AJOMN-American Journal of Obstetric and Maternal Nursing
Volume 2, Issue 2 | November-2025
e-ISSN: 3065-8144 Print ISSN: 3065-8136

Individual-focused dialogues in healthcare: A conceptual exploration through communication theory perspectives

Dr. Helena Sørensen[1], Dr. Anders Møller[2]
[1]College of Nursing, University of Copenhagen, Copenhagen, Denmark
[2]Faculty of Health Sciences, Aarhus University, Aarhus, Denmark
Received: 13-09-2025; Revised: 25-09-2025; Accepted: 15-10-2025; Published: 20-11-2025

Abstract
This teoretical reflection dwells upon the idea of individual-oriented discussions in the nursing and healthcare fields in terms of the communication theories. Based on the interpersonal, relational and dialogic models of communication, the research focuses on the context of the personalized, respectful and empathetic communication being the basis of person-centred care. It criticizes the typical task-based communication and propagates changing the practice to the authenticity of conversations, reciprocity and value of the patient voice, values, and lived experience. The paper provides a conceptual basis in terms of which meaningful member-patient relationships and better care outcomes can be made by synthesizing positions of a nursing theory, health communication and relational ethics.
Keywords: ***Person-centred communication, nursing dialogue, patient engagement, healthcare interactions, interpersonal communication, therapeutic relationships, relational care, communication theory, empathy in nursing, patient-centred care.***

1.Introduction
The nature of communication between practitioners and the patients plays a crucial role in the healthcare procedure today, which determines the experiences and results. Nonetheless, it has been agreed on the wild assumption that healthcare providers operate out of empathy and attentiveness; yet many patients accuse these efforts of made to ignore, misunderstand, or not to see them. These disconnects elucidate a very important issue, which is that good intentions are not always a guarantee of efficient or efficacious professional communication. Having this complicated interpersonal place, there develops somehow the need of a more subtle, human-oriented exchange, the exchange which takes into consideration both the systemic constraints of the institutional environment and the subjective, everyday experiences of care-seeking individuals(1).

Linear information-transfer models have always dominated the traditional perspective of communication in healthcare, and in the cases when conversations get narrowed down to the scene of procedural instructions or administrative work. These types of models might serve the operational requirements, but they are deficient in terms of establishing connection, meaning, and understanding. As a reaction to this deficiency, the current analysis advocates the transition of transactional communication into person-oriented relational communication. The main idea here is that genuine healthcare communication should largely exceed mere exchange of information; it should also verify the factor of uniqueness of the individual and answer to his/her psychosocial, emotional, and existential aspects.

Philosophical underpinnings account to this change in thought, especially the thinking of Paul Ricoeur, whose sense of the person is both vulnerable and acting upon. Ricoeur also supposes that people were not mere objects of care, but also had the potential to suffer and reflect as individuals. This being the case, person centred conversations should henceforth address the entire individual, and not just the diagnosis, symptoms and treatment schedule. Such a practice is opposed by the clinical inclination to standardize patients as cases or problems that have to be handled. Rather it is about how to acknowledge that patients are the authors of their own life stories with their own experiences, provided with different biographies, ideologies, and abilities to find meanings in life.

The necessity of such paradigm shift is further underpinned by the changing context within which the medical interactions take place within the society. The communication patterns have also altered dramatically due to digital technologies, enhanced accessibility of information, as well as the heightened focus on patient autonomy. Patients and their families will continue to arrive on clinical settings with heightened expectations of participation, decision-making and disclosure. This kind of climate has demanded relegation of a strictly top down or one way type of interaction. On the contrary, health professionals are invited to become co-navigators, also known as

listening partners, whose role is to allow patients to define their problem, to discuss their possibilities, and to co-create knowledge.

Based on various theory views, the article outlines four major models of communication applicable in nursing and healthcare contexts. They are: (1) information transmission model, (2) the dialog model as the philosophical approach to relation, (3) the constructivism model, (4) communication as the way of creating shared social worlds. Among these, only the three last can be of good foundations of person-centred dialogue. Much in use and still widely supported, the linear model is criticised as reductionistic, and lacking appreciation of contextual, reciprocal and interpretive components needed in therapeutic and caring communication(2).

Hidden in this theoretical model is a workable typology of person-centred conversations, which consists of five unique forms that include: (1) problem-identifying dialogues, (2) instructional exchanges, (3) guiding and supportive conversations, (4) caring and existential dialogues, and (5) therapeutic engagements. All those types are of a different nature in a clinical setting and are conditioned by the situational requirements, communicative competence of a professional, and the readiness of the patient to cooperate. These types illustrate the complexity of healthcare communication and give credence to the views that dialogue is never a one-dimensional, wholesome entity that can be reduced to a form, function, and sentiments.

One of the most important elements of person-centred communication is its openness not only as the verbal word but also to the non-verbal messages like body language, silences, feeling tones. This kind of openness involves the ability of the professionals not to merely listen but hear, not merely observe but perceive, and not respond but relate. To be able to practice at this level one must be aware of self, ethical sensitivity and ability to negotiate ambiguity. There is also a change of epistemology: that changes the way of looking at knowledge: instead of looking at it as objective facts, knowing becomes relational, situated and constituted in dialog. This is in tandem with the hermeneutic tradition which sees human understanding as open and narrative(3).

Moreover, health discourses are not a one-off event. They are influenced by power gradient and institutional hierarchies, sociocultural values, which tend to position the patients in a lower category. The patient is institutionally predisposed to be put in triple disadvantage: institutionally, owing to inequalities of power and access; existentially, in a state of vulnerability caused by sickness; cognitively, in a state of knowledge deficit and health literacy. All these aspects confront the assumption of equal status when communicating and call health professionals to contribute actively to the leveling of the communicative field. In respectful communication, thus, lies a type of ethical behavior, a way of healing a patient by giving him or her his or her voice, agency, and dignity. The redesign of dialogues as co-created, ethically rich processes as opposed to mundane encounters makes the process of communication a key ingredient in healing. The doctor-patient relationship, whether on the occasion of the actual diagnosis, a regular follow-up, or a subtle text in terms of end of life care plan, the quality of communication can have a drastic impact on the emotional state of the patient, his/her treatment compliance, and self-identification. Thus, when encouraging the development of human-oriented theoretically informed dialogue, one should not perceive it as an amount of optional addition to clinical practice, this is the indispensible element of ethical, effective, and person-centred care.

2.Reconceiving the Person in Health Contexts

When thinking about person-oriented communication and the ways we should implement it in the context of healthcare, we need to determine what it is to become a person in the first place. That might sound like a philosophical or even abstract pursuit or effort, it has tremendous repercussions on the manner in which care is given, the manner in which it is received, and the manner in which it is understood. Healthcare in traditional biomedical models has been designed according to dysfunction and pathology which is primarily based on the physical manifestations, organ system, or physiological deficits. This paradigm tends to place the individual in the passive position to receive care instead of being an agentic person within the context of personal narratives, social roles, and intricate identities. This reductionist perspective overlooks the variety and complexity of human existence and this is why a more humanistic and holistic perspective is so crucial.

Personhood is strongly conceptualized by the French philosopher, Paul Ricauer, which has been of great relevance in clinical practice. He depicts the individual as naturally constituted and capable and vulnerable, one with the ability to act but at the same time susceptible to slavery and coercion. The moral basis of human experience of illness consists in such duality. The idea of the capable human being as expressed by Ricour indicates the ability to decide, establish a relationship, and seek meaning. Meanwhile, when this ability is interrupted, whether due to

Volume 2, Issue 2 | November-2025
e-ISSN: 3065-8144 Print ISSN: 3065-8136

pain, sickness or existential anguish, it constitutes a form of suffering of extreme proportions. It is in this realization that all healthcare events are marked by negotiating ability and affliction, autonomy and dependency.

Understanding of such dichotomy may enable the professional to turn their focus beyond the deficit model. Rather than considering patients merely in terms of what is wrong or lacking, health care professionals are encouraged to learn what remains possible without limiting the person to what is wrong or missing(4). The necessity to tackle healthcare issues starting and ending with what is not working in the body too frequently excludes the wider picture on who the person is and what their life means to him/her. To illustrate, one may see a patient with a chronic condition, yet s/he will still have aspirations and habits, social life, and inner world that contributes to his/her way of seeing and managing a disease.

Bengt Kristensson Uggla, the other great thinker on modern philosophy, develops this ethical requirement further by stating what he labels as the threefold disadvantage of patients in a healthcare context. To begin with, patients feel institutionally vulnerable, as they occupy the young position in a hierarchy of a procedural system. Hospitals and clinics are disciplined places where routines, documentation, procedures, and time limit do not necessarily focus on the narrative of the individual. Second, patients are vulnerable existentially, since most times that they come in contact with illnesses, they are faced with fear, loss of identity, and uncertainty concerning the future. Lastly, they are vulnerable in their cognition, not in terms of being less intelligent but in a state of having lesser knowledge on medical terminologies, diagnostic thinking, or treatment procedures. In combination with each other, those three levels of vulnerability expose patients to a communicative and epistemic disadvantage that health professionals should not overlook.

Notably, the recognition of cognitive vulnerability should not be seen as an absence of reflective and rational capacity on the part of patients. Quite the contrary, human beings have the innate capacity to think, reason, and make sense out of their lives. Nevertheless, the same most eloquent human beings may be blindsided by health emergencies (health emergencies are particularly sudden medical conditions or illnesses that grow worse), which potentially leads to failures in normal line of thinking. That is why communication needs to be sensitive not only to spoken words but to emotion and intellectual plethora of the moment. The concept of health literacy is transformed into a dynamic and situational concept, as opposed to a fixed one.

The other important conceptual explanation is the use of the word, person, and individual. Although the two terms tend to be utilized interchangeably in normal speech, they have rather different meanings in philosophical and sociological circles. The word individual can be characterized by the accent of separativeness and autonomy whereas the word person by embeddedness, responsiveness and relation identities. Date-wise, the concept of the person has evolved. The importance of rationality and thought process replaced embodiment, emotions, and social persona during Enlightenment. What has come out of it is a disjointed perspective- one that values the mind as opposed to the body, the quantifiable over the subjective.

The renewed stress is put today on the individual as a lived being, as a whole, an integrated person who plays various roles in various situations, the one with metaphorical masks that he/she plays during the social interactions, who gets accustomed to each situation and the expectations and demands that it set around. Based on symbolic interactionism, Johan Asplund, a sociologist indicated that identity is not something we own on our own; it is developed as a way of responding to others. According to him, we are ourselves in the everyday. In a time in which illness intrudes into this everydayness, it poses a challenge to our sense of coherence, stability and identity. That person will then retreat and become more of a watcher than a participant in life, a psychological withdrawal that will not only impede recovery, but involvement in care.

Such vulnerability to existence requires an ethically concerted context-sensitive communication. In the actual person-centred dialogue, the opposite healthcare provider does not only discuss the sickness but the interruption in the narrative of the person. Fear, hope, confusion and sight have to be present in the conversation. It has to assure that the individual is not a case number or a medical record. Sometimes the person is not genuinely prepared to disclose inner truths; he/she would rather stand aloof or enact a socially-acceptable version of himself/herself. This can not be only respected(5). Person-centredness is not to say to force intimacy but make the background so that we can get the realities out in case the person is willing to express it.

The status of healthcare communication has also got complicated in our fast changing more and more digitalized society. The way to have virtual consultations, electronic medical records, portals by patients, along with self reporting mechanisms are changing the established equations of face-to-face conversation. These innovations increase access and efficiency, but can also be a dehumanizer of care by being implemented without consideration.

The danger is not only technological alienation but also moral erosion - when the man is hidden behind the monitors and information points. This is environment under which the duty to protect personhood in communication is all the more pressing rather than the lesser.

Thought speculations should also be attributed to real results. That is why, when we realize that healthcare conversation is not a clinical transaction, it involves co-construction, relationship, ethically loaded exchange, we have to do things differently. We have to be interested, humble and communicative. The biography of the patient needs to be taken into consideration and not only their biology. We have to realize that every dialogue is an interaction with a complete human being, traveling through his or her ever-complicated wilderness of meaning, identity, and survival.

3.Reimagining Healthcare Communication Through Alternative Conceptual Frameworks

In order to advance real person-centred dialogues into clinical and nursing practice, we need to reconsider what we base our dialogues on. The traditional healthcare communication has been subject to at least a century of adherence to a model based on behaviorist and mechanistic paradigms in that communication has been regarded as a linear process of information transfer between the sender and the receiver. This tendency is usually implemented in the form of scripted checklists and typical standards, according to which knowledge is provided by the health professional, and consumed by the patient. Although this model can certainly be functional, e.g., it can be key to maintaining consistency, safety and regulatory compliance, it is becoming clearer with every experiment, that it does not quite cut the ice where humanity is introduced, i.e., where people bring complexity, uncertainty, emotion, meaning making to the room.

This controlling linear model has its basis in the thought that communication is all about relaying of factual information. It is felt in the healthcare sector through statements such as, the patient was informed, or instructions were provided, not considering the fact that there is an automatic attainment of understanding after delivery. However, lived experiences and empirical evidence always show the shortcomings of such unidirectional approach, especially in emotionally-compelling or ethically-sensitive contexts. Communication is not only about facts; it is about connection, shared-understanding, co-construction. Accordingly, person-centred communication requires different theoretical frameworks - the ones which emphasize the aspects of relationality, mutual encounter, and responsiveness to context(6).

The four conceptual perspectives of communication that are described and critiqued in this paper provide four possible ways of looking at the concept of communication as applied to the nursing and health practice field; each of them has a particular set of prerequisites and assumptions that allow interpreting the controversies and peculiarities of interpersonal dialogue. They are not only theories to help the healthcare professionals form their own listening, talking and sharing, but it is a guide of how to do so.

3.1 Linear Transmission: The Old-Fashioned Default

The earliest and the deep rooted model is that communication is a mechanical process, through which information is delivered along a definite path between sender and receiver. This model is more concerned with clarity, rapidity and accuracy of the message whereas it does not care much about how context of the meaning is being received and what could be the emotional, cultural or thinking filters involved. This structure makes language a means of instruction or explanation and does not leave much space of a dialogue, ambiguity, and reflection. Although this model can be appropriate in individual situations, providing emergency instructions or talking about procedures, it is not flexible and sufficiently sensitive to resolve existential issues, relationships, or complicated chronic disorders.

The linear model is especially weak in situations where there is a vulnerable group of people this could be people with low levels of health illiteracy, people going through life changing diagnosis or end life care. The model ignores the importance of considering communication as bidirectional by looking at the interpretations, resistances, misunderstandings or emotional reactions of the patients to what is communicated. In that respect, it threatens to turn communication into a bureaucratic practice, as opposed to a human exchange.

3.2 Dialogical Relation: Not Talking but Talking With

The second perspective is the reaction of the limitations of the linear view it is based on opposing philosophy of Martin Buber who says that the ethical and existential implications about human communication. In Buber, real dialogue happens when people relate with each other in a totality mode, an I-thou relationship, not a relationship

of object to object, an it. In the medical field, this would translate into treating the patient as a person, with a story behind him and not an it to be handled.

This dialogic view encourages openness to one another, presence and listening. It also acknowledges that the clinician has their views, backgrounds, fears, and hopes and so do the patients. The professional does not want to dominate in the exchange and be in control but strives to create an environment where meaning is constructed collaboratively(7). This type of conversation is a way to hear the patient, validate him/her, and answer with the implication that it is not a sign of sympathy but the basis of building collaboration care planning and trusting relationships.

Nevertheless, the romanticized image of dialogue by Buber, which is frequently compared to friendship, casts doubt upon its use in business settings where the relationship between people is asymmetrical in its nature and limited by economic restrictions of the institution. Although health professionals might tend to aim at an authentic dialogue, the exigencies of time constraints, the hierarchies of the system and the limits of the clinic might complicate the possibility to sustain a long-term I-Thou relationship. However, the dialogical framework also becomes an essential antidote to depersonalised modes and an ethical ideal to which the clinical practice can be aspiring.

3.3 Constructivist Practice: Collaborative Means Making

The third and more modern approach to the communication is the co-constructive practice of communication and is based on social constructionist theory. With this model, it is possible to forget about fixed messages and focus on the mutual ground where people jointly create meaning. In this perspective, conversations are not only about telling out already formed ideas, but they are about constructing meanings through a continuous existence. The context of any exchange, the relations of participants, and the outer socio-cultural surrounding determine the actual meaning of this exchange.

This constructivist approach is of special value in a clinical environment. An example is that when the patients report about their symptoms, their language can be in the form of metaphors, emotional words, or cultural terms that need explanation. A clinician also has to follow up with the patient on the interpretation of these narratives rather than just translating these into medical codes. This may include asking rethinking questions, probing the beliefs and fears of the patient and improvising the conversation itself. Its chat is therefore unrestrictive and dynamic in a way- it is not a scripted dialogue(8).

The incorporation of others, including family members, caregivers, or peer support networks has also found a place in this model since other individuals can be able to influence sense-making processes of the patient. It acknowledges that the knowledge does not exist but it is negotiated and contextualized. In this perspective, health professionals are seen as zestful talkers of sense and mutual interpretation and not instructors of information.

3.4 Meaning-Making Dialogues: Community-Building Dialogue: Shared Belonging

The fourth point of view, which is the last according to the list, imagines communication as a social community-building exercise based on theories such as Etienne Wenger and his communities of practice. According to this approach, dialogue may be regarded not only as the exchange of information or an emotional support, but also as a kind of the way of forming a common identity, values, and belonging to oneself by the participants. The application in healthcare may be viewing it through group therapy, peer support group, patient association or even the online communities of health where communication leads to solidarity and mutual learning along with agency in the group sense.

This model occurs in the case of a one-on-one interaction in clinical environments when both the professional and the patient together are expected to make up a shared world, or a space where they both are regarded as co-participants in the process of care. This does not dissolve or diminish professional expertise or authority but it decenters it in favour of co-productive knowledge. An example is that a nurse can help a patient to change his/her way of life, however, the success of patient guidance is often conditioned by the level to which the patient is integrated into the process. This perception of collective involvement may boost motivation, confidence and compliance.

Furthermore, it is also the dominating view in situations of long-term care where relationships are maintained over time, and communication is no longer only the instrument in care control, but a core care component. As soon as patients are listened to, respected, and encouraged to participate, the process of illness may seem more bearable, and the process of care more human.

4. Typologies of Human-Centred Dialogue in Clinical Practice

As a vibrant environment, healthcare communication is not a neutral exchange, but rather an executively presented discourse that builds sense-making, confidence, emotional security, and the resolution. Although communication may be perceived as the so-called soft skill or a formality in procedures, through a person-centred perspective it can be viewed as profound practice in relation to its ethics, situational relevance, and building relationships. Having realized the manifestations of assortment of interactional requirements and aims in healthcare, it is vital to classify the varieties of conversations that most recurrently exist in clinical settings. This type of classification assists practitioners with the reflection of the approach and the adjustment of the communication tactics to the goals, emotional atmosphere and personal conditions of every interaction.

Using the constructivist, dialogic, and relational approach, there are five major categories of person-focused conversations in nursing, and health practice. All these have different purposes and interactional strategies, but they are flexible and tend to merge in the real-life situation. The knowledge of such typologies will help clinicians to develop spontaneous interaction, co-construction of meaning with the patient, the incorporation of technical expertise and emotional intelligence(9).

4.1 Exploratory Conversations: Naming Problems and Undertanding Misunderstandings

The problem-identifying conversation is the most common communication in healthcare, perhaps, because it is the first conversation that helps a healthcare provider to understand a patient situation, symptoms, concerns, and expectations. Although this discussion may be seen as rather common, as it is seen in a point of intake, assessment, or a clinical review, altogether, it is much more about the effect of the conversation itself. A pro forma conversation may appear like a form of interrogation, particularly when it is patterned and cast in a check-list. On the contrary, taken as a willing and interested dialogue, this discussion is the key to the world of a patient.

The process of effective exploratory conversation can be initiated with an open non directive question, which encourages the patient to speak freely. Clinicians ought not to jump into conclusions about what constitutes the so-called problem but rather attempt to get an understanding of the way the patient makes sense of what they are experiencing. An example would be out of a few questions that go, are you feeling pain here instead one would ask, what is worrying you today, or what has been challenging you recently? This re-description is not only the demonstration of the clinical problem but also its emotional and existential aspects.

Clinicians also ensure that they assist the patients to make sense of their condition. Metaphors, visual aids or analogies are some of the strategies that can help demystify abstract or complex information. As an example, surgeons could resort to models or sketches to show anatomical modifications or the result of surgery, which serves to ground the discussion on the patient and his or her own words and awareness of the body. These strategies encourage knowledge construction and support that the patient is competent to participate in his/her own care experience.

4.2 Instructional Conversations: Empathic teaching and relevance teaching

Didactic discussions form a major component of patient education especially when the patient is being trained on how to handle chronic illnesses, take medicine or operate function such as wound care practices or insulin injections. Instruction however, can easily turn off the energy after truncating to monologue or a mechanical form of transmission. An individual-centred didactic interaction makes the teaching situation a two-way communication process- influenced by readiness, experience and confidence, and the lived experience of the learner(10).

Instead of simply presenting instructions, the clinician does some sort of discussion questions, monitor understanding, set pace, seek questions, acknowledge what the learner already knows. Non-verbal cues, like the movement of the hands as in physiotherapy, or stressed speech, or silences, also form part of what constitutes instructional grammar. This bodily co-participation backs up the idea that it is not only a matter of learning compliance but also a matter of each other finding out and getting adjusted to each other.

Instruction according to this view is a relational process. It assumes that the patient can be insightful, change and reflect. Treating patients as learning partners makes clinicians recognize their independence, and gives them the confidence to act. Performed properly, such conversations are empowering processes, but not a passive, didactic exercise.

4.3 Supportive Conversations, Facilitating Reflection, Enhancing agency

The aim of supportive conversations is to help the patients go through difficult decisions, or emotional problems, or behavioral change. In comparison with teaching-based dialogues, these conversations are not task-centered but

aimed at making people to think about their experiences, compare them with their alternatives, and develop self-motivation.

Such type includes driving some, coaching, and cognitive-based approaches. As one example, a nurse treating a diabetic will be able to discuss his or her ideas of diet, anxieties over using insulin, or internal struggles regarding lifestyle alteration. The idea is to not convince someone, but to use his own logic and reasoning to find and use it. Such an approach is also characterized by the possibility of the clinician to listen and be non-obstructive, tolerate silence and keep to the emotional rhythm of a patient. The communication transforms into the mirror in which the patient can "hear" his or her thoughts. Popular strategies include summarizing what the patient is reflecting on, posing evocative questions or challenging counter-productive assumptions in a gentle manner. Such discussions respect the autonomy of the patient and provide a structure with respect to becoming clear and confident.

4.4 Caring Conversations: Providing Presence and Validation and Comfort

Caring conversations bring in a non-solution to recognize the emotional and existential situation of the patient. These interactions are characterized by their focus on presence, empathy and affirmation. They can either emerge informally in the waiting room, in hard situations at the bedside, or in formal planned therapeutic sessions. The main characteristic of them is an emphasis on presence in the context with the patient instead of performing actions to him or her.

The caring conversation is emotional in the sense of being attuned rather than only responding to words, but to the affects that are present, sensed, and channeled through the body. Other techniques that can aid in providing that message are eye contact, affirmative body language, providing silence, and compassionate touch (where it is appropriate).

On a philosophical level, such discussions can be connected to Martinsen differentiation between the registering gaze and the sensing gaze. the former is technical, assessment-based; the latter is social, compassion-based. That care will be richest when such gazes are kept in balance a balance in which the clinician is equally sensitive to symptoms heard and seen and able to recognize distress as well as to detect signal.

Other than tangible clinical results, such talks can be therapeutic to an unimaginable level. They have the potential to prevent or mitigate the feelings of loneliness and fear; they can also assist patients in recovering the lost sense of dignity due to their vulnerability.

4.5 Therapeutic Conversations: Building Change and Awareness

The fifth subtype is the therapeutic conversations, which is a specific niche, in which psychological and emotional healing, as well as cognitive restructuring, are involved. Based on psychotherapeutic and counseling traditions, these conversations are meant to assist patients to cope with trauma, dissolve inner conflict, and build healthy coping skills.

Therapeutic conversations differ with the supportive conversations in depth and intention. They frequently incorporate formal methods taken out of cognitive behavioral therapy, narrative therapy or other empirically supported methodologies. When a nurse with a background in therapeutic communication or a licensed mental health professional treats the patient, they assist him or her in branching out on his or her thoughts, their emotions, and behavioral trends.

More importantly, a therapeutic conversation is not based on providing solutions, but on helping one self-discover. The healer offers a secure container upon which hard feelings are expressed and reframed. This interaction itself is transformative, not because there is some text or other content but because there is the jointly constructed experience of empathy, trust and insight.

These dialogues enhance the idea that healing is more than a physical process; it is emotional, relational and narrative. Therapeutic encounter provides patients with opportunity to make meaning out of their suffering and to incorporate it into larger narrative of self.

5.Conclusion and Future work

Through such a re-approach to the role of communication in nursing and healthcare, it is clear that person-centred dialogue cannot be described as an optional extra of the good care provided, it is a core practice that marks the ethical and relational heart of healthcare. This theoretical inquiry has depicted how health communication has to shift away even further (than the linear interpretation of information sharing models) to models that recognize a sense of human contact along with cooperative meaning making and interconnected comprehension. Recognizing

the fact that patients are individuals rather than simply the objects of care requires an approach to acknowledge the agency of each patient, their vulnerability, and their narrative identity in every interaction taken place in clinics. With the considering of other views, dialogic communication, social constructionist practice, and community-building dialogue, we can have a broader idea of meaning co-creation in conversation. Such opinions provide an opportunity to remake the clinical encounter into a place where rather than teaching somebody about something (doctors to patients; patients to doctors), instead of this the place of mutual interaction is different stories, emotions, and hopes are told, received, and affirmed. Not only are such relational aspects ethically sound, but they are also practically effective: the more patients see themselves as being seen, heard, and respected, the more they have that sense of trust, treatment compliance, and well-being.

Moreover, the five primary forms of person-centred conversations identified match exploratory, instructional, supportive, caring, and therapeutic conversations which proves that dealing with healthcare has many different and intricate communicative forms. They all have different functions, but they are all founded on common values; the acknowledgement of the patient as a whole individual, the situation sensitivity of the encounter, and the relationship presence of the health professional. Such dialogue is not a mechanical thing; it is interactive, ever-changing, and it is highly contextualized to the emotional, cultural, and existential lives of the patients.

Significantly, change of setting towards person-centred communication also means a shift in epistemology, the idea of focusing on behavioural control by means of instruction, towards facilitating action by means of common understanding. This requires an ethical self-reflective position of the professional who has to constantly bargain institutional pressure, time limitations on the individual, and the uncontrollable aspects of the human experience. It also demands the reconceptualization of education practices and the curriculum so as to facilitate communicative competence in the form of paramount element of the professional growth.

Finally, person-centred approach to communication is not a definite approach but an ethical orientation. It asks healthcare providers to tune in to specifics of each individual they encounter, to be open to different layers of meaning, and to open up the room to stories that can make a difference. This is the healing process which is not merely the healing of the body, but the person as a whole and in his or her wholeness.

Acknowledgement: Nil

Conflicts of interest

The authors have no conflicts of interest to declare

References

1. Street RL Jr, Makoul G, Arora NK. How does communication heal? Pathways linking clinician–patient communication to health outcomes. Patient Educ Couns. 2009;74(3):295–301.
2. Epstein RM, Street RL. The values and value of patient-centered care. Ann Fam Med. 2011;9(2):100–103.
3. Mishler EG. The discourse of medicine: dialectics of medical interviews. Qual Health Res. 2005;15(8):1051–1067.
4. Ong LM, de Haes JC, Hoos AM. Doctor-patient communication: a review of the literature. Soc Sci Med. 1995;40(7):903–918.
5. Silverman J, Kurtz S, Draper J. Skills for communicating with patients. Radcliffe Medical Press. 2013;1(1):1–182.
6. Watzlawick P, Beavin JB, Jackson DD. Pragmatics of human communication: a study of interactional patterns, pathologies, and paradoxes. Norton. 1967;1(1):1–264.
7. McCabe R, Healey PG. Miscommunication in doctor–patient communication: a review of dialogue models. Patient Educ Couns. 2018;101(12):2166–2174.
8. Buber M. I and Thou. T&T Clark. 1937;1(1):1–120.
9. Arminen I. Institutional interaction: studies of talk at work. Ashgate Publishing. 2005;1(1):1–240.
10. Heritage J, Maynard DW. Communication in medical care: interaction between primary care physicians and patients. Cambridge University Press. 2006;1(1):1–420.