (2001) views the practice of medicine as not only essentially a meeting, but it is also interpretation of clinical hermeneutics. This kind of hermeneutics is dialogic rather than based in the reading of texts and takes place through language; the dialogue is spoken and it is through dialogue that physical examination and therapy are guided towards their aim. Gadamer’s Wahrheit und Methode takes between moving on to an analysis of language and dialogue from the readings of texts in the humanities (p. 33).

Svenaeus (2001) reminds us that Gadamer’s hermeneutics should be understood as proceeding from an ontology of being in the world, in which the role of language is primarily dialogical rather than textual. Gadamer’s understanding of hermeneutics, which could lead to the development of a communicative hermeneutics of medicine, is his emphasis upon application. Interpretation always takes place in a certain situation with a special aim in view. For Gadamer, medicine is characterized as a dialogue by which the doctor and patient together try to reach an understanding of why the patient is ill (p. 98).

**Conclusion**

It is through the work of Gadamer, Heidegger, and Buber that we come to appreciate the richness of a hermeneutic phenomenological approach as a gateway to understanding the human experience of health and illness. This chapter offers a way for researchers to stand, for a moment, above the clinical setting and hover over the wholeness of the experience of illness as a state of being unhomelike or unbalanced in the world before descending once again into the lived experience of health and illness. This
notion, when applied to the interactions that occur between clinician and patient, sparks a phenomenological understanding that evokes feelings and emotions, creating “true” dialogue between and among all persons in the medical encounter. Emerging from application of the hermeneutic philosophies of these premier philosophers is the role of language and the significant impact it has within a medical environment.

The next chapter offers a demonstration of hermeneutic phenomenological praxis through the work of Kübler-Ross and her work with dying patients and their understanding of illness in this critical stage of life. This final chapter provides a glimpse of a significant event in the human lifespan: facing death. For health communication research, there can be no more meaningful event. From this case study, implications for further research from a phenomenological perspective can emerge for the field of health communication.
Chapter 8: Kübler-Ross’s Contribution to Health Communication

The phenomenological and hermeneutical applications of Elisabeth Kübler-Ross’s research are conveyed in the dialogues and real-life scenarios of patients explaining their reactions to loss as she explores the process of grieving and its natural and necessary connection to healing and one’s acceptance of one’s illness. In death and dying experiences the hermeneutic approach is to examine the experience phenomenologically which would involve a detailed description of the patients experience and revealing what life’s experiences and thoughts are brought to the surface by the patient to explain their perception of this death and dying event. The engagement of real-life voices deeply enriches our understanding of healthcare and clearly identifies a new pathway for health communication research to explore a qualitative, experiential direction for understanding health and illness through the investigations of people's experiences. This chapter offers an exploration of the work of Kübler-Ross as an exemplar for such research, beginning with an overview of her work and continuing with a careful analysis of her work from the lens of hermeneutic phenomenology.

An Overview of the Work of Elisabeth Kübler-Ross

The research methods used by Elisabeth Kübler-Ross involved participant observation coupled with in-depth interviewing as data were collected over years through conversation with patients, family members, healthcare professionals, and those involved with the terminally ill. Elisabeth Kübler-Ross shares her unique perspective of rhetoric and communication in her book about dying patients in hospitals, On Death and Dying, published in 1969. Her work reveals explicitly the harsh reality of terminally ill patients, exposing the social and psychological issues that are confronted as patients, family
members, and health care professionals cope with this final stage of life. Through the interviews conducted with terminally ill patients, Kübler-Ross opens up an intimate dialogue with patients and provides health communication scholars an opportunity to experience a true qualitative phenomenological application.

**Rhetoric and Philosophy of Communication and the Work of Kübler-Ross**

A few issues of interest related to rhetoric and communication that can be applied to the work of Kübler-Ross include audience analysis adaptation from the vantage point of the physician who must decide when and how to tell each patient about his or her terminal illness. Interestingly, Kübler-Ross highlights a variety of case studies of patients who experience difficulty in talking about their impending death. Throughout her research, Kübler-Ross illustrates the effective use of communication in helping people—patients, the families, and hospital staff—adjust to a human exigency (Kübler-Ross, 1969), part of the inevitability of the human condition (Arnett, Fritz, & Bell, 2009). The real contribution of Kübler-Ross’s work, however, is in the area of hermeneutic phenomenological investigation within the health communication context.

Theoretically situating death and dying rhetorically can create a socially constructed reality of death and “although the denial of death has been common, the twentieth century has seen a rhetoric of denial unique in its absoluteness and its primary form, silence” (Cline & Gifford, 1980, p. 1). Western society has taken a stance toward the stages of death and dying that is one of total alienation toward the death experience by separating people and steering clear of any expression of those experiences associated with death. Through the dialogues provided by the work of Elisabeth Kübler-Ross, health communication researchers can embrace a new rhetorical perspective to frame the
experience of death and give meaning to those who are dealing with this stage of life—the final temporal exit. Kübler-Ross views death as a process that is a shared phenomenon. Situating the experience of death and dying rhetorically provides communication scholars an opportunity to facilitate effective communicative praxis that can adapt people to the end-of-life experience in a way that merits the potential to enhance what remains of one’s life—and the lives of those who remain on this earth.

The Kübler-Ross Approach

Kübler-Ross’s work provides an opportunity for health care professionals to step back from the clinical “tasks at hand” and refocus on the patient as a human being, an attitude that needs to be included in the overall dialogue about the patient’s medical care. The Kübler-Ross approach to hospital management of patients is a unique blending of the work of the medical team and the patient. This encounter opens up a communicative understanding that is responsive to the strengths and weaknesses of each party (Kübler-Ross, 1969, p xi). Kübler-Ross viewed the patient as the teacher and embraced the opportunity to learn more about the final stages of life with all its anxieties, fears and hopes. Kübler-Ross states,

“I simply tell the stories of my patients who shared their agonies, their expectations, and their frustrations with us. It is hoped that it will encourage others not to shy away from the hopelessly sick but to get closer to them, as they can help them much during their final hours. The few who can do this will also discover that it can be a mutually gratifying experience; they will learn much about the functioning of the human mind, the unique human aspects of our
existence, and will emerge from the experience enriched and perhaps with fewer anxieties about their own finality” (Kübler-Ross, 1969, p. xi).

In chapter 6, a phenomenological lens was used to view the stories that describe health and illness as a rich relational experience between clinician and patient promoting a sense of “wholeness” that encompasses all aspects of life necessary to understand a lived human experience. In the current chapter’s application, this perspective comes into conversation with the work of Kübler-Ross. Therefore, the next section of this chapter looks once more at phenomenology and hermeneutics, framing the underlying assumptions of these philosophically-grounded methodologies to explore the fundamental components of these approaches—approaches that underlie the work of Kübler-Ross. Observation is the pathway to phenomenological and hermeneutic engagement of lived experience.

**Observation, Phenomenology, and Hermeneutic Methodology**

Through the research lens of observation in its encounter with phenomenology, and hermeneutic methodology, we extract meaning from an individual’s lived experience that provides health communication scholars an opportunity to go beyond traditional research methods by combining quantitative and qualitative approaches to extract a rich and meaningful understanding of real life experiences associated with death and dying. Elements of observation and phenomenology and hermeneutic methods are clearly defined and illustrated to demonstrate the usefulness in health related research providing the necessary tools to understand the intimate structure of the life world experiences of those afflicted with illness.
**Observational Stance**

The role of the researcher implementing the phenomenological hermeneutical approach is to record accurately the experience of the patient through a rich qualitative approach to research. It is important to note that Gadamer (1989) contended that hermeneutics is the study of texts. He used that term broadly to include the use of language which represents any symbolic activities that one experiences (p. 448), which includes one’s articulated experience of health and illness. Cohen, Kahn and Steeves (2000) view the basic principles in conducting phenomenological hermeneutic research as an understanding of the object of the research, which includes language and the individual person who expresses language. The world of everyday experiences is accessible, according Cohen, Kahn and Steeves (2000), through our “natural attitude” (p. 8).

Brown and Lloyd (2001) argue that the observational methods found in qualitative research “must be based on empirical evidence or it cannot claim to be research. The difference is that the evidence (the data collected) is not innumerical form and requires interpretative rather than statistical analysis” (p. 350). Borg & Gall (1983) outline three types of observational variables descriptive, inferential, and evaluative (p. 477). This observational approach is known as the descriptive observational variable, which Cherry (2012) defines as “observing behavior in everyday settings… positioning the researcher to design experiments to determine what it produces that will benefit or interfere with the research outcomes” (p. 1).
The interview is an observational and recording process that requires very close attention to detail as well as all the events surrounding the interview. Kübler-Ross interviewed many patients who were experiencing very critical near death experiences. The effective observational skills of Kübler-Ross captured this human experience, through the application of hermeneutic phenomenological praxis of experience. Evans and Hallett (2007) studied a group of nurses as they worked with dying patients and found that “hermeneutic phenomenology is an important method for uncovering the complex realities of nursing work. The nurses’ perspectives on ‘comfort care’ they offer to patients were revealed by the data presented here, which were interpreted to offer a unique perspective on this type of nursing work” (p. 742). The interviews conducted by Kübler-Ross illustrate phenomenological hermeneutic methodologies as in the course of her work with dying patients she obtained detailed descriptions of each patient’s feelings and then carefully analyzed the description using historical references from the patient, which provided a very deep, interpretive understanding of each patient’s unique experience.

**Phenomenological Methodology**

Polkinghorne (1982) defines phenomenological research as a process that “involves the researcher reviewing the subjective experiences of an individual or self, identifying stable aspects of the experience, and mapping the experience in how it is associated with the other parts of life” (p. 47). According to Polkinghorne, this methodology is viewed as an opportunity to “describe the phenomena, not to explain the event” (p. 47). It is the phenomenological approach that organizes the experience through the details of experience giving. What emerges by using phenomenological methods,
according to Polkinghorne (1982), are schemata and/or themes that constitute a human experience (p. 47). Phenomenological research is generally ignited by a defined hypothesis and description. The researcher becomes the key “ingredient” for developing an emerging understanding of the fundamental human experience through explication of the essential themes found in the data (Collen, 1984).

**Hermeneutic Methodology**

The hermeneutic approach concentrates on the historical meaning of the experience and its developmental and cumulative effects on the individual and society (Polkinghorne, 1982, p. 47). Zweck and Pentland (2008) turn to Crotty (1998), who notes that hermeneutics is the science of interpretation and is thereby situated in the interpretive paradigm. Zweck and Pentland (2008) also reviewed the work of Schleiermacher, who suggested that through hermeneutics, researchers could develop *empathy* with text, a relationship similar to what occurs when listeners understand information conveyed by a speaker (p. 118). Hermeneutic research should be designed to obtain a complete understanding of a human event/phenomenon, encompassing the entire event from all perspectives and aspects (e.g., Sokolowski, 2000). According to the research conducted by Baydala, A., Hampton, M., Kinunwa, L., Kinunwa, G., & Kinunwa Sr, L. (2006) hermeneutic research “does not intend to reliably predict meaning, but to deeply understand possibilities and thereby open existing meaning to a world of potential actions” (Gadamer, 1998; Ricoeur, 1981 cited in p.161). Baydala et al view the act of “hearing and understanding the traditions of one family, end-of-life educators and health
care providers may be in a better position to reclaim a more (p. 161). Hermeneutic research as a multi-level, multi-dimensional understanding of the entire event of the dying patient with a focus on the dying person's definition of dying and death understanding that this event as an impact on all aspects of an individual’s daily life, influencing family and work related relationships.

The process of data collection that is obtained from a variety of sources and texts such as data regarding to the individual religious, social and psychological perceptions is then subjected to a hermeneutic review. This hermeneutic review provides the researcher a view of this human experience. The process of hermeneutic research analysis is continuous researching into the understanding of the human phenomena, which creates new questions, which result in new understanding, which then creates new questions. This continuous, circular process is called the hermeneutic circle.

**Uniting Observation, Hermeneutics, and Phenomenology**

Ajjawi and Higgs (2007) describe the use of hermeneutic phenomenology as a research approach that enables “the exploration of participants’ experiences with further abstraction and interpretation by the researchers based on researchers’ theoretical and personal knowledge” (p. 616). Observation, hermeneutic methods, and phenomenological methods support each other. Hermeneutics attempts to analyze and understand the overall perception of the individual human experience from different angles rather than from the specific phenomenological event. Hermeneutic methodology is attentive to the philosophies underpinning both hermeneutics and phenomenology (van Maanen, cited in Ajjawi & Higgs, 2007, p. 616). It is a “research methodology aimed at producing rich textual descriptions of the experiencing of selected phenomena in the lifeworld of
individuals that are able to connect with the experience of all of us collectively” (Smith, 1997, p. 80). From identification of the experience of phenomena, a deeper understanding of the meaning of that experience is sought (Smith, 1997). This understanding occurs through increasingly deeper and layered reflection by the use of rich descriptive language.

The research methodology chosen depends on the research hermeneutic methods, and phenomenological methods support each other. Hermeneutics attempts to analyze and understand the overall perception of the individual human experience from different angles rather than from the specific phenomenological event. The phenomenological approach focuses beneath the surface of the experience in order to describe the event. Hermeneutics attempts to analyze and understand the overall perception of the individual human experience from different angles rather than from the specific phenomenological event. The hermeneutic approach focuses on the language either verbal or non-verbal to extract meaning from live world human experiences. In the work of Kübler-Ross, we see all three elements emerge to inform health communication research.

**The Observational Approach of Kübler-Ross**

During a five-year period, Kübler-Ross interviewed about 500 terminally ill patients. Her method of interviewing was creative, providing multiple options for symbolic representation of experience: The patients either spoke in English when they talked about death and dying or used symbolic language or drawings (Wyschogrod, 1973, p.18). This approach permitted patients to express themselves in whatever way they wanted to report their phenomenological experiences of the event.
After each interview, patients were taken back to their rooms and the dialogue continued among researchers as to what they had learned. It provided an opportunity for health care professionals and the research team to express their feelings and emotions immediately following each interview. Through this team dialogue, a unique understanding of the experience emerged that united and embraced the emotions and views on an interdisciplinary front that proved beneficial for the staff and the patient (Wyschogrod, 1973, p. 18).

**How the Interview Process Affected Patients**

The interviews conducted by Kübler-Ross prompted patients to express many thoughts, feelings, and concerns not only to the researcher but also to family and friends. The patients were able to expose inner burdens of concern and find a sense of solace and peacefulness moving them through this journey. This act of self expression facilities the patient’s addressing the concrete issues of managing final details for family members, such as financial closure, details of patients’ wills, and even matters relating to funeral arrangements and burial locations (Kübler-Ross, 1969, p. 231). These phenomenological realities that faced patients were concrete items that called patients to responsibility for others even in the face of impending death.

Cohen, Kahn and Steeves (2000) view the role of a phenomenologist in a context such as this one as generating particular questions about dying, about grief, about growing old, and about developing cancer. Phenomenological methods focus on asking those specific questions that directly relate to the inner meaning of the experience (p. 9). The questions are a gateway to understanding those experiences. The researcher
specifically asks a patient to interpret those experiences. From the patient’s relating of experience, meaning emerges.

**Phenomenological and Hermeneutic Praxis**

The application of combining phenomenology and hermeneutics into the communicative praxis of health and illness can be evaluated through the research conducted by Elisabeth Kübler-Ross in an analysis of audiotaped and videotaped interviews of patients that highlights the theoretical foundations of the phenomenological and hermeneutical approach. Several factors of importance in the emotional adjustment of dealing with death are highlighted in her work: ability to cope with stressful situations in the past, the feeling of having lived a meaningful and fulfilled life, a warm and supporting relationship with one’s spouse, hope of a joyful life after death, the ability to talk frankly about the meaning and the consequences of one’s illness, an explanation from one’s physician that combines tactful candor with assurance of support, and a feeling of concern from one’s children and close friends (Kübler-Ross, 1969).

Kübler-Ross’s work was also guided by a sense of wholeness, but in this case, the entire context provided the gestalt. She focused on the “wholeness” of the experience of the patients, health clinicians and research teams as they described health, illness, and death and dying. The interviews and documentation of the experiences provided Kübler-Ross with concrete material to examine each finite detail of each person’s unique interpretation which was then examined under a phenomenological lens to understand the “wholeness” of the experience. The research techniques used by Kübler-Ross eventually led her to the identification of the five stages of grief.
The phenomenological research of Elizabeth Kübler-Ross (1969) identified five stages of dying and the meanings associated to each of the stages. The phenomenological techniques recorded in *On Death and Dying* were “based on the simple assertion that by inviting dying patients to share their thoughts, experiences, and concerns, the patients’ lives are improved” (Kübler, p. 275). Kübler-Ross described the effects of each interview experience as having improved and deepened relationships with significant loved ones, as finding meaning in being able to help others by sharing their experiences, and as resolving care issues for those the dying person is leaving behind.

Kübler-Ross categorized the attitudes of dying patients by means of categories known as the five stages of grief. It can be said that a category can yield understanding and provide a key to insight concerning particular patients. Understanding a patient’s interpretive process can be a vehicle by which to empathize and to relate. But analysis and categorization can lead to treating a state of affairs as a problem to be overcome and mastered, and the particular patient can again be hidden behind new labels that prevent genuine communication (Kübler-Ross, 1969, p. 264).

It is important to reflect back to Gadamer’s views on prejudice, which one can see clearly at work upon an examination of the labels embedded in Kübler-Ross’s five stages of grief. When a patient is labeled “in denial” about the impending death, an understanding emerges from that label that implies a level of patient understanding about the illness that places that patient in a “unicategory” that does not yield any personal knowledge about a patient’s illness (Kübler-Ross, 1969, 264). The work of Kübler-Ross demonstrates the need to expand clinical practice such that it includes the implementation of phenomenological hermeneutic methods to fully understand the lived experiences of
patients in a medical environment. Such understanding prevents mindless categorization of persons’ experience, but permits the uniqueness of each experience to emerge.

The Impact of Phenomenological Hermeneutics on Health Communication

The last few sections of this dissertation reflectively place the phenomenological hermeneutic methods side by side with the realities of a clinical environment that significantly impact a patient “unhomelike” experience. The case studies found in Kübler-Ross’s work are used to explore the significance of a phenomenological hermeneutic philosophy which Svenaeus (2001) defines as a good “earthbound philosophy” that embodies the human experiences with all of life world characteristics, including embodiment, culture, sociality, and history (p. 6) The clinical examples chosen demonstrate the importance of the interpretation of the facts of the experience that need to be captured in language to enhance meaning and justify the significance of the phenomena of an individuals’ everyday life. The use of hermeneutic phenomenological approaches provided the researchers and clinicians with the opportunity to gain insights into their own practice. Such insights also permit expanding the scope and depth of their practice, specifically as it touches human interaction and meaning, through interpretation, dialogue, language and the impact each has on embodiment, culture, and sociality in a clinical environment. The following examples demonstrate the needed for these methods in areas of patient/physician communication,

The Medical Meeting: Interpretation through Dialogue

Kübler-Ross’s interviews and stories are living proof of hermeneutical phenomenological practices in action. The stories told by the patients, families, and researchers set the hermeneutic phenomenological process in motion. Each interview has
elements of the successes and failures found in each step of the hermeneutical phenomenological process. The practical views of Van Manen describe three levels of reflection where the first and second levels of reflection include technical aspects and understanding practice, while the third level involves exploration of the underpinnings of practice, including the moral-ethical aspects (Van Manen, 1997, cited in Donnelly, 2006, p. 1). These elements provide meaningful perspective for medical clinicians. For many medical professionals, practicing a balanced perspective of care that blends phenomenological principles is difficult. This blend translates into a broader perspective that requires planning and improved focus on understanding the meaning of each patients lived experiences.

The goal of the researcher/clinician is to engage in an intensive phenomenological interview with the patient and then to proceed with a thorough engagement, through hermeneutic method, of the information provided by the patient to develop a complete understanding of the life experiences of the patient, family and health care professionals—in other words, the phenomenological engagement of the patient. Hermeneutical phenomenological research is situated in descriptive methods of interpretation guided by language (and, in some cases, illustrative depictions of symbolic experience through drawings). The meanings of words are an important component of language from which understanding and self-expression emerge. The following interview demonstrates exactly what happens when elements of the process are left out and when language and the meaning of words are not expressed and the overall lived experience of each person involved in the context is not fully understood:
A 51-year-old patient was unable to breathe without a respirator and unable to communicate to anybody of his needs, thoughts, and feelings. He had amyotrophic lateral sclerosis. The doctor assigned to this patient extended his life. When the patient fully recovered he asked, “Now what?” He could live only on the respirator with 24-hour nursing care, unable to talk or move a finger, alive intellectually and fully aware of his predicament but otherwise unable to function. The physician had done his best to prolong life and had succeeded but he elicited nothing but criticism and anger from the patient. Eventually the patient was able to talk for a few minutes at a time and could speak a few words. A flood of feelings was expressed in this interview. He emphasized he was not afraid to die but was afraid to live. He also empathized with the physician but demanded of him to “help me live now that you so vigorously tried to pull me through.” The patient smiled and the physician smiled. There was a great release of tension when the two were able to talk to each other. The patient described his increasing panic when he was unable to communicate by speaking, writing, or other means. He was grateful for those few minutes of joint effort and communication, which made the next weeks much less painful. Once he saw how much ease and comfort such direct explicit dialogues can provide, he continued them on his own, having used merely as a kind of catalyst to get the communication going (Kübler-Ross, 1969, p. 18).

Svenaeus (2001) stresses that the basic concept of phenomenology is the explication of the meaning of experience to find and articulate in medical practice what is already there. The task of phenomenology is to draw out what is already known “pre-
reflectively” by the participants in the clinical encounter. Phenomenological hermeneutics is suitable analysis to explicate features that would have otherwise have remained hidden in an exclusively natural scientific approach (p. 6). This case study represents the catastrophic results caused by the lack of understanding on the part of the physician as he failed to communicate with his patient and come to understand the patient’s lived experience of dying. The patient could not communicate effectively due to his disease and the physician failed to find alternative methods. The power of language is ever present in this representative study as the physician continued to respond to the patient, not by communicating, but by the physician’s own personal preconceived lived experiences—not those of the patient. The physician placed more value on the technical aspects of this patient illness than the experience of the patient.

**The Clinical Environment**

Medical institutions place value on the achievements related to the technical successes associated with illness. For many health care professionals an ideal of care emerges that tends to focus on a set of social standards and achievements that define success, resulting in an emerging social phenomenological perspective that adds another layer of understanding associated with the human experiences of health and illness. The study of phenomenology and hermeneutic medicine, according to Svenaeus, (2001), can be viewed as a form of practice, because medicine has been suggested to be interpretive helping meeting between two persons aimed at bringing about health for the ill, help seeking party. Phenomenology and hermeneutics have then been used to generate understanding of what is meant by interpretive, helping meeting with the primary goal as health (p.177).
When a patient is labeled terminally ill, Kübler-Ross (1969) explains, one interpretation from the medical perspective is that of “failure”: “The patient whose disease cannot be cured—the human being who is dying—inexorably perceived to be a failure to the healing professions, a failure of the mandate given to the professionals and to the institutions” (p. 245). The organizational prejudice toward the dying patient—that is, the formal organizational response—must be understood as an institutional reaction to a societal interpretation of failure. This sense of societal judgment of death as failure may be interpreted by health care professionals and a reminder of the shortcomings of medical knowledge and capabilities (Kübler-Ross, 1969, p. 234).

The prejudices associated with terminally ill patients are the silent barriers that keep health care professionals always at arm’s length from engaging the lived experiences of death and dying and the meanings implicated in this experience. The labels provide an answer for a patient’s behavior in the form of prejudice and shield the health care professionals from any personal connection to the experiences of a patient facing a terminal illness; there is no shared understanding of this process of life. Svenaeus (2001) argues that modern medical science and technology tend to promote a conceptualization of the patient as an object instead of a subject (p. 178), a result that is surely inevitable when the human element is masked behind technology, a danger highlighted by Neil Postman (1992) in his work *Technopoly*.

**The Effects of Technical Language**

Chapter 6 highlighted the philosophical roots of language as a way in which humans experience the world. In the work of Kübler-Ross the use of language emerges as the praxis of a hermeneutical phenomenological process as she warns of how
technology is impacting the way in which clinicians interact with patients. Kübler-Ross’s use of language as praxis help guide hermeneutic phenomenological philosophies through the medical tensions of the clinicians as they care for the terminally ill patient.

Kübler-Ross (1969) describes tension as “making an opening through which we can hear the patient’s voice and creating techniques that re-mask the individual--permeate our efforts in clinical bioethics. Medical institutions have moved into an age of increasing technique and specialization in dealing with the dying process (p.20). The process is driven by diagnostic categories, reimbursement guidelines, clinicians’ judgments of patient needs, and appropriate levels of care, not the voices of patients and families (Kuzcewski, 2004, p20.)

The Importance of Narrative

The interviews Kübler-Ross conducted on dying patients are driven by the use of narrative as an interpretive framework. As patients tell their stories, listeners derive meaning from the “telling of the story.” According to research conducted by Gale, D. D., Mitchell, A. M., Garand, L., & Wesner, S. (2003) culture and tradition play a major role in the interpretation of the story and influences specificity of meaning that is embedded in centuries of cultural traditions. Western culture values an agentic narrative, one focused on self-determination and personal responsibility, and devalues the victimic narrative, defined as the inability to effect change in one’s life and submission to the control of others (Ezzy, 2000; Frid, Oehlen, Bergbom, 2000; Polkinghorne, 1996; Strand, 1997). It is important to note that the clinician’s skills of listening, questioning, interpreting, and explaining (Greenhalgh & Hurwitz, 1999), as well as the narrator’s “telling of the story,” may have as much influence on the outcome of an illness or situation as the more

**The Health Care Professionals and Communicative Praxis**

The acceptance of death and dying as a process of life is difficult. Many health care professionals avoid the issues that center around death when talking with patients resulting in a breakdown of professional communication. It is through the use of language health care professionals can find clarity and to help the patient and clinician expressively blend their concerns associated with death and dying. Svenaeus (2001) views hermeneutics of medicine as a kind of understanding and interpretation put to work in a certain setting with a specific goal. It is the dialogic interpretation, according to Svenaeus (2001) that is consequently a shared project which contains more than the sum of two perspectives and which is put to work in the service of healing (p.180).

The praxis of health communication of the dying cannot be a skill that is turned on and turned off only when health care providers confront a person during the terminal stages of an illness. It is through the implementation of a phenomenological and hermeneutic lens that care givers of the dying patient can develop an intuitive understanding that Barrell et al. (1985) view as the final step in hermeneutic inquiry analysis. Barrell et al. (1985) view the relationships between patients and health care providers be represented as a network of overlapping circles representing related experiences and different contexts of the human phenomena. This applies to clients whether they are seriously ill or whether they are recovering and are about to return to daily life as a healthy person. The entire network of relationships with patients is subject to much more deliberate concerns, improvements, and possible impact than is frequently
allowed in the medical curriculum or in the day-to-day practices of patient care (Kübler-Ross, 1969, p 245).

Summary

Elisabeth Kübler-Ross gave the dying patient a voice that can be heard as she recorded the live “stories” of their final days. Each patient interviewed told their unique “story” expressing their feelings, concerns and needs and trying to extract meaning from their life’s journey (Kuczewski, 2004, p.18). The hours of interviews and the data collected by Kübler-Ross provides health communication scholars with a tool chest of material that can be used to build a concrete hermeneutic phenomenological foundation to explore the multiplicity of research issues within the field. The research conducted by Kübler-Ross brings to action all of the resources of a hermeneutic phenomenological approach demonstrating the significant contribution it has to offer to scholarship that is otherwise entrenched in scientific methodologies. This dissertation turns the key to open up and acknowledge a philosophy that has been locked inside the chambers of health research, shedding light on potential applications within health communication research.

Conclusion

This dissertation project reviewed the literature of health communication scholarship to identify phenomenological and hermeneutic approaches focused on human meaning. The first chapter laid out a plan for the dissertation, and chapter 2 situated health communication as a field. Chapters 3 and 4 addressed the current trends and theoretical issues that the field of health communication is currently facing. The most prominent reoccurring theme in the history of health communication centered on concerns regarding traditional doctor-patient communication, an issue that remains problematic even in the 21\textsuperscript{th} century. An article written by Roter, Stewart, Putnam,
Lipkin, Stiles, & Inui (1997) describes some work done during the late 20 century, which confirmed that the traditional approaches to doctor–patient communication regarding attitudes about power are still present in medical encounters, although there seems to be a noticeable transition of change (p. 356).

In the past, the traditional model of doctor–patient communication focused on biomedical issues. Today, emerging alternatives all seem to share, to varying degrees, a number of qualities and characteristics, including a shared doctor–patient agenda for the medical interview, the incorporation of patients’ understandings and expectations concerning health and illness, the inclusion of psychosocial issues and information, shared decision making about treatment options and management, expectations of empathy, and the development of trust and mutuality. The 21st century brings a new perspective on doctor patient relationships. The research conducted by several health communication scholars is highlighted in the previous pages of this dissertation has demonstrated that the trends are moving towards more phenomenological hermeneutic methods of praxis that are used to teach communication competency.

Physicians are now practicing and seeking ways of improving their communication skills and practices through continuing education and professional development. Over the years scholars in the health communication field sought to integrate communication skills training into continued medical education for practicing physicians. A study conducted by Novack, Volk, Drossman and Lipkin (1993) found” virtually all medical schools now offer teaching in medical interviewing and interpersonal skills. More faculty from a greater variety of disciplines are involved in this teaching” (p. 2101).
Patient empowerment ranked high on the list of theoretical issues that scholarship of health communication faced over the last 25 years. In 1998, a team of health care professionals (Stone, Bronkesh, Gerbarg, and Wood) examined ways to improve patient compliance from a behavioral and social scientific approach. According to their findings, members of the medical community were attempting to find ways to influence patients to become adherents of good self-care as managed care organizations began to focus on empowering their members with information and self-care skills. Today the concept of patient empowerment is important in modern medicine and one of the central pillars of health communication strategies, which improves patient awareness about a disease and its treatment. Through the concept of empowerment, patients are better equipped to engage in informed discussions with their health care providers and therefore participate in treatment and prevention decisions (Schiavo, 2007, pp. 58 –59). The practical application of hermeneutic phenomenological methods outlined in this dissertation can be viewed as a “way finder” towards improving the quality of health communication in the future.

Chapters 5 and 6 identified qualitative, interpretive, phenomenological, and hermeneutic research extant in the field of health communication and in the field of nursing. Chapter 7 brought the voices of Heidegger, Buber, and Gadamer to bear on issues of health, thereby opening the conversation of prejudice and cultural influences that impact health communication scholarship and praxis. Heidegger’s reflections on being-in-the-world and Buber’s dialogue provided insights into the ontology of the human condition related to health and illness and to the fundamentally relational nature of our engagement with others in the health care setting. Gadamer’s work offers
ontological, epistemological and methodological perspectives relevant to cultural traditions and prejudice, which is considered to reside within an interpretivist/constructivist paradigm of inquiry. Gadamer believed that understanding comes from interpretations embedded in our linguistic and cultural traditions, which contribute to our inherent prejudices (Byrne, 2001, p. 968). Recognizing the interpretive process in the context of health communication is key to deeper understanding of human health and illness.

Chapter 7 set the stage for an examination of the work of Kübler-Ross in this final chapter. Implications for incorporating hermeneutic phenomenological practices were examined in the Kübler-Ross chapter of this dissertation, which clearly pointed the way towards a very positive use of these methods as new trends in health communication emerge. The reflections of Kübler-Ross as she interviewed patients using a qualitative approach to hermeneutic phenomenological methods provide a meaningful understanding of the “whole” health and illness experience as viewed by the patient. Chapter 8, therefore, offered an application of the methods reviewed in the previous chapter.

Medical clinicians approach clinical decision-making through philosophical constructs such as patient autonomy. Clinical observation quickly shows that such approaches are insufficient in capturing the richness of the lives and the complex interpersonal processes involved in the medical encounter. Medical clinicians develop intimate relationships with patients as they experience health and illness exposing insight into their fears, hopes, and conflicts. Kübler-Ross embraces a health and illness experience and invites scholars to look beyond the fears associated with death. Kübler-Ross’s research methodology demonstrates a beauty of understanding as patients
experience this stage of life and extracts powerful, deep, multi-layered meaning from each patient’s experience.

The scholarship of health communication can apply the observational, phenomenological and hermeneutic approaches to examine culture, tradition, interpersonal, social, political and psychological as well as physiological issues. The theoretical application of narration is observed in each interview conducted as patients tell their “story,” sharing feelings and emotions that require complex analysis to interpret each unique experience. During the Kübler-Ross interview process, patients and family members communicated those end of life decisions that could have been otherwise easily evaded.

Health communication scholars can apply the work of Kübler-Ross to examine many of the physician-patient issues as her work highlights certain tensions inherent in working with dying patients, tensions that are clearly reflected in ethics case consultation. Ironically, the problem of clinical bioethics is how to keep the tensions alive rather than to resolve them (Kuczewski, 2004, p. 23). Routine encounters with patients can be enhanced through a hermeneutical phenomenological praxis in developing a rich understanding of the ways in which patients and their families come to make end-of-life decisions.

In closing, an interpretive approach to health communication emphasizes the construction of meanings related to health and medicine. Drawing from the theoretical traditions of hermeneutics, phenomenology, interpretive theorists and the work conducted by Kübler-Ross, health communication scholars can seek to understand how meanings are constituted and contested through interaction. Scholars applying the interpretive
approach to health communication are following the tradition of Kübler-Ross in their search for human meaning in the meeting of health and illness, life and death, the perennial questions of human existence.


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