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Diabetes and the Motivated Patient: Understanding Perlocutionary Effect in Health Communication

Erin G. Roth^{a,*}, Laura M. Girling^a, Sarah Chard^{a,b}, Brandy Harris Wallace^{a,b}, and J. Kevin Eckert^{a,b}

^aUniversity of Maryland Baltimore County, Center for Aging Studies, PUP, 1000 Hilltop Circle, Baltimore, MD 21250, USA

^bUniversity of Maryland Baltimore County, Sociology & Anthropology Department, PUP, 1000 Hilltop Circle, Baltimore, MD 21250, USA

Abstract

Healthcare providers (HCP) understand the importance of keeping patients motivated but may be unaware how their words may have unintended negative effects upon their patient's lives. People with diabetes report being told by their HCP that they are "cured" or that they are praised for strides made in weight-loss and/or lowered blood glucose, and interpret these messages in unexpected ways. For this paper, we focus upon one case to illustrate the depth and nuance of the patient-provider communication as it emerged within a larger interview-based ethnographic study. Audio-recorded interviews and transcriptions were analyzed discursively. Discourse analysis reveals the ways ideology affects how the patient responds to HCP's utterances and how this affects diabetes self-care. Findings indicate significant perlocutionary effects upon health outcomes, varying both positively and/or negatively. This study points to the importance of carefully considering the power of words and whenever possible knowing the patient's ideological orientation to their world. HCPs should be explicit and deliberate with their communication. Sensitization to the various ways patients hear and react to messages in a clinical setting may lead to improved health outcomes, especially for those with chronic health conditions such as diabetes mellitus.

Introduction

Diabetes is the seventh leading cause of death in the United States (USA) (CDC, 2008). A national epidemic (Aston, 2013), type 2 diabetes mellitus (hereafter referred to as diabetes) accounts for 90–95% of diagnosed diabetes and rates are predicted to nearly double over the next 15 years (Beckles, Zhu, & Moonesinghe, 2011). Diabetes-related health care costs account for an estimated 20% of total health care spending in the USA and are expected to nearly triple by 2034 (Huang, Basu, O'Grady, & Capretta, 2009). Accordingly, addressing diabetes prevention and treatment is a leading US public health priority.

*Corresponding author at: University of Maryland Baltimore County, Center for Aging Studies--PUP, 1000 Hilltop Circle, Baltimore, Maryland, 21250 United States. eroth@umbc.edu.

Given the complexity and chronic nature of diabetes, conceptions of diabetes treatment must shift from “acute and reactive to proactive and planned,” according to the American Diabetes Association’s (ADA)-recommended Chronic Care Model (Coleman, Austin, Brach, & Wagner, 2009, p.75). To increase the effectiveness of patient-provider interactions, the ADA recommends investigating avenues for more effective and actionable communication, suggesting the critical need for communication styles that are patient-centered (American Diabetes Association, 2015; Levinson, Lesser, & Epstein, 2010).

This paper aims to uncover pathways to improve patient-centered communication by drawing attention to some of the pragmatic challenges and successes involved in the patient-provider interaction. Put simply, this paper is a descriptive exploration of patients’ perceptions of the messages conveyed by healthcare providers (HCP) and how these perceptions inform health behaviors. We demonstrate qualitatively that words do indeed matter and their effect has variable and unpredictable consequences that can result in critical health benefits and/or setbacks.

We have selected a case study approach for this exploration to provide a level of description and specificity to better understand the complex patient-provider interaction (Ray, 2005). According to Radley and Chamberlain (2001), a case study is not “merely a medical instance,” but rather the key to unlocking the social and interactional phenomena that are critical to health and healing. Although not expressly generalizable, this case offers several representative themes found throughout the larger dataset, cutting across gender and ethnicity/race.

We feature study participant Keith Guthrie (pseudonym) whose case is an especially salient exemplar, illustrating the full range of perlocutionary effects. Mr. Guthrie reflects upon both positive and negative exchanges with multiple HCPs over time, sharing his understanding of those exchanges and how they shaped his health behaviors. The pragmatic discourse analysis for this paper is from the patient’s perspective as described by that patient *about* the exchanges with their physician after the exchange, providing sufficient space and time for the patient to take in the message, react, and reflect on the exchange.

The sociocultural context of a medical office visit is also a factor in health communication. The literature notes the inherent power imbalance between medically trained providers and their patients whose biomedical knowledge varies, and whose personal realities and bodily symptoms are at times minimized by the medical professionals they rely upon (Brady, 2001; Kirmayer, Groleau, Looper, & Dao, 2004). It is especially critical to explore the assumptions that patients with chronic health conditions, such as diabetes, are uncooperative and lack compliance (Balsa & McGuire, 2003; Kleinman, 1988). Indeed, miscommunication or a lack of understanding between the patient and the provider can lead to poor health outcomes (Stewart, 1995; Street, Makoul, Arora, & Epstein, 2009).

HCP-Patient interaction

Discursive approaches to qualitative health research involves analyzing recorded exchanges between the patient and physician within the medical office visit, examining pragmatically

the social roles of doctor and patient, power dynamics, and how identities are constructed and maintained (Ong, De Haes, Hoos, & Lammes, 1995; Roter & Hall, 1989). Our analysis of interviews conducted *after* the clinical encounter contrasts with much of the existing health communication literature that focuses on the clinical interview and analysis of the transcripts from those office visits.

Discursive pragmatics brings to the analysis of discourse the idea that it is within and through the social interaction that the participants establish meaning and are led to some action or inaction (Kasper, 2006). The conceptual framework for this paper relies upon the work of Austin (1962) and is concerned with what meaning the listener takes from the speaker's illocution and its subsequent perlocutionary effect, whether intended or not. One particularly relevant notion is that the message could serve as a declarative or "performative" utterance, so that the act of speaking the words communicates to the listener that 'it is so' or may in some way call it in to being.

The power of the performative utterance has been the focus of health research noting the curative (or not) effect of the words, "You are cured" or "Try this [medicine]; it might help" (Weinfurt, Sulmasy, Schulman, & Meropol, 2003). Austin's concept of performative utterance has also been employed to better understand the therapeutic power of the placebo in double-blind, clinical trials (Myers, 2010; Thompson, Rittenbaugh, & Nichter, 2009), recognizing the power of HCPs words and their potential to affect research outcomes.

While the literature indicates health outcomes are indeed influenced positively and negatively by the patient-physician communication, there has been a noted lack of qualitative evidence for the specific ways communication and health outcomes are linked (Stewart, 1995; Street, et al., 2009). The literature has suggested that it is the *quality* of the relationship between patient and HCP, as communicated through words, which has an indirect influence upon health status. For example, patient-physician communication that decreases patient anxiety can lead to increased patient adherence, which could result in positive health outcomes (Street, et al., 2009). This paper seeks to fill the literature gap by examining qualitative data through the pragmatic conceptual lens of perlocutionary effect.

Diabetes from both provider and patient perspectives is experienced and understood within their own sociocultural and personal history contexts (Lange & Piette, 2006). Individuals develop an explanatory model of their illness (Kleinman, 1980), informed by a variety of information sources as wide-ranging as Dr. Oz or one's sister-in-law, in addition to their own healthcare professionals and experiences. HCPs likewise hold an explanatory model of illness and well-being, informed by their biomedical training, clinical, and personal experience (Beverly et al., 2011; Brady, 2001). These ideas and experiences form a system of beliefs or 'underlying ideologies' (Van Dijk, 2006) that in large part guide what patients hear and do and what HCPs say and ultimately informs the provider's effectiveness and the patient's health and well-being.

Sample/Methods

Data for this paper were drawn from a 3-year National Institute on Aging-funded interview-based study entitled, “Subjective Experience of Older Adults with Type 2 Diabetes” (SED). The purpose of SED was to better understand the *subjective construction and definition* of diabetes mellitus among 83 older adults living in Baltimore City. The data was gathered using an established semi-structured ethnographic interview instrument, McGill Illness Narrative Interview (MINI), designed to elicit the story of the interviewee’s illness, listening for notions of etiology, treatment seeking, and health beliefs (Groleau, Young, & Kirmayer, 2006). The MINI, modified to specifically address issues related to diabetes, was not administered as a survey instrument but instead used as a guide to ensure the important and relevant topics were addressed. Utilizing a type of ethnographic, in-depth, semi-structured long-form interview (Miller & Crabtree, 1992), the interviewer encouraged the narrative to unfold at length with simple prompting by asking opening questions such as “Please tell me the story of your diabetes.” The level of questioning becomes more specific as the interview unfolds. Lines of questioning might include the following: “Who has been helping you with your diabetes? What have you learned from them about diabetes? How have they helped you (or not)? What do you talk about in terms of your health/diabetes?”

When possible, we matched ethnicity of the interviewer with the study participant’s as this technique has the potential to provide increased rapport and opportunity for disclosure (Sherman, 2002). The lead author, a white female, Baltimore resident with graduate training in folklore, anthropology, and social gerontology, conducted the interview this paper draws upon. Mr. Guthrie made several self-conscious comments about his lack of formal education, likely having an effect on what and how Mr. Guthrie chose to share and present himself (Cameron, 2001).

Interviews ranged in length from 41 to 246 minutes. The recorded interviews were transcribed verbatim by a professional transcriptionist and checked for accuracy by the interviewers. Team members used a collaboratively developed codebook to code the interviews. Codes were identified a priori as well as inductively across the study’s cases through reading and re-reading and team discussions. Qualitative data analysis software, ATLAS.ti assisted in data management as well as analysis and saliency by providing the tools to search codes across and within cases.

Analysis

The aims of the larger study did not include a focus on health communication. Rather, the themes and patterns of health communication and perlocutionary effect presented here emerged organically within the SED study’s sample. The first author’s iterative approach included the interviewing of 47 of the 83 participants, coding, listening to the recordings, and reading and re-reading transcripts from the entire sample. We chose a sociolinguistic, pragmatic approach to guide the analysis for this paper, taking the words and actions in the interviews into account (Briggs, 1986; Agar & Hobbs, 1983).

Brief Portrait: Underlying Ideologies of the Case Study

An individual's personal ideologies and sociocultural contexts lay at the base of all social interactions. Better understanding of each patient's underlying ideologies can improve communication by providing insight into how HCP's messages are being received by any one individual. To achieve this level of understanding, we offer the following brief portrait of the single case study selected here to represent the SED study's emergent theme of perlocutionary effect.

Mr. Guthrie lives in a narrow, two-story row house surrounded by many boarded up row homes in Baltimore. At the time of the interview (December 2013), Mr. Guthrie, 60, is single and has no children. He described his family as "poor white people," growing up in a racially mixed, Baltimore City housing project. (He self-identified as "white," although the family had a "Hispanic background.") Mr. Guthrie refers to himself as a "high school dropout" who is largely self-educated through films and books; four feet-high stacks of VHS tapes, DVD box sets, and paperback books were neatly arranged inside his crowded living room.

In his 20 years as a corrections officer, he witnessed corruption and withstood physical threats and injury. He presented himself as a principled person who is fearless to those in power. "I mean, I always told what I saw as the truth so I mean even my co-workers didn't... they used to say, 'Guthrie'll get you in trouble.'"

Mr. Guthrie's past experiences with institutional authorities such as the police and his identity as someone who is poor and lacks a post-secondary education, influences how he interacts with medical professionals. In his view, "...doctors think they're gods. They're a pain in the butt. They just thought that we were a bunch of slumlord type kids and we wouldn't know how to act," he said of his mother's doctors who he said refused to communicate with him and his siblings.

Results

Over the course of the study, a pattern of reactions to healthcare professionals' words emerged as participants spoke about their disease experience. Without explicit prompting by the interviewer, participants within the SED sample made a direct link between what their HCP said to them, their reaction, and how it led to certain health behaviors. Analyses identified a range of perlocutionary effects, both negative and positive. For instance, participants told us that HCP's words at one time had no apparent effect upon their health behaviors, but later proved to be a latent, motivating effect that resulted in a desired positive outcome (positive effect). However, it's important to acknowledge that messages that positively motivate one participant may not work with others; and perhaps most surprising, some HCP's messages that were likely intended to congratulate and encourage patients, led them to take steps that worsened their health (negative effect).

Mr. Guthrie's narrative is particularly salient and indicative of the theme of perlocutionary effect. He speaks primarily about Lia Chung, his HCP at the time of our interview, and less so about his previous HCPs. We learn from Mr. Guthrie that Ms. Chung, a nurse practitioner

nearing retirement explained to him that she worked afterhours in effort to “get you right before I’m gone.” According to Mr. Guthrie who had been seeing her for over ten years, Ms. Chung’s care and commitment to her patients made him feel cared for.

She’ll go in the office; she’ll be there 8:30 in the morning [...] until 9 or 10 and I know this because she’s calling me complaining about my numbers [HbA1c] and it’s 9 o’clock. So I’m like, ‘Lia, why don’t you go home to the family and let us dummies just worry about it on our own,’ [to which she responds,] ‘I got to do this!’ Really nice person.

As Mr. Guthrie states, his past and present HCPs have been at different times dismissive, admonishing, encouraging, inattentive, and attentive. His various reactions to what was being communicated and how he felt about it have had different and often lasting effects upon his health and continuity of care.

Positive effect

“You could drop dead any minute!”

When Ms. Chung said to him, “You could drop dead any minute!” Mr. Guthrie felt a sense of urgency that motivated him to take action. He notes that his success in losing weight was a response to Ms. Chung’s stern admonition and recommendation. “It’s just that, um, for ten years [Lia] told me, ‘Man, you could drop dead any minute; you could drop dead.’” For some individuals, the crisis mode may not provide motivation and could lead some patients to find a new HCP. Even for Mr. Guthrie, a HCP twenty-five years earlier used similar scare tactics that did not seem to have any effect, positive or negative, a point we discuss below.

“You aren’t helping me!”

A common response within our study sample was the participant’s decision to “fire” the HCP when participants felt dismissed or disrespected. Guthrie and others portrayed the firing of their HCP as an exertion of power over the medical professional, viewed as a proactive measure to maintain dignity and improve one’s health care. Mr. Guthrie describes his interaction with a previous HCP and how this led him to switch to Ms. Chung, his current primary care professional with whom he is very satisfied.

One time I was really stressed out—I was calling out sick regardless. So I told her [the HCP he had been seeing] I needed a sick slip for a certain date. She wouldn’t give it to me. [...] She’s like, “Where you going Mr. Guthrie?” I said, “You’re supposed to be my doctor. You won’t give me nothing! You’re going to give me platitudes: ‘Everybody’s stressed’?! ” I’m like, “You’re not helping me. Bye!” I said, “I’ll go up front and pick me another one.”

Negative effect

“fell right back off the wagon”

Mr. Guthrie describes a type of miscalculation by the practitioner when communicating with the patient. Once he had his blood glucose under control, Ms. Chung shifted her stern stance to a congratulatory one.

Mr. Guthrie: It's just that, um, for ten years [Lia] told me, "Man, you could drop dead any minute, you could drop dead." And then a year ago she said, "Oh, your numbers are so great!" And I fell right back off the wagon and that always happens.

Interviewer: Are you saying because she told you that, you thought, "Well, now I can relax a little bit"?

Mr. Guthrie: That's exactly what. With me, as long as we're in crisis mode I can deal but once you tell me everything's cool... Didn't I tell you I'm lazy? I just chill right back out. I like my snacks; my numbers started going up.

In this example, Ms. Chung expressed her enthusiasm for Mr. Guthrie's success in losing weight and keeping his blood sugar levels low. For Mr. Guthrie, he reacted to her positive messages about his improved health condition by reverting back to poor eating habits and lack of exercise. Consequently, his blood sugar "numbers" had been creeping back up and he had started to regain some of his weight, which led Ms. Chung to express growing concern, which Mr. Guthrie apparently needed from her to help motivate him once again.

Latent effect

"Time to get right."

Mr. Guthrie's interview reveals how provider communications that may appear to be ineffective or ignored by the patient often are internalized. His experiences suggest that patients may later turn to these internalized messages when ready to face the issue. For example, Mr. Guthrie notes how a former HCP had been "worrying me to death," continually advising him to stop smoking, lose weight or suffer the consequences. But it was some years later that he found motivation to lose 70 pounds of weight and quit smoking when faced with serious illness within his immediate family.

I was like, 'Whoa!' you know. 'That's it. Time to get right.' [...] I was already going to the doctor and like I say, they'd been worrying me to death about, 'You got to do this; you got to do that.' But when I decided to do it, I went to them and got [...] help as far as advice and what, like on quitting smoking. They gave me some pamphlets. I read them. I took the things that I thought I could work with and then I quit smoking. I mean it took me three weeks and that was it, boop.

Although we do not know the context in which this interaction took place because Mr. Guthrie did not elaborate, it is clear in this example that the HCP's words or "worrying" had a latent perlocutionary effect upon him. The doctor's message lay dormant until the moment Mr. Guthrie decided to really explore the steps he needed to make positive health changes.

Performative Utterances

Austin's concept of performative utterance (1962) or pronouncement describes those particularly pivotal moments where words have the authority to call into being a new reality. For example, receiving a diagnosis of diabetes from a HCP can have the effect of changing one's reality and prompt someone to take seriously what were bits of information, advice, and warnings from HCPs.

Mr. Guthrie described a situation with previous HCPs in which despite all the classic diabetes symptoms he was experiencing, they continued to tell him he was not diabetic. In his interview, he said he *needed* an official diagnosis to help him get started and motivated to make some health changes.

For ten years I kept telling [the doctors], ‘I’m diabetic.’ They kept saying, ‘no.’ And then one year they were saying I was prediabetic. Now that’s the one year I probably should have done something but I didn’t believe them because I thought, I was already diabetic. And [...] then they said, ‘oh, you’re diabetic, type II. We’re going to have to give you this and this.’ I’m like ‘OK.’

Even though he had lost faith in those HCPs’ ability to diagnose and understand the disease, his eventual medical diagnosis as “diabetic” brought him into a new reality. Mr. Guthrie welcomed the diagnosis because it forced him to make the changes he needed to make.

Mr. Guthrie twice mentioned the doctor he referred to as “the dummy” who told him he was cured and whose declaration he subsequently linked to a significant set back. Although it is not clear precisely what his doctor said to him, Mr. Guthrie took in this information and considered himself free and clear of the condition that had prompted him to make positive health changes. He noted how he had managed to get his weight down from 260 to 197, and his cholesterol from 262 down to 146. “I mean, I was in shape,” he said. “But then [the doctor] said, ‘you’re cured’ and it took me three years and [my weight] was back up to 260. At one point I had gotten up to 273.”

Toward the end of the interview, the interviewer asks Mr. Guthrie to clarify his reaction to the Ms. Chung’s compliments on his efforts and improved health.

Response: Well, I mean if somebody tells you everything’s hunky dory, then you don’t really need to put the effort in. And that’s I guess what I do. I just say, ‘oh, good, I’m done.’

Interviewer: Maybe instead of saying hey, you know, you’re cured you could say, it would be better to hear something else, something that ...

Response: Well, if they’d say ‘you’re doing better’ instead of ‘Oh! You’re doing great!’ Well, you know, that’s cool; better is better but it can be *better* still.

Discussion

Crucial to any successful patient-practitioner relationship is the ability of the HCP to effectively communicate so as to motivate the patient to take the necessary steps to improve their health. Effective communication depends not only upon the words themselves, but also the manner in which they are shared and the context of the patient-HCP relationship and the institutions themselves. All individual patients are unique and so what motivates one patient at one time, may never work on others or will only work when heard at a more effective time. The apparent contradiction and pure idiosyncratic factors are evidence of how complicated the health communication between patient and HCP can be and often is. We suggest that it is this very point that makes so difficult the call from Street et al. (2009) for

concrete, measureable evidence to link patient-practitioner communication with health outcomes.

The life experiences that Mr. Guthrie describes – establishing a reputation of being crazy and fearless in the prison where he worked, defying the culture of corruption in the prison by refusing to participate – fit together with a western cultural belief that on one hand privileges biomedical professional knowledge and on the other, is skeptical of the power structures that disregard someone of his class and education.

These cultural attitudes, beliefs, cognitive formations, experiences, and social interactions work together to affect how he hears what HCPs are telling him. His relationship with his nurse practitioner, a professional who he feels respects him, is a highly significant factor in how he understands and manages his diabetes. Yet, as Mr. Guthrie has explained, the effect of her words is not always positive. The relationship between provider and patient can be both therapeutic and potentially unhelpful at the same time.

The desired outcome of health communication, particularly in the context of chronic conditions, is to create an environment in which patient-provider interactions are increasingly “productive” (Coleman et al., 2009) through better understanding of the varied-sociocultural filters through which we speak, hear, and react. Current diabetes care best practices encourage interactions that provide patients with “actionable information” to encourage patients to engage in their own care.

It is perhaps not surprising that the task of motivating patients and understanding their perceptions of risk and the internal logics of individuals with diabetes is very difficult. Discourse analysis of ethnographic interview data that reflects on these patient-provider interactions makes it possible to better assess the outcome of these exchanges – to see how the information is perceived, internalized (or not) and what actions (or inaction) follows.

Interestingly, the relationship between Mr. Guthrie and his nurse practitioner, Ms. Chung defies the literature on physician-patient concordance. The preponderance of evidence notes positive healthcare outcomes when patients see physicians of the same race or cultural background. According to LaVeist and Nuru-Jeter (2002), patients are more likely to opt for providers of the same racial /cultural background when given the choice. Moreover, domains such as patient trust and satisfaction are related to physician-patient concordance in values and beliefs (Street, O’Malley, Cooper, & Haidet, 2008).

In addition, a relationship strained by racial difference and mistrust does not necessarily mean the patient will *not* make positive changes, as with one of the study’s African American participants who felt her Korean doctor was prejudiced against Blacks. There were many instances in which she felt dismissed and disrespected but before she “fired” this doctor, she reported that she successfully quit smoking, motivated over time by his stern imperatives to stop.

Limitations

While the present study provides valuable insight into perlocutionary effects among patient-provider interactions, it is not without its limitations. Firstly, Mr. Guthrie's experience should not be considered representative of men his age, ethnicity, social class, etc.

Secondly, because the study's aims were not specifically intended to study patient-practitioner communication, the line of questions and in-interview follow-up on this particular topic were limited in terms of depth and detail. For example, we do not know very much about the HCP (he referred to as a "dummy") who Mr. Guthrie said first told him he was "cured" or the next HCP who refused to give Mr. Guthrie a note for missing a day of work. Gender, ethnicity, age, healthcare credentials are all unknown and so it is difficult to draw any further conclusions about how the exchange may have been affected by social and cultural factors. We do know Ms. Chung is originally from China and is preparing to retire. Mr. Guthrie makes a point about her Chinese ethnicity when he talks about his fondness for Ms. Chung. He notes without prompting, "She's Chinese and she went to China last year—took the whole family. She was gone for six weeks; she enjoyed it. Good people, though. What you going to do?" It is not entirely clear what he means by inserting this but it may offer some insight into his cultural attitudes that affect how he feels about Ms. Chung. It would also be useful to find out what, if anything, about Ms. Chung's ethnicity contributes to his positive relationship.

Thirdly, as with any type of interview, we recognize that the interviewer-interviewee relationship impacts the content and quality of the interview – both trying to save "face" or manage the relationship in terms of how one is being perceived (Cameron, 2001). Furthermore, we recognize that the narrative being constructed is being done so in a certain kind of engineered context – a social science interview is its own speech genre, different from a medical office visit or ordinary conversation. Nonetheless, data from this study's interviews provides important insight into a largely under-utilized method in health communication that may prove useful in various healthcare settings.

Conclusion

This paper explores the complexity and importance of effects HCPs words have upon their patients. It points to the importance of knowing the patient's ideological orientation to their world and thinking carefully about how something is said and perceived. Yet, this is very difficult to do given the mercurial idiosyncrasies of each patient, the complicated interpersonal and cultural dynamics in each relationship, and the obvious demands on HCPs time and required expediency.

Our proposal is to encourage greater awareness of the power and authority with which HCPs communicate with their patients. Keep careful notes, recording communications as a way of returning to those messages on subsequent visits. Check back with the patient, asking them to reflect on what was said in the last visit. What effect did they have upon the patient and how might the HCP learn more about the individual patient – motivations, attitudes and beliefs, for example – that encourage positive health behavior and keep motivated patients such as those with diabetes whose health so depends upon their daily choices.

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The term health care professional (HCP) refers to any member of the health care team.

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