THE POETICS AND POLITICS OF RE-COVERING IDENTITIES IN HEALTH COMMUNICATION

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In 1995, medical malpractice cases produced the most frequent awards from lawsuits emphasizing health issues such as toxic waste, childbirth delivery procedures, and equipment failure ("Study lists top suits," 1996). These medical malpractice verdicts ranged from $40 million to $98.5 million and partially represent the political nature of health care delivery. With the implementation of managed care in many hospitals and the increased competition between health care providers and hospital "CEOs," health care practices today are as much about the management and strategy of the organization as they are about improving an individual's health. Although the examination of health care from an organizational perspective is not new (e.g., Gates, 1995; Geist & Hardesty, 1992; Kreps & Thornton, 1992; Ray & Donohew, 1990; Thornton & Kreps, 1993), investigating and theorizing about organizational communication in health care delivery has given limited attention to the human dimensions of these political arenas.

Hospitals, as organizations in the business of providing care, are not immune from the widespread, often unnecessary standardization and industrialization that plague contemporary organizations (Deetz, 1992, 1995). Health care organizations have been greatly affected by the same economic and political changes that have affected other organizations. Within health care organizations, these changes take the following forms: (a) an increase in organizational "managerialism," where certain interests are privileged over others (Deetz, 1992, 1995); (b) a greater capability of meeting the technical rather than the symbolic requirements of human existence (Zook, 1994); (c) a quest for profit in ways that limit the choices available to medical professionals, and ultimately, the quality of care provided to patients (Geist & Hardesty, 1992; Lupton, 1994; McKinlay & Stoeckle, 1988); and (d) a shifting of health services from hospital-based facilities to out-patient ambulatory and community-based facilities without a corresponding shift in communication skills and practices (Sharf, 1993). All of these political issues further remove people from the institutions they rely on and force changes in individuals' participation in the construction of their identities, knowledge, and meanings (Deetz, 1992; Gates, 1995). Too often, the stories or poetics concerning health care interactions are not considered, negotiated, solicited, or understood (Geist & Dreyer, 1993). Inattention to poetics is often justified by citing any number of reasons, including the constraints placed on providers' time with each patient and patients' difficulty in being succinct communicators (Mann, 1996). However, failure to address this human dimension of the hospital experience may result in poor health care for the patient, increased costs for the institution, and increased medical malpractice suits.

This essay begins by establishing the significance of theorizing about the poetics and politics of re-covering identities in health communication. Specifically, we argue that a crisis exists concerning whose voices are represented (or not represented) in health care interaction and in our theorizing. We then present a narrative written by the first author, describing her hospital experience with minor surgery. The narrative becomes the basis of our theory of the poetics and politics of re-covering identities in health communication–the identities of both the researched and the researcher. This analysis

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is a response to the call by health communication scholars to engage in the development of critical health communication theory. As Lupton (1994) suggests:

> Until health communication, as a new, multi-disciplinary field takes cognizance of recent developments in social and political theory, media and cultural studies, discourse analysis, and their application to communication in the health setting, it is destined to remain a derivative, paternalistic, and narrowly focused version of health education. (p. 64)

By considering the poetics and politics of theorizing about communication in the health care context we respond to Lupton's challenge.

THE POETICS AND POLITICS OF THEORIZING IN THE HEALTH CARE CONTEXT

While the question, "Who cares?" in the changing health care arena, concerns both the personal (Wood, 1994) and the organizational (Miller, 1995), much of the research studying organizational communication in health care (hospitals, medical centers, clinics, nursing homes, etc.) has failed to consider this micro/macro link. Too often a functionalist, noncontextual approach is utilized in health communication texts studying the message flow, internal and external communication, or the levels (interpersonal, group, organizational, media) of communicating in organizations. Health communication, as a field of study, has been limited by a lack of critical reflection about the notion of health (Zook, 1994), by accepting a "top-down" and paternalistic view of communication (Lupton, 1994), and by a general inability to capture the context, complexity, and consequences of the available research (Sharf, 1993).

Re-covering Voices in Health Care

From our perspective, vital to the process of theorizing about communicating in health care delivery is an understanding of the poetics and politics of constructing identity in interaction. The micropolitics of medical interaction reveals a great deal about the ways dominant ideologies are reproduced and control the discourse of both health care professionals and patients (Waitzkin, 1991). The significance of theorizing about politics in the health care context is what this understanding reveals about the suppression of some voices and the privileging of others (Mishler, 1984). This not only applies to the physician-patient relationship; it also concerns the organizational "voice" that determines and constrains professionals' interactions with both patients and other professionals.

Re-covering these voices necessitates consideration of not only the politics of health communication, but the poetics. Poetics, as defined by Aristotle, is an art of language, particularly the art of storytelling (Corbett, 1984, p. v). In *A Poetic for Sociology,* Brown (1977) offers the poetic as an aesthetical rationality concerning knowledge, method, and theory. In his view, poetics represent interpretive procedures that serve as a critical way of knowing, both in methodological self-consciousness and in bridging theory and praxis as two moments in the same dialectic.

Theorizing about poetics is part of the crisis of representation that has led us to challenge our assumptions about scientific knowledge in the process of theorizing (Bochner, Ellis, & Tillmann, 1996; Denzin, 1992; Mumby, 1993). Essentially, the crisis of representation has opened a space for dialogue about the poetics of our experience. Theorizing about politics without the poetic creates what Fine (1994) describes as a colonizing discourse that fails to work the hyphens. The "science-ing" (of our research, our medicine, our lives) is a silencing in the sense that it marginalizes aspects of our

identities that we attempt to incorporate in our interactions with others. Instead, Fine (1994) suggests that *we* engage the contradictions that litter our texts by struggling *with* those who have been exploited and subjugated. In the process, we reveal "far more about ourselves, and far more about the structures of Othering" (p. 72). Marshall (1993) would agree. She suggests that developing theory and practice necessitates a contextual awareness and questioning that explores the "ideological positions that act invisibly to underpin our theorizing" (pp. 140–141). The pattern of self protection that often dominates research restricts our reflexivity (Marshall, 1993). As researchers, theorists, and practitioners, we must challenge ourselves in ways that acknowledge and explore how "we are continually being changed by as well as changing the experience of others; . . . the other is seen in the light of one's own experiences and the activity of trying to fathom the other in turn illuminates and alters one's sense of self" (Jackson, 1989, pp. 3, 34).

The Crisis of Representation and Ethnographic Reflexivity

Ethnographic reflexivity necessarily blurs the boundary between insider/outsider and subject/object "by situating our experiences within the problematics from which inquiry begins and by acknowledging our political and positional biases" (Gottfried & Weiss, 1994, p. 42). For many researchers, this turning back of one's research experiences upon oneself (Steier, 1991) means making ourselves experimental subjects and treating our experiences as primary data (Jackson, 1989). As Ellis (1991) indicates, the process of introspection is not just listening to one voice arising alone in one's head. Usually it consists of interacting voices, which are products of social forces and roles. Sense-making and self-making are continual processes that never end and sometimes the task of confronting the changing self is arduous because of how difficult it often is to make explicit, both to ourselves and to our audience, the ground on which our concepts are constructed (Fujimura, 1991).

Focusing our energies on ethnographic reflexivity and our own positioning means facing incompleteness and precariousness (Jackson, 1989), relying on emotion as a messenger from the self (Ferguson, 1984), stressing human need more strongly than rights (Ferguson, 1991), engaging with differences and issues of valuing (Marshall, 1993), embracing an invitational rhetoric–converting experience to one of many views (Foss & Griffin, 1995). Inevitably, the pattern of self protection that often dominates research (Marshall, 1993) must be challenged in ways that acknowledge and explore the ways that "we are continually being changed by as well as changing the experience of others; . . . the other is seen in the light of one's own experiences and the activity of trying to fathom the other in turn illuminates and alters one's sense of self" (Jackson, 1989, p. 3, 34).

Creating organizational health communication theory means abandoning familiar dichotomies (Martin, 1990), developing a more integrated inclusive theory (Gates, 1995), developing greater theoretical stamina to explain diverse communicative phenomena successfully (Foss & Griffin, 1995), and incorporating the ideological positioning of the researcher (Geist, 1995). All of these issues are particularly relevant to theorizing about organizational communication in health care. Health communication is personal and ultimately connected to our feelings of ontological security (Giddens, 1979, 1984, 1991). We depend on health care providers, in their positions of authority, to inform, counsel, evaluate, advise, and treat us so that we can carry on with our daily lives. Narratives provide one avenue for exploring our efforts to negotiate the politics and poetics of re-covering identities in health communication.

COVERING AND RE-COVERING IDENTITIES IN THE MEDICAL CRISIS OF REPRESENTATION

The crisis of representation in theorizing has led to a clearer understanding of the significance of the poetic and political dimensions of communication. We are beginning to discover and discuss the patriarchal bias that undergirds ideologies and theories of health care specifically (Lupton, 1994; Waitzkin, 1979, 1983, 1991; Zook, 1994) and theories of communication generally (Bochner, 1994; Bochner et al., 1996; Czarniawska-Joerges, 1995; Foss & Griffin, 1995). At the same time, the crisis of representation in our theorizing about health communication is challenging our definitions of health, illness, medicine, and generally our struggles for defining our responsibilities and identities in provider-patient relationships. In the same way that a poetics and politics of theorizing calls for a balancing of the scientific and the humane, the rational and the emotional, the theoretical and the practical, health communication theorists are asking for a movement from biology to biography (Zook, 1994). In this way, theorizing about health communication moves from a biomedical model to a biopyschosocial model (Engel, 1982; Zook, 1994) and from a paternalistic and narrow focus on health education to a sociocultural, political, and historical understanding of health care (Lupton, 1994).

In our attempt to address the crises of representation in scientific/medical theorizing, we have focused our analysis on a narrative of a surgical procedure, called dialation and curettage (D & C). Dialation and curettage is a common procedure used following miscarriage or for treating endometriosis. The narrative represents what Giddens (1991) refers to as a fateful moment. In his words, "fateful moments are those when individuals are called upon to make decisions that are particularly consequential for their ambitions, or more generally for their future lives. Fateful moments are highly consequential for a person's destiny" (Giddens, 1991, p. 112). Further, Giddens states that "fateful moments are transition points which have major implications not just for the circumstances of individual's future conduct, but for self-identity" (p. 143). Examples of fateful moments include undergoing surgery, hearing the results of a medical test, birth, death, and, in this case, miscarriage then surgery.

The analysis of the episode reveals how the poetic and political dimensions are intrinsically connected in constructing identities in health care interaction, in the process of researching, in articulating our positions as researchers, and in constructing a written account of the research (Mumby, 1993). Our analysis represents a sensitivity to the roles played out in the episode and it becomes a collective reflection on the value of covering and re-covering identities through narrative knowledge. In our first section, "Covering Identities," the analysis begins with the patient's perspective, describing her interpretation of communication in light of the constraints placed upon her by the system in which she is operating. We then move to the attending nurse anesthetist's perspective of this same episode, describing her interpretations of being in the same context, after reading the patient's account. The poetics of constructing identity is clearly constrained by both the politics of health care delivery and the contradictions between the patient's and provider's interpretations. The second section, "Re-covering Identities," analyzes three constraints on the poetics of interaction in light of the patient's and provider's interpretations. First, the *continuity* of health care is revealed in the attempts by the patient to enact her own interpretation of anesthesia. Second, the *routinization* of interaction in the care provider/patient relationship becomes part of the foreground when the poetics and politics are examined. Third, the *perceived objectivity*

and precision of medicine is revealed through a consideration of the poetic and political aspects of health care.

Anesthesia As Overkill: One Patient's Story

The patient, now in the hospital gown, paper cap, and paper shoes, under the warm covers of the hospital bed, situated in the curtain-walled cubical of pre-op, awaiting surgery is discussing her choice of a local, rather than a general anesthetic, and minimal amounts of sedation. The anesthesiologist, relaxing in a chair beside her bed, in a Hawaiian-print cap, states, "You are what we call a minimalist."
"What does that mean?"
"That means you prefer to utilize anesthesia minimally."
"Is that a negative term, minimalist?"
"No, no, not at all. It has more to do with your tolerance for pain and the kind of control you want to have. But some people have trouble with the consciousness that minimal anesthesia allows. They may feel more in control because they are more conscious, but they are not truly in control in the sense that they cannot get up and leave in the middle of the operation. So rather than experience the contradiction, they prefer to have a stronger sedation or to have a general rather than a local."
"But isn't a general really an overkill for this type of operation?"
"Well, yeah, it is like using an elephant gun to kill a mouse."
"Oh, I guess overkill isn't the best choice of words here, but . . . ."
"Yeah, I wouldn't use the word overkill, but yes, it's much more than you need. So there you have my philosophy of anesthesia in reader's digest form. Okay then, we will administer a local with minimal amounts of sedation."
"So, do I even need sedation?"
"Well, it is up to you, but most patients prefer to have at least some sedation to calm their nerves going into surgery."
"But I have been through this surgery so many times before, I really don't think I need any sedation."
"Maybe not, but most people don't realize they're nervous or anxious until they actually are wheeled into the surgical unit and so a little sedation just takes the edge off."
"Well, I'm just not sure. I guess just a little. Minimal sedation would be okay."

No one really explains to the patient the possible variance in amounts of sedation, or even what constitutes the "minimal" amounts they begin to administer through her IV. But one thing she is certain of: she is glad to be aware enough to ask for the Windham Hills sampler CD.

As the music begins to play, she realizes that the anesthetist (at least she assumes the woman monitoring her IV is the anesthetist) may or may not know her preferences for minimal sedation. Just as she is about to communicate these preferences once again, the woman takes her hand and says, "I think a bit more sedation would be good. . . . Now doesn't that feel better?" "It feels like a truck has run over and crushed my hand," she states before the fuzzy feeling takes over.

The next day, the patient vividly recalls with a surprising degree of anger her feelings of loss of control, being misunderstood, and not listened to. But it's over now. She can't help but feel like she should call the doctor who performed the surgery and ask who was the dark-haired woman who monitored her IV during surgery. She desperately wants to exert her control by reporting this incident to the doctor and she is curious as to how the doctor will respond.

Covering Identities

This episode of health communication begins as a casual, informal conversation between the anesthesiologist and the patient. They seem to be engaged with one another, the patient is listening and asking questions and the physician is listening and responding to the patient's questions without reflecting any sense of impatience. His demeanor appears to be relaxed (e.g., the Hawaiian-print cap), and he seems to be taking the concerns/questions of the patient seriously. The patient seems relaxed enough to continue asking questions and even advancing her position: "I really don't think I need any sedation."

However, no agreement is negotiated concerning the patient's sedative and anesthesia directives. In other words, the physician does not ask the patient if she would prefer to have the surgery performed without sedation. In fact, the physician asks no questions of the patient, and even defines the interaction as a monologue (e.g., "a reader's digest" philosophy). The conversation indicates no sense of "what can we do for you," rather it takes on a character of instilling an identity onto the patient as a "minimalist." At the same time, the patient does not follow through after requesting a verbal agreement that "minimal sedation would be okay." And in fact, not until the next day does the patient consider how important it was for her to double check with the "new" anesthetist in the operating room to see if she was clearly informed of her request for minimal sedation.

In the end, from the patient's perspective, there is a direct violation of her request. The violation occurs in two senses. First, she receives a second dose of sedation that moves her beyond the minimal sedation she went into the operating room with, and in this sense, the increased sedation violates the request she made in pre-op to the anesthesiologist. Before the second dose of sedation, she had experienced a sense of control because her degree of consciousness and ability to dialogue with the medical staff remained intact. The second dose caused the patient to perceive that her alertness and ability to interact was reduced and she felt estranged from the scene. The patient perceived a second violation had occurred when the provider did not ask her if she wanted more sedation, but instead injected it without any attempt at consent. There is a contradiction and lack of continuity between the scene in pre-op and the interaction with the provider in the surgical suite. The juxtaposition of these two scenes is alarming in the sense that the patient's wishes are initially listened to, but then modified and nullified by the direct violation during the surgical procedure.

Reading this episode of health communication another way, we may interpret the behaviors of all the health providers as clearly and effectively following hospital procedures. It may not be at all unusual for one provider to discuss anesthesia protocol and another to actually administer the anesthesia. It may be highly unusual and inefficient for the two providers to dialogue about the first anesthesia consultation. Perhaps in this situation few patients ask questions, consider options, or request minimal sedation. From an anesthetist's point of view, it may make perfect sense for a patient to be agreeable to, maybe even feel relief because of, additional sedation (Mann, 1996).

We interviewed the "dark-haired" nurse who administered the anesthesia in this episode (Mann, 1996). We asked her to read an earlier draft of this paper and then to comment on her interpretation of the episode. She began by indicating that this episode stood out in her mind because no one had ever asked for the Windham Hills Sampler compact disc and she remembered distinctly how talkative the patient was before she administered additional sedation. After reading the episode she indicated that this

patient was highly unusual in the number of questions asked and in her desire for minimal sedation. She focused her response to this episode on three separate but interrelated issues.

First, the nurse anesthetist indicated that signing a consent form for a surgical procedure by definition includes the administration of general anesthetic. By signing the consent form, a patient is agreeing to the sedation that the anesthesiologist (physician or nurse) deems appropriate. So even though the patient in this episode had discussed a preferred treatment, the anesthesiologist, by consent, has the authority to make decisions during the course of treatment. Legally, patients are incapable of consent after sedation has been administered.

Second, the nurse indicated that even though she understands why the patient interpreted and responded to the situation as she did, it is very likely that the patient is not remembering the events as they occurred because the drug midazolam, the sedation typically used for this procedure, is designed to cause amnesia so that the patient will not remember the pain or the procedure.

Third, she told us that the philosophy and practice of anesthesiology is premised on keeping a patient pain free and safe. When a patient becomes more alert and talkative, as this patient did in this episode, it signaled the nurse anesthetist that there was a good chance this patient would feel the pain of and even hear the procedure that was about to take place. In addition, the patient, under minimal sedation, is at risk for reactions such as vomiting (Mann, 1996). At what point, the nurse asked us, do patients place their trust in the anesthetist to act in their best interest?

Juxtapositioning the perceptions of the patient and provider raises issues that must be addressed if the fateful moments in health care delivery contribute significantly to our self-identity. Re-covering identities in health communication necessitates reconsidering the implications of episodes such as this in light of the constraints placed upon communication in health care organizations.

Re-covering Identities

There are several interrelated constraints on the poetics of interaction in the health care setting. In the case of the narratives presented, one primary constraint is the *lack of continuity of health care.* That is, generally speaking, interactions are tenuous and lack authenticity (there is an unstated assumption that things are done a particular way and they will be carried out regardless of who interacts with whom). As the narratives illustrate, a patient may interact with multiple care providers in one visit. The assumption on the part of the patient in this case is that care providers will coordinate in order to carry out her specific wishes, and thus the continuity of care will be promoted through communication. However, with the routine administration of anesthesia as a part of legal and consent issues, the patient's desires may or may not be met. The nurse anesthetist indicated that the "typical" patient is one who conforms to routine, without asking questions and certainly without negotiating an alternative to the general anesthesia normally performed (Mann, 1996). From this perspective, interaction takes on a functional character: interaction is a matter of passing information from one person to another, with no clear indication of who talked with whom about what.

The routine nature of medical care under the managed care system creates a *routinization of interaction* in the patient care provider relationship. As the nurse anesthetist pointed out, time is money and physicians are trained to communicate information about procedures in minimal amounts of time (Mann, 1996). In this way, the poetic becomes an inconvenience, a nicety, an unnecessary part of the caring

process. Because providers are not afforded the time to be self-reflexive, interaction may not result in any change to what will happen to patients. Even when there is agreement to forego or modify a particular aspect of treatment (i.e., receive less sedation), the power situated in the routine limits patient-provider interaction, which too often means the patient's wishes will go unrealized. The focus of the consent agreement between the physician and the patient about the amount of sedation to be administered may have provided the patient with some confidence and control over the situation. But when the anesthetist administered more anesthesia, the patient interprets the situation as far worse than if no dialogue had occurred. That is, because the prior interaction with the physician established what the patient wanted, and because it was agreed to, and further because it was expected by the patient that her wishes would be honored, the perceived indifference demonstrated by the anesthetist may have done more than physically numb the patient's physical sensations–it says to her that what she wanted was irrelevant. Further, no one ever followed up to determine if her experience was what she expected (or remembered).

This routinization of health care interaction results in providers treating just another patient. It renders reflexive interaction a moot point. And for the patient, the care provider is just another technician, nurse, or physician. Everyone is interchangeable. In the case of the narrative, the patient was simply another surgical procedure. And with that procedure, what becomes important in the current system is protocol. The patient's desire to tailor her medical experience to meet her own expectations was undermined by the policies and procedures established in the medical routine.

The *perceived objectivity and precision of medicine* is another constraint on the poetic. In addition to the power that routinization has in health care and its effect on interaction, the "mystique" of the medical industry as providing all the answers (or at least having some good answers) to our important health questions constrains the poetic. Because patients often believe they have few answers to medical questions, they may become reliant on the advice and wisdom of their health care providers. In fact, many patients do not care to know, might not understand, may not want to listen, or even may not remember anything to ask about. The irony is that at the same time that we, as patients, are encouraged to take responsibility for our care by asking questions, we are denied this opportunity by providers who either resist these efforts or who are constrained by institutions that do not afford this "luxury" of time in the practice of medicine.

What may get lost in the care provider/patient relationship is the insight and knowledge of the patient about his or her own condition. Failing to consider the knowledge of the patient makes the voice of the physician central to the construction of meaning in the interaction. The physician's voice, therefore, becomes central to the patient's identity formation. These kinds of perceptions constrain patients' ability to freely create authentic interactions and have their own voices heard.

In the narrative, the patient's discourse takes the form of question asking. In her mind, the physician has the answers to her most important questions. Further, the physician actually labels the patient a "minimalist"–influencing her own identity in the process. In entering into the care provider/patient interaction, both parties understand the expert nature of that relationship. The poetic gets lost in the care provider's attempts at explaining the procedure and in translating into "reader's digest" form the complex medico-legal language of the administration of anesthesia. Even though the patient has experienced the procedure "so many times before," her historical experience is invalidated by the science that dictates a set of routine procedures. The "final word" beyond this narrative looms larger than any of the provider's discourse in this

episode. Any desired changes in treatment, procedure, or interaction remain unrecognized and unspoken in the final outcome. What could be re-covered in health care communication remains lost.

RE-CONSIDERATIONS

Re-covering identities in health communication means facing a crisis of representation, not only in our sciences, technologies, and authorities but also in ourselves. Considering the poetics and politics of our interactions in sickness and health lead us to become more fully aware of our own and others' expectations, responsibilities, and identities. Our analysis takes a step in this direction. Theorizing about health communication in organizations must continue to explore poetics and politics, by examining the historical, structural, organizational, and cultural circumstances that affect care provider/patient relationships (Sharf & Kahler, 1996). Working toward this objective means utilizing alternative frameworks of thinking about communication, including cultural sensitivity (Sharf & Kahler, 1996), postmodern feminism (Mumby, 1996), dialogic discourse (Arnett, 1992; Bakhtin, 1981; Baxter, 1991; Geist & Dreyer, 1992), and the "ethnopoetics" of medical cultures and the poetics of our own ethnographies (Atkinson, 1992).

A poetics and politics of theorizing about communication also would include reflection about the research process. Specifically, we must continue to expand our notion of communication theory beyond the "classical" (hypothetical-deductive) models, beyond the applied-theoretical (practical-pure) dichotomy, and beyond any narrow conceptualizations of "appropriateness" of method. This includes a consideration of the position of the researcher in relation to the people in the context of study and the various forms of legitimate styles and forms of writing about research (Bochner et al., 1996; Czarniawska-Joerges, 1995; Ellis, 1995; Foss & Foss, 1994; Mumby, 1993; Perry, 1989; Redding, 1992; Sharf, 1993). By considering the poetic with the political in the health care context, we consider the aesthetic workings of narrative texts (our own and others) to recover identities often suppressed by the politics of care provider/patient interactions in health care organizations.

The examination of the poetics and politics of interaction centers primarily on opening up spaces for participation in one's own health care with greater vigor and freedom and therefore should be considered first and foremost in health care situations where one's interpretation is vital. Some may argue that this would encompass all health-related circumstances. While this may be true, it is especially true in health communication encounters that are tied to fateful moments (Giddens, 1991). For example, waiting for the results of a diagnostic test may be routine procedure for many care providers, but that singular test may be what informs a person whether or not they have a life-changing disease or illness. Fateful health care moments, such as pregnancy, miscarriage, and surgery are filled with uncertainty and may also have spiritual implications for the patient (Gonzalez, 1994). When such moments are treated as opportunities for constructing identity by care providers and patients, the potential exists for patients to feel as if they have some sort of influence and impact on their courses of treatment. The vital insight and information a patient brings to the medical encounter–knowledge about self, motivations, and experience connected to a wider social context–become essential to diagnosis, negotiation, and treatment of illness (Sharf, 1990).

NOTES

[1]We would like to acknowledge Dennis Mumby for his use of this phrase in his 1993 article exploring critical organizational communication studies over the next ten years.

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