Received: 30 December 2022 | Revised: 13 February 2023 | Accepted: 1 March 2023

DOI: 10.1111/nup.12432

ORIGINAL ARTICLE

WILEY

Person-centred conversations in nursing and health: A theoretical analysis based on perspectives on communication

Joakim Öhlén PhD, RN, Professor, Centre Director[1] | Febe Friberg PhD, RN, Professor[2]

[1]Institute of Health and Care Sciences and University of Gothenburg Centre for Person-Centred Care, University of Gothenburg, and Palliative Centre, Sahlgrenska University Hospital Västra Götaland Region, Gothenburg, Sweden

[2]Faculty of Health Sciences, University of Stavanger, Norway, Stavanger

Correspondence
Joakim Öhlén, PhD, RN, Professor, Centre Director, Institute of Health and Care Sciences, University of Gothenburg, Box 457, SE-40530 Gothenburg, Sweden.
Email: joakim.ohlen@gu.se

Funding information
University of Gothenburg Centre for Person-Centred Care

Abstract

In this paper we use the concept of the person to examine person-centred dialogue and show how person-centred dialogue is different from and significantly more than transfer of information, which is the dominant notion in health care. A further motivation for the study is that although person-centredness as an idea has a strong heritage in nursing and the broader healthcare discourse, person-centred conversation is usually discussed as a distinct and unitary approach to communication, primarily related to the philosophy of dialogue—the philosophy of Martin Buber. In this paper we start with the concept of person to critically reflect on theoretical perspectives on communication to understand person-centred conversations in the context of nursing and health. We position the concept of the person through the use of Paul Ricoeur's philosophy and follow by distinguishing four theoretical perspectives on communication before reflecting on the relevance of each of these for person-centred communication. These perspectives are: a linear view of communication as transfer of information, communication as a relation in the sense of philosophy of dialogue, practice-based communication on constructionist grounds, and communication as a practice to create social community. In relation to the concept of the person, we do not find transfer of information relevant as a theoretical underpinning for person-centred conversations. From the other three perspectives that are relevant we distinguish five types of person-centred conversations pertinent to nursing and health: problem identifying conversations, instructive conversations, guiding and supportive conversations, caring and existential conversations, and therapeutic conversations. Through this analysis it is argued that person-centred communication and conversations are substantially different to transfer of information. We also discuss the significance of communication adjusted to specific situations, including emphasis on how we speak in relation to the aim or topic of a conversation.

KEYWORDS
communication, conversation, dialogue, health care, nursing, nursing philosophy, theoretical inquiry

1 | INTRODUCTION

Many people, in the role of patients, confirm that they do not feel like they are being taken seriously or are seen as the person they are. Health professionals of all categories may perceive themselves as being both sensitive and respectful, even though patients feel they have not been treated this way. The conditions in which meetings between patients, their families and professionals take place present challenges to all parties and put the patient in a particularly disadvantaged position. Simply having good intentions is not enough to act professionally. In addition to knowledge of the professional task at hand, the healthcare context, the patient's life situation, type of treatment and care forms and the professional mandate, knowledge is also required as to how the professional and organizational context influences the opportunity to communicate and talk. Knowledge and conversation skills are required that open up dialogue with the other person.

Following the millennium shift, in line with evidence-based practice, we recognize protocolized interventions as a means of improving communication in health care, implying prediction of standardized actions in practice is increasingly advocated (e.g., Curtis & White, 2008; Ilott et al., 2010). Consequently, the practice of conversation tends to be limited to the fact that one should be conducted with the patient (e.g., presurgery or at discharge) together with brief characteristics of the conversation practice without explicating *how* to perform the conversation. However, if the way in which a conversation is conducted is limited to a pre-cited task, there is a risk it becomes reductive. In our experience, openness and flexibility is characteristic of person-centred conversation and, in addition to what and how something can be said and communicated, the communicative situation itself and the immediate and wider context of the conversation often becomes very meaningful (see, e.g., Motschnig-Pitrik & Nykl, 2014) in ways that seek to avoid both stigmatization (cf. Leplege et al., 2007) and an idealizing and stereotyped view of the person. Equally, however, it may also reproduce stereotypes (Foth & Leibing, 2022; Imafidon, 2022; Smith et al., 2022; Tieu et al., 2022). Thus, person-centredness must be related to the circumstances and conditions of our time and can be seen as a centrally ethical positioning for the shaping of healthcare practice and promotion of health. Grounding person-centredness in ethics and philosophy of the person (Ekman, 2022; Jobe, 2022; Kristensson Uggla, 2022) makes the normative foundation accessible to critique.

Person-centredness is often described along with the attributes of being unique, being heard and having a shared responsibility, although a number of different terms are used, for example, patient-centredness, client-centredness (Feldthusen et al., 2022). Here we use 'person-centredness' to take the person as our starting point and to avoid, for example, confusing person-centredness with the view of putting the *patient* at the centre. In regard to person-centred communication, Buber's philosophy of relation (1997), the client-centred approach of Carl Rogers based in humanistic psychology (1961) and early nursing frameworks by Peplau (1952) and Travelbee (1971) have over the years been radical alternatives to linear communication perspectives, but these have perhaps had greater impact in nursing and healthcare education than in practice (apart from, e.g., individual and family therapy contexts). Still, an assumption for this study is that Buber's philosophy of dialogue has become the most central ideal for understanding person-centred communication, which then risks inhibiting the practice of person-centred conversation.

The aim, therefore, is to analyse how person-centred dialogue is different from and significantly more than transfer of information, and in so doing critically reflect on theoretical perspectives on communication to understand person-centred conversations in the context of nursing and healthcare practice. Specifically, we start from perspectives of the concept of 'person' to frame what person-centred communication may be and then outline the historical societal context for person-centred conversation. This provides a frame to highlight how the concept of person has become increasingly relevant today. The analysis puts forward four perspectives on communication that are important to consider for person-centred conversation, along with five types of person-centred conversation. Person-centred forms of conversation and communication are presented as something essentially different from the simple relay of information. Throughout, we focus on the importance of situationally adapted communication and how we converse in relation to the topic or aim of the conversation.

2 | FRAMING: BEING PERSON

What is meant by 'person' is a philosophical question. Because healthcare can historically be seen as organized on the basis of an emergency care model focusing on lack of function (e.g., Gustafsson, 1987), we draw on the view of a 'person' as someone who has both failings and abilities. The French philosopher Paul Ricœur (1992) has put forward such a multifaceted view, based in ethics. He starts with the view that a person is capable and obstruction of the 'being-able-to-act' (Ricœur, 1992, p. 190) entails suffering; thus, being the capable person involves suffering at the same time. These two words should then be seen as an expression of two diametrically opposed dimensions that we cannot avoid in life. Striving to meet patients and their families in this dichotomy can assist in avoiding traditional patterns in healthcare contexts that refrain from highlighting the patient's own ability to care for themselves, their willpower and other resources. However, in a healthcare situation we all present ourselves as patients, usually on the basis of what we cannot manage, what does not work or what we perceive is threatening our health or life. Thus, there is a risk that health professionals will only respond to the articulated need and do not enquire about the patient's wishes, preferences, resources, and so forth.

The philosopher Bengt Kristensson Uggla (2014, 2022) chooses to highlight the significance of this issue in healthcare by starting with the patient's three disadvantages. Firstly, in connection with

professional health care, the patient finds themselves at an *institutional disadvantage*. Encountering a healthcare service is an encounter with an institutional organization that is largely characterized by hierarchies, and in which the patient as end-user is at the bottom. Secondly, life situations connected to fears about failing health indicate an *existential disadvantage*. Kristensson Uggla adds a third dimension to this—the *cognitive disadvantage*—that is, the person needing and seeking health care does so because they do not have sufficient knowledge themselves to handle the problem in question. When we use the expression 'cognitive disadvantage', it is important to emphasize this is not the same thing as saying the person lacks the thinking ability to reflect or express their opinion. Rational ability is a gift to humans and a fundamental in life, regardless of the person's actual knowledge. Nevertheless, we cannot dismiss the fact that a person's usual ability to comprehend may become changed as a consequence of failing health and reaction to crisis. This may be termed functionally impaired health literacy[1] (e.g., Mårtensson & Hensing, 2012). The fact that a person may have different abilities from one occasion to the next presents ethical challenges in the person-centred conversation.

In everyday language, the words 'individual' and 'person' are often synonymous. However, even though we say animals have personality, the word 'person' is only used for humans. Social psychology has asserted that the historic change that made us 'persons' is to do with when we differentiated our way of life in relation to the collective (groups such as family and local community) and that this became increasingly important in tandem with the development of self and identity (Asplund, 1983). For example, during the historical period of the Enlightenment, the cognitive aspect of being human started to be emphasized and the body, which had previously been a natural part of the concept of person, became less clear. Thus, the definition of person became changed (Smith, 2010). This shows the concept of person has not always meant the same thing and that even now it can be culturally interpreted to vary in significance. Today, it is common for the word 'person' to be used to emphasize idiosyncrasies and uniqueness but historically it has been attributed to the persona in the sense of 'mask' and originally in the sense of a mask that the gentry might hold up in front of their faces. How we exhibit different facets of who we are, act in different roles and respond differently to the same questions depending on the situation and context can be likened to symbolically wearing different masks.

Using the word 'person' can be seen as a way of emphasizing both our sense of taking responsibility and our biography—that we have our own unique life story. And when we seek healthcare, it will impact on our life story in ways that are connected to our experiences (how we lived life before), the present situation and our future (such as hopes and fears). Nevertheless, we can never be certain that the person will be prepared to share who they perceive themselves to be—who they are. Sometimes, it can feel safer to keep the mask on or play a role. In the view of Asplund (1987) (based in symbolic interactionism) we can call the person[2] a product of social responsiveness, that is, the ability to bond and relate to another human and that 'it is in the everyday that we are ourselves' (p. 134). If our everyday lives are disrupted, as is often the case with illness, our identities are affected. According to Asplund, there is a risk that we will withdraw and become 'observers'. Ricœur (1992) might have attributed this to the dialectic of a person being both vulnerable and able to act—that being capable involves capacity to suffer. If this is related to the three disadvantages of the patient described earlier, the ethical challenge posed to health professionals is very clear. Nevertheless, person-centred conversation must communicatively address the other in these dimensions.

Thereto, we live in a very changeable society and world, which involves a societal context for conversations in health care which is hard to delimit. An information-dense and increasingly globalized and digitalized society exerts demands but also provides opportunities—and this is evident in medium and high-income countries but clearly limited in underprivileged groups. Special challenges include a risk of excluding the other based on difference (Imafidon, 2022). To try and pinpoint what this can mean, we turn to the North American sociologist Giddens (1997). Giddens maintains that people who are expected to take a stand and continually make choices affect how we see ourselves and our identity. We both influence and are influenced by the idea of belief in reason and belief in progress—what is traditionally called modernism. If we relate this to today's patient, they have greater freedom now than at the beginning of the 20th century. Today we have so many options and both patients and their families expect to be communicatively involved in a completely different way than before. E-health, virtual conversation, 'doctor on demand', patient-accessed e-journals and electronic patient and family self-assessment reporting can be seen as health policy ambitions to make health care more accessible to patients and their families and are therefore positive from a patient perspective. 'Being informed' in terms of health professionals conveying a message is not enough. This 'send-receive' metaphor (Reddy, 1993) is far too linear.

From a behaviourist perspective, communication as a transfer of information became the predominant model for large parts of the 20th century—a model that chiefly emphasizes the sender. A concrete example is phraseology, such as 'this patient has received information'. This has become an expression to show that we as health professionals are knowledgeable and speak clearly—overall a focus on health professionals—and led to the other in need of health care, to be hidden, obscure and marginalized as a person. It is this linear approach of the prevalent tradition in health care that no longer has explanatory power. A different perspective on communication is needed for conversation with patients and their families in a complex scenario of mutual expectations and requirements.

3 | PERSON-CENTRED CONVERSATIONS—SOME INITIAL FEATURES

An assumption that both health *professionals and patients are persons* is a statement of equality and reciprocity. Both have previous experience and knowledge and both may have hopes and fears

before, during and after the conversation. From Ricœur's (1992) view of the person and inter-personal communication, person-centred communication can be seen as a *shift from focusing on verbal statements to narrative* as the basis for a person to interpret and make sense of life and its circumstances and events, and equally for communicating meaning (see, e.g., Josephsson et al., 2022).

In our view, person-centredness is an approach that is clearly linked to perspectives put forward by Martin Buber (1993, 1997) and Carl Rogers (1961). In regard to Buber (1997) we can say that we try to meet each other in dialogue as *I* and *thou*.[3] In this way, we meet each other on the basis of *who* we are, with experiences that shape things like hopes and doubts that stem from our history and life situation. Thus, using the language of 'patient', 'care user' or 'client' simply points to *what* and not *who* is receiving health care. By *centring on the other*, the patient can relationally share their knowledge and experiences.

When the other is invited in and given opportunity to talk about their experiences, and these experiences are affirmed and perhaps challenged in dialogue, the other becomes a person. For this reason, in person-centred communication, openness is a feature:

Openess towards different communicative layers is at the core of person-centred dialogues between patients and providers. Beliefs and perceptions are sometimes embedded in the patient's story, and not clearly articulated, but still part of the communication. The professional must consider preparedness for additional or alternative explicit and implicit meanings. Awareness of the patient's logic in reasoning or way of understanding health-illness is thus of significance in dialogues (Öhlén et al., 2016, p. 217).

The healthcare team inviting the patient to be a partner in jointly planning and performing care can be seen as different to, for example, putting 'the patient in the centre'. This is not in opposition to the fact that we are 'bodies'. In a phenomenological sense, the *body is a field of expression for meaning* (Merleau-Ponty, 1995; Schutz, 1997). When a health professional listens to the patient's narrative, experiences and symptoms, they simultaneously observe things like the tone of voice, movements and hesitation. The same is true, of course, when the patient meets the gaze of the professional. It is the patient's narrative (and also many times the family's) that assists us as health professionals to go beyond a one-dimensional point of departure in signs of bodily functionality, which often characterizes our professional assessment of the patient's problem and situation.

The bodily fields of expression—that the person is always a body—is understood by the phenomenologist Alfred Schutz (1997) to mean that what the person says (speech) and does (actions) are indications of what they think in relation to something the body is expressing. Of course, what we can see does not have to be identical to what the patient thinks in this case. Bodies are not just subjective and limited—they direct themselves out in the room and form a field of expression (Merleau-Ponty, 1995; Schutz, 1997). Both the patient and the health professional are phenomenologically termed 'lived' bodies in this sense. The body is, among other things, a vehicle for our communication—it communicates something. It is through the body that the person is given access to the world. What a patient in a healthcare encounter speaks about can be interpreted as a mutually influential interaction developing between the body's signals of the patient and the health professional, and both interlocutors' interpretation of these signals. This interactively created understanding of the bodily experience may lead to new questions arising and being interpreted by the patient and health professional in their conversation. In this, the English pedagogue Peter Jarvis (2006) states there is potential for 'transformation of experience'. The conversation creates the opportunity to highlight experiences in some way that makes them visible and understood in a new or different way: learning takes place.

Attributes assigned to the concept of 'patient' (e.g., anamneses, signs, diagnosis, genetics) and 'person' (e.g., narrative, symptoms, experiences, resources) can cause us as health professionals to reflect on things we take for granted and scrutinize the 'categories' we often work with. In person-centred conversation, one particular intention is to give the parties the opportunity to meet each other with both resources and functional decline. While in some situations we are patients or care receivers, as people we are always persons. Thus, the aim of person-centredness is not to avoid terms like patient or care user, but to be reminded that anyone in the role of patient is always a person. It is not unusual for a person seeking care to see themselves as a patient in this situation, but they are still a person. Person-centredness is therefore more about assumptions and premises than choice of terms. In health care, it is an orientation to the patients' relations to self, significant others influencing their health (including family and informal carers) and health professionals, as well as the local and wider society.

Patients may nevertheless be selective about what they share in healthcare conversations. Sometimes the conversation is pitched at a general level, for example, when discussing national guidelines for diabetes care. At this third-person level, the conversation takes place without direct relation to personal experiences. Sometimes, the patient might want the conversation to take place in precisely this neutral manner and the professional must respect this. However, when the conversation becomes more dialogue focused, the patient and professional participate in the second-person level. Finally, the first-person level encompasses the person's inner reflections, which the patient can choose whether or not to share. With reference to Ricœur (1992), Smith (2016) states that *this* is what maximally demonstrates the person-centred conversation's ethical character and challenges.

Further, person-centred communication presupposes a problematization of the *immediate context* in the meeting between the health professional and patient. The conversation is 'created' between me and you, in a borderland that is not owned by either party. In this metaphorical no-one's-land, the conversation can be developed thanks to the ability to communicate. This is where listening to what the other has to say takes place—the narrative that expands into the shared conversation, how the other's ideas and experiences are reflected on, and so forth (see, e.g., Cederberg et al., 2022; Dahlberg & Ekman, 2017; Fors, 2014; Öhlén et al., 2016).

It is not only *what* is said and *how* it is said but also how the individuals position themselves *bodily* in relation to each other. The conversation can therefore be seen as *created interactively* and *intersubjectively*. This does not contradict the fact that patients sometimes choose (more or less consciously) to have the conversation on a more general level (third person level). There is a risk, however, that the patient does not share things that are important for the professional to be able to understand the problematics and situation. There is also a risk of falling into an information-relay focused conversation, in which the health professional speaks to the patient rather than converses with them (Pettersson et al., 2018).

4 | PERSON-CENTRED COMMUNICATION IN PERSPECTIVES

As previously stated, the prevailing perspective on conversation and communication in the practice of nursing and health care has been to convey information. We call this perspective a linear view of communication as transfer of information and this builds on the sender-message-receiver model (Figure 1a). Even though this view is still commonplace, it can be seen as contradictory to current policy for health care, which emphasizes patients' participation and the right to knowledge to participate in decisions about their care and treatment (e.g., Inkeroinen et al., 2022).

Another perspective usually associated with person-centred communication is communication as a relation in the sense of philosophy of dialogue (Figure 1b). In Martin Buber's, (1993, 1997) philosophy of relation, the Me (or It) meeting the You (or It) is about a mutual exchange between the two in the conversation, whereby a shared field of understanding is co-created around the dialogue partners. When we meet someone who has been in the same existential situation as us, it can move us in a way that creates favourable conditions for us to feel listened to, understood and affirmed, as might be the case when a person has been assaulted, lost a loved one in a traumatic event or experienced some kind of treatment. Buber's view of conversation might be considered an example of an early theoretical influence on conversation in nursing and health care, but it is questionable whether it is *the only* theoretical foundation, when we look at the current way in which

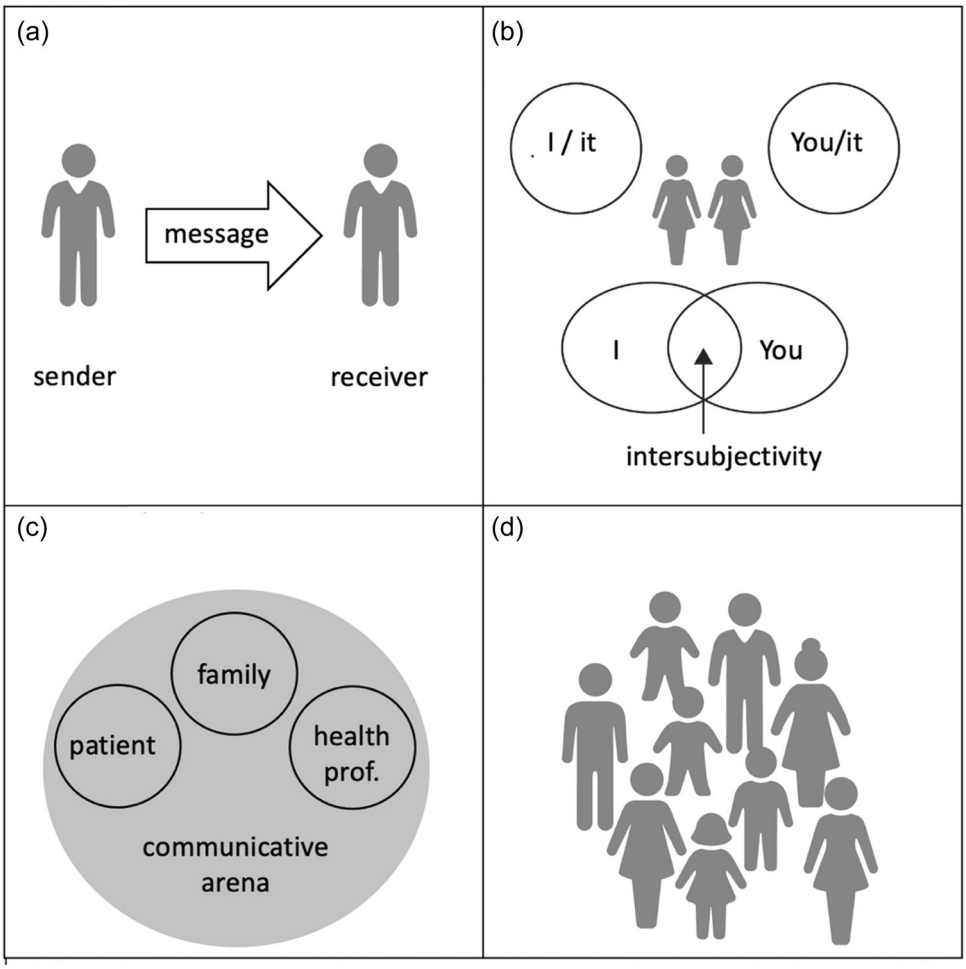

FIGURE 1 Four theoretical perspectives on communication of importance for conversations in nursing and health care.[4,5] (a) A linear view of communication as transfer of information. (b) Communication as a relation in the sense of philosophy of dialogue. (c) Practice-based communication on constructionist grounds. (d) Communication as a practice to create social community among the participants.

someone meets a health professional to seek help. Buber's view of communication presupposes a relationship that has greater similarity to a friendship than to a professional relationship.

The perspective Practice based communication on constructionist grounds (Figure 1c) emphasizes the co-created context in which the patient, family and health professionals meet. The space where these parties meet and communicate cannot be simply delimited—it is more like an open arena. To illustrate: the patient may refer to family (even though they are not present for the conversation) and to what they have learned from the internet, while health professionals might refer to informational support, guidelines and colleagues. From this perspective, conversation is assumed to have an uncertain point of departure, where all parties are influenced by each other. This can be risky in the sense that each person may come to understand something in a new way for them. Nevertheless, this perspective can be seen as meaningful and relevant to realize the patient's participation and to create opportunities for person-centredness on the patient's terms.

Here, a constructionist basis points to the fact that reality is socially constructed through words and deeds (Smith, 2010)—that as a person, I both influence and am influenced by the context I find myself in. The conversation is created due to our ability to respond to each other's words and actions—communication as co-created. Thus, conversation and reflection can be used to develop the skills necessary for managing, for example, life with a long-term illness (Zoffmann & Kirkevold, 2012; Zoffmann & Lauritzen, 2006; Zoffmann et al., 2008).

Starting from the person's experiences and ways of understanding especially comes to the fore, along with a number of conversation strategies: statement of the actual situation, reflection on possibilities and choices, shifting responsibility from the impersonal third person (one) to the first person (I), gaining inner strength and courage to master small and larger life undertakings, and a tactful and challenging stance from a holistic perspective (Berglund, 2012, 2014). Family members are often involved in relation to long-term conditions, which prompts making both patients and their families—in addition to health professionals—visible as actors in a conversational situation. Moreover, in conversations, several layers important to conversation can take place, and these may range from patients hovering from living in the wait to living in the present (especially in life-limiting situations) and health professionals considering evidence and ethics (Öhlén et al., 2016). Although sensitizing concepts for person-centred conversations are emphasized (such as the person's identity and self-determination, social relations, symptoms, retrospection on life context and forward-looking strategies) such concepts are often also followed by examples of questions that health professionals can use (Österlind & Henoch, 2021).

Yet another (constructionist) perspective that can be seen to add to the philosophy of dialogue model is seeing Communication as a practice to create social community among the participants (Figure 1d). This perspective stems from Wenger (1998) 'communities of practice' in which learning is seen as developing through engaging and sharing in different types of social communities. By 'doing' something together, a group that shares interests and activities (such as a patient association, blogger or other social media group) will create a social community and share a communicative understanding of what they are doing together.

Indeed, many are active in patient associations and social media, and through this sharing, they increase their knowledge and understanding of managing life with illness, or whatever the subject may be. Although these participants are meeting each other in a similar way to Me and You (Figure 1b) it is by communicating with each other that they create a community together, which in turn creates understanding and shared knowledge (Figure 1d). The person-centredness previously mentioned in relation to the meeting of people who have experienced similar existentially challenging situations (e.g., assault, a certain type of treatment or disease) are examples of this communication perspective.

In summary, these perspectives presuppose an epistemological shift from 'behaviour' to 'action' (Schutz, 1997). It may seem an exaggeration to point this out when many do equate behaviour with action. However, when conversation changes from a linear perspective to a dialogue-focused one, something special happens. In terms of communication, it means promoting the other's ability in communicative action: things like the ability to share stories, make sense, reflect, formulate arguments, put forward a standpoint, articulate experiences in words and turn insight into action. Seeing a consultation, for example, as an arena for constructing meaning presupposes an epistemology on constructionist grounds. This critically realistic perspective also presupposes that the individuals are understood as socially interactive and thus able to act (Smith, 2010). Although we have only highlighted four perspectives on communication (Figure 1), there are of course more. We have limited ourselves to these four because we see them as poignant to the problematization of views significant to communication in nursing and health care. From these described perspectives we can identify some generic characteristics of person-centred conversation (see Box 1).

BOX 1. Generic characteristics of person-centred conversation

- The parties to the conversation meet and act towards each other as persons.
- The person is seen as both able to act and be vulnerable, capable and suffering.
- The bodily field of expression (movement, gaze, voice) is seen as part of the conversation.
- The conversation is co-created.
- Communicative strategies are directed at what is being said, how the narrative is shaped, experiences, notions, resources, open question, bodily field of expression, listening.
- Each conversation takes place in a particular situation and context.

5 | TYPES OF PERSON-CENTRED CONVERSATIONS RELEVANT TO NURSING AND HEALTH CARE

The purpose of categorizing the different types of person-centred conversations (Table 1) is to describe those that commonly occur and are relevant to health care. As the table shows, these conversation types are not mutually exclusive but can be seen as overlapping. For example, focus and common strategies are generally the same for all five types of conversation. Consequently, it is *the purpose* of the conversation in combination with common strategies that makes it poignant and distinct from the other types of conversation. To demonstrate the complexity of the communication, we have provided examples (avoiding the obvious and simple) of each type of conversation. Our aim is to highlight person-centred communication as a multifaceted interprofessional field, not to create polarization between the different types of conversation or perspectives.

5.1 | Problem-identifying conversations

This type of conversation is probably the most common in health care. Arrival conversations before moving into special housing, hospital visits and outpatient consultations are some examples. It is not certain the patient will perceive such conversations as problem-identifying (they might experience it as interrogation) or that the health professional will show interest and appear knowledgeable, unless they have a conscious communicative strategy. To successfully identify the issues that are most important—for patients and their families as well as health professionals—it is important (at least initially) to avoid questions which are too narrow. Indeed, it is well-known that the answer to a question depends on how we ask it. It may therefore be critically important to pose open questions but the nature of the situation will often require focused questions to also be asked.

One example is a patient who seems anxious and worried. How health professionals perceive this is often determined by the character of the situation. An example of a focused question could be 'Is there something worrying you that you can tell me about?' or 'Is there something you think would help calm you?' but the situation will determine what is appropriate.

Identifying problems is often coupled with helping patients understand the nature of the problem and how it can be managed. In an intervention project on person-centred communication in connection with colorectal cancer surgery, a study was made of what surgeons did to get patients to understand changes in their bodies as a result of cancer (Friberg et al., 2015). The data consisted of audiotaped consultations and the analysis shows the surgeons had a clear ambition to identify the patient's understanding of the situation and its consequences for everyday life and continued treatment. The surgeons used a number of communicative strategies to help the patients understand, such as visualization and contrasting the position of the tumour and its appearance in the abdomen. They might also explain the feel of the tumour when they touched it during the operation (soft/hard, size) and its location in the abdomen (showing on X-rays, drawing it on paper, asking how it felt in the abdomen, showing and feeling the abdomen) to help the patient understand variations of how it feels ordinary (when you are not sick) compared to when you have a tumour in your abdomen. With the help of these clearly pedagogic strategies (which the surgeons seemed unaware that they were using) they centred the conversation on the patient's comments, questions and therefore openness to this existentially vulnerable situation. In the course of the conversation between patient and surgeon, the patient's questions and experience of the situation was mapped and any problems identified.

In a problem-identifying conversation (as with other person-centred conversations) it is important to identify the patient's way of understanding things. We can describe this as focusing on critical aspects of what the patient says. We cannot be certain the patient knows the position of the organs in the abdomen or how much space a tennis ball sized tumour takes if it is lying close to the liver. So, it is about helping the patient 'see' what the health professional is talking about. At the same time, it is about helping the patient understand variation in that a tennis ball sized tumour can reduce to the size of an egg. All of this is central to understanding and therefore central to learning (Hansson Scherman & Runesson, 2009) and to problem-identifying conversations. This is also an example of a problem-identifying conversation that might not always be considered to be one and that most closely ties in with the perspective on co-created conversation (Figure 1c). If such strategies are made explicit, health professionals may probably become more successful at identifying the problems that are most relevant to both patients and health professionals. Making these strategies visible as objects for problematization and learning is most likely pivotal for education and further training.

5.2 | Instructive conversations

The word instruction itself is often used for activities that promote learning of practical skills, and patient instruction often contains such elements. Traditionally, an instructive conversation has been focused on *how* the practical skill is carried out, as well as the various stages, for example, of correctly self-injecting insulin. This focus on *how* was often expressed as a message from health professional to patient and can be compared with a linear view of communication (Figure 1a). We can immediately see how this is problematic, as in a person-centred instructive conversation, the actual strategy (*how* to do it) cannot be separated from the content (*what* is to be instructed, *what* is to be learnt). Moreover, we must look at *who* the person is and *where* the conversing parties are (see, e.g., Friberg et al., 2007).

The question is what form the instruction, with its starting point in the patient as a person and assuming the person to be learning, will take. To illustrate, a study by physiotherapist Martin (2004, 2009) has shown how a patient with back pain should train to strengthen their muscles. When the patient raises their shoulder incorrectly, the

TABLE 1 Types of conversation of particular importance to person-centred conversation.[6]

	Problem-identifying conversation	Instructive conversation	Guiding and supportive conversation	Caring conversation	Therapeutic conversation
Type example	Admission conversation	Patient instruction: patient education	Patient instruction: care and treatment objectives	Comfort and affirm	Individual-, family-, art- and music therapy
Purpose	Map and analyse resources and problems	Promote learning, practical skills, readiness to act	Promote learning, insight, readiness to act	Promote wellbeing, comfort, mediate consolation	Explore notions, create meaning, support management, treat
Focus of the conversation	Narrative Experiences Notions Explanations Understanding	Experiences Notions Practical action Understanding	Narrative Experiences Notions Explanations Wishes	Narrative Experiences Notions Suffering; existential threat Understanding	Narrative Experiences Notions Understanding
Strategies	Listen Open questions Identify the problem/the patient's understanding Models Identify standpoints, resources and understanding Summarize Readiness to act	Listen Open questions Demonstrate Practise, test, reflect Identify and check understanding and sufficient action Reflect and summarize Readiness to act	Listen Open questions Identify goals, wishes Discuss options Resources Goals Understanding	Listen, Flexibility—follow and allow yourself to be followed Being present, sharing Open questions	Being present Open questions Listening, flexibility and confidence building Exploring the patient's notions Guiding the patient in discovering perspectives and reconsidering

movement has to be corrected for the fundamental problem of pain to be eliminated. The instruction is based on an interplay between patient and physiotherapist—when some aspect of the movement is wrong, the physiotherapist puts their hand on the patient's shoulder to alert them to the problem in the movement. According to Martin, the correction is a kind of attention focusing tool. The hand on the shoulder means something for both the physiotherapist and patient. Things like movements, speech, pauses, where your gaze is directed and the position of the body are meaningful in and for the conversation. Reflective questions can be posed, such as 'How are you sitting now?' or 'How does it feel when you hold your arm like that?' or 'What crossed your mind when I put my hand on your shoulder?' In this case, the patient is involved in the conversation in a bodily sense. Both parties are participants, observing each other and responding to one another both verbally and by pointing.

In the above, instruction is not linear in the sense that the patient only needs to demonstrate correct behaviour. The instructive element to the conversation presupposes that the physiotherapist ascribes certain abilities to the patient, such as thinking, reflecting and responding to something being done. Here, Martin is talking about participation because both parties are participating in an activity. Learning, which is often the aim of instruction, is then understood as a changed participation. Thus, the patient is understood to be capable. The instruction is co-created (Figure 1c) and not linear in the sense of 'sender-receiver' (Figure 1a).

5.3 | Guiding and supportive conversations

This type of conversation has various characteristics depending on the purpose. Advice-giving conversation, coaching conversation and motivating conversation—to name a few—have contributed to building important communicative competence in a whole host of health professions, for instance, specialist nurses in fields like diabetes, asthma and hypertension care. Even if such conversations are not always counted as person-centred ones, there are of course similarities. In a guiding conversation, finding out the other's/the patient's way of thinking and their notions is key. This is the focus of what is known as cognitive conversation and encompasses things like listening to understand the other person, opening up to their world of notions and guiding them to 'see' these and reconsider them (d'Elia, 2004). Guidance is often about helping the person to see different courses of action. Whether the conversation is labelled cognitive or not, it is important to open up to the person's thought pathways, otherwise it will be difficult to know what the conversation should focus on. Even if the cognitive aspect is communicatively central to a guiding conversation, we should factor in a number of other situational aspects that are important to consider. In one project, midwife consultations were studied (audiotaped consultations and interviews) as a communicative and relationship-creating arena for pregnant women with diabetes (Furskog Risa, 2017). The women visited the midwives every 14 days for guidance and to check their blood sugar levels and the progress of the pregnancy. Furskog Risa demonstrates that the communicative strategies of listening, chatting and 'abdominal palpation' create an interpersonal space for a shared view—an oasis of understanding for the existential and practically challenging situation the women find themselves in.

Listening to the hesitancy in the women's voices or their narratives was interpreted as an indication of the need for sharing and understanding in the situation. Chatting helped as a warm-up at the beginning of the consultations and certain expressions facilitated communication, such as a 'hmm' from the midwife, signalling she was giving the woman space to say something. When the midwife 'palpates the abdomen' to check the foetus, a kind of existential meaning is conveyed in expecting a baby and becoming a mother. In Furskog Risa, 2017 view, this bodily, 'hands-on' communicative activity opens up for the woman to share comments and questions, and for the midwife, palpating the abdomen (Leopold's manoeuvre) can be seen as a profession-specific communicative tool. This is an example of communicative strategies that are situationally adapted.

5.4 | Caring conversations

Caring in this sense means being sensitive to care-creating and comforting dimensions of a conversation that allow the other to feel seen and affirmed in ways that relieve, comfort and create presence and allow the parties to be themselves. Hence, a feature here is affirmation and confirmation and not necessarily expecting a change in the short-term perspective.

Such conversations may be planned in time or space or be spontaneous—initiated by patients, family or health professionals. It is especially important for health professionals to be observant of whether and how the patient expresses a desire to speak or comment on something. Listening and observing the body's field of expression is key. Also critical is the ability to listen in the sense of 'waiting' for the other—for example, using pauses, affirming body language and open questions without direct demands for explanations or similar. In the end, however, it is always the other who decides if the conversation is perceived as caring or not. Both conversations that aim to be caring and those without that aim can be caring.

To clarify what is meant by a 'caring dimension' of conversation, we turn to the philosopher Kari Martinsen (2000), who in simple terms explains that we can 'see' the other with chiefly two different and interrelated types of gaze: a registering one and a sensing one.

A registering gaze presupposes distance to the other to facilitate observation, analysis and professional assessment, for example, a health professional registering the patient's discussed symptoms and how they relate to their observed bodily movements, breathing pattern, pulse, and so forth. In contrast, a sensing gaze presupposes the distance to the other is reduced, almost eliminated, and that the carer is perceived to be meeting the other from a view of communication most akin to that of the philosophy of dialogue (Figure 1b). Here, it is about trying to understand meanings in the other person's way of seeing their situation, which makes insight and empathy key.

These two types of 'gazes' are not mutually exclusive. Indeed, both are crucial to what we consider a professional approach. However, Martinsen's (2000) historically critical perspective highlights how the registering gaze alone came to shape what is called the 'clinical gaze', which means the relevance and significance of the sensing gaze needs to be given special attention in today's health care. Being seen as a person in your existential situation can be described as encountering honesty that gives hope, encountering engaged listening, having continuity in trusting relationships and having your life view affirmed (Öhlén, 2001). It also means giving support for life on the other's terms (Nyström, 2003).

Fredriksson (2003) has developed what we see as the key to caring conversation from a suffering perspective, that is, from the meaning of a threat to the person's existence and that may be expressed and conveyed to others. For a more thorough description of this perspective on caring conversation, see, for example, Martinsen (2005) and Wiklund Gustin (2014) (also Arman & Rehnsfeldt, 2011; Santamäki Fischer & Dahlqvist, 2014), and Norberg et al. (2001) for mediation of consolation as caring. What these sources have in common is an ethical framework for communication and conversation, where focus is on the ethical issues of meeting and conversing with the other. For these forms of caring conversation, further perspectives on person-centred conversation can open up from those we began with: through communication as a relation in the sense of philosophy of dialogue, from a constructionist basis, or as a practice for creating social community among participants (Figure 1b–d). The perspective that best ties in depends on which communicative aspects are most productive to highlight.

For caring conversations, affirming suffering is our point of departure—it can be seen as the health professional affirming the other person's understanding of the existential threat perceived (e.g., Norberg et al., 2001). Even if it appears obvious to both parties that the other's picture of the existential threat is not the most fundamental threat, in order for care and comforting to be conveyed it is crucial the health professional does not make critical comments that cause that picture to crack. Instead, in some situations it can be productive for the suffering person to wear the 'mask' of a particular explanation of the existential threat that the person later rejects (e.g., Fredriksson, 2003). But before this happens, wearing a symbolic mask can be protective and help the person manage their vulnerable situation.

Symbolically setting the mask aside may involve a scenario such as this: 'just imagine, I've been longing to spend a week with the family on our boat so much but I've realized for a long time now that it will never be possible because of the way my illness has progressed, and that feels so sad and difficult'. Here, affirmation and provision of support in the person's suffering can be comforting—symbolically giving the other space to open up to the expanse of what is emotionally experienced as an existential threat. Affirming the other's suffering is key. However, we cannot say what is most appropriate to say—it depends on the situation. Meeting a fellow human in existentially vulnerable situations involves a degree of uncertainty that requires sensitivity to what is the most appropriate response. Perceiving and recognizing expressions of existential threats in the other person are essential, as are carefully interpreting and trialling your interpretations without taking for granted what you have perceived to be the most important and meaningful to the other person. Here, the perspective of conversation as a practice to create social community among participants (Figure 1d) can be illuminating, as it emphasizes the conversational parties as the ones who can mutually explore and understand how best to perceive a situation.

5.5 | Therapeutic conversations

Traditions of therapeutic person-centred conversation can be traced to the client-centred, therapeutic approach of Rogers (1961). Therapeutic conversation is a multifaceted field, wherein cognitive therapy and psychotherapy can be included. Supporting a person in managing life's problems and simultaneously helping to change patterns of thought and action in relation to the original problem is central to therapeutic conversation (Berge & Repål, 2015). Hence, creating change can here be regarded a feature and a difference from caring conversions.

A particular emphasis is sensitivity to what the person is talking about—capturing elements that are central to the narrative, empathetically affirming what is happening in the conversation 'right now'. A therapeutic effect has to do with the therapist/conversing person having conscious strategies that make the client see themselves and/or their perceived problem differently in some way. This, among other things, is what Carl Rogers (1961) describes in his book *On becoming a person*. The alliance between patient and therapist, as well as relational factors, is highlighted as important for experiencing that they share a conversational space where feelings, thoughts and frustrations are accepted. One therapeutic effect of conversation is to be personally moved. In our view, the variations in conversation that are said to be therapeutic in character are person-centred. There is a long tradition of therapeutic conversation and an extensive field of practice, theory and research. Cognitive therapy (Perris, 1986) has been developed and is used in several fields, both as a special clinical method (e.g., Miller & Rollnick, 2013) and as a tool in, for example, nursing (Wiklund Gustin, 2012). However, we are not addressing this type of conversation in detail here but would refer to the specialist literature.

6 | CONCLUDING REFLECTIONS

The significance of person-centredness has been covered in the ethics of Ricœur and the historical background of the concept of person. On this basis we have analysed central aspects of, and for, person-centred conversation. The perspectives on communication we are highlighting aim to clarify the complexity of person-centred conversation in nursing and health care. The sender-message-receiver model from a linear view of communication has been used to contrast with person-centred communication. The remaining three perspectives highlight how person-centredness can be expressed in conversation from starting points in philosophy of dialogue and constructionism. For person-centred conversation on constructionist grounds, we have identified conversation in the

meeting between patients and health professionals as a practice for creating social community among participants (see Figure 1).

In our view, one change that has occurred and that is advantageous to these perspectives is an epistemological change from seeking knowledge for predicting and controlling behaviour to knowledge of how a person's actions in a situation can be interpreted and addressed. This makes the previously predominant linear view of communication as transfer of information all the more problematic.

Finally, the five different types of person-centred conversation we have discussed all point to the opportunities and challenges of person-centred conversation. They point to generic characteristics of person-centred conversation, that is, common features of problem identifying-, instructive-, guiding-, caring- and therapeutic conversation from a person-centred standpoint. Our analysis shows all of these rest on the same assumptions of humans as persons. This put demands on the health professional to unite ethics and communication. Continued analysis of person-centred conversation is necessary with various points of departure.

ACKNOWLEDGEMENTS

This article is based on a previously published chapter in Swedish entitled Personcentrering—samtal och kommunikation (Person-centredness—dialogues and communication) by Joakim Öhlén & Febe Friberg in 2019 in an edited volume by Björn Fossum, Ed.: *Kommunikation—samtal och bemötande i vården* (*Communication— dialogues and approaches in health care*) published by Studentlitteratur. Replicating parts of the chapter has been approved by the publishing company Studentlitteratur (Publisher Peter Stoltz). A special thank you to Professor Catherine Green, who provided constructive and valuable feedback when the study was presented at the 25th International Philosophy of Nursing Society Conference in August 2022 and for a previous version of the manuscript. The study was supported by the University of Gothenburg Centre for Person-Centred Care: GPCC, University of Gothenburg, Sweden. GPCC is funded by the Swedish Government's grant for Strategic Research Areas (Care Sciences) and the University of Gothenburg, Sweden.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflict of interest.

DATA AVAILABILITY STATEMENT

Data sharing is not applicable to this article as no new data were created or analysed in this study.

ENDNOTES

[1] Health literacy is here understood as a functional ability that can vary in relation to a number of factors, for example, changes in disease, the care experience, crisis reactions and suffering in the sense of existential threat.

[2] Asplund (1987) also uses the terms 'individual' and 'ego'.

[3] Buber's concept of 'I/thou' will be more practically referred to in our context as 'me and you'.

[4] Originally in Öhlén and Friberg (2019, p. 167).

[5] Originally in Öhlén and Friberg (2019, p. 170).

[6] Originally in Öhlén and Friberg (2019, p. 172).

REFERENCES

Arman, M., & Rehnsfeldt, A. (2011). *Vårdande som lindrar lidande: etik i vårdandet* (2nd ed.). Liber.

Asplund, J. (1983). *Tid, rum, individ och kollektiv*. Liber Förlag.

Asplund, J. (1987). *Det sociala livets elementära former*. Korpen.

Berge, T., & Repål, A. (2015). *Håndbok i Kognitiv terapi*. Gyldendal.

Berglund, M. (2012). *Lärande vid långvarig sjukdom: utmaningar för patient och vårdare*. Gleerups.

Berglund, M. M. U. (2014). Learning turning points—in life with long-term illness—visualized with the help of the life-world philosophy. *International Journal of Qualitative Studies on Health and Well-Being*, *9*(1), 22842.

Buber, M. (1993). *Dialogens väsen*. Dualis.

Buber, M. (1997). *Jag och du*. Dualis.

Cederberg, M., Fors, A., Ali, L., Goulding, A., & Mäkitalo, Å. (2022). The interactive work of narrative elicitation in person-centred care: Analysis of phone conversations between health care professionals and patients with common mental disorders. *Health Expectations*, *25*, 971–983. https://doi.org/10.1111/hex.13440

Curtis, J. R., & White, D. B. (2008). Practical guidance for evidence-based ICU family conferences. *Chest*, *134*(4), 835–843.

Dahlberg, K., & Ekman, I. (Eds.). (2017). *Vägen till patientens värld och personcentrerad vård. Att bli lyssnad på och förstådd*. Liber.

d'Elia, G. (2004). *Det kognitiva samtalet i vården*. Natur & Kultur.

Ekman, I. (2022). Practising the ethics of person-centred care balancing ethical conviction and moral obligations. *Nursing Philosophy*, *23*, e12382.

Feldthusen, C., Forsgren, E., Wallström, S., Andersson, V., Löfqvist, N., Sawatzky, R., Öhlén, J., & J. Ung, E. (2022). Centredness in health care: A systematic overview of reviews. *Health Expectations*, *25*, 885–901. https://doi.org/10.1111/hex.13461

Fors, A. (2014). Personcentrerade samtal inom hälsopromotivt arbete. In I. Ekman (Ed.), *Personcentrering inom hälso- och sjukvård: från filosofi till praktik* (pp. 226–244). Liber.

Foth, T., & Leibing, A. (2022). Rethinking dementia as a queer way of life and as 'crip possibility': A critique of the concept of person in person-centredness. *Nursing Philosophy*, *23*(1), e12373.

Fredriksson, L. (2003). *Det vårdande samtalet* (Diss.). Åbo Akadademi.

Friberg, F., Lidén, E., Håkanson, C., & Öhlén, J. (2015). Communicating bodily changes: Physicians' ways of enabling patient understanding in gastrointestinal cancer consultations. *Palliative & Supportive Care*, *13*(3), 661–671.

Friberg, F., Pilhammar Andersson, E., & Bengtsson, J. (2007). Pedagogical encounters between nurses and patients in a medical ward—A field study. *International Journal of Nursing Studies*, *44*(4), 534–544.

Furskog Risa, C. (2017). *Communication in midwifery consultations in specialist antenatal care—pregnant women with diabetes and their midwives* (Diss.). Faculty of Arts and Education, Universitetet i Stavanger.

Giddens, A. (1997). *Modernitet och självidentitet. Självet och samhället i den senmoderna epoken*. Daidalos.

Gustafsson, R. Å. (1987). *Traditionernas ok: den svenska hälso- och sjukvårdens organisering i historie-sociologiskt perspektiv* (Diss. Göteborgs Universitet, 1988). Esselte Studium.

Hansson Scherman, M., & Runesson, U. (2009). Som patienten ser det. In M. Hansson Scherman, & U. Runesson (Eds.), *Den lärande patienten*. (pp. 87–113). Studentlitteratur.

Ilott, I., Booth, A., Rick, J., & Patterson, M. (2010). How do nurses, midwives and health visitors contribute to protocol-based care? A synthesis of the UK literature. *International Journal of Nursing Studies*, *47*(6), 770–780.

Imafidon, E. (2022). Beyond continental and African philosophies of personhood, healthcare and difference. *Nursing Philosophy*, *23*, e12393.

Inkeroinen, S., Virtanen, H., Stolt, M., & Leino-Kilpi, H. (2022). Patients' right to know: A scoping review. *Journal of Clinical Nursing*, 1–14. https://doi.org/10.1111/jocn.16603

Jarvis, P. (2006). *Towards a comprehensive theory of human learning*, Routledge.
Jobe, I. (2022). Reflections of the collaborative care planning as a person-centred practice. *Nursing Philosophy*, *23*, e12389.
Josephsson, S., Öhlén, J., Mondaca, M., Guerrero, M., Luborsky, M., & Lindström, M. (2022). Using Ricoeur's notions on narrative interpretation as a resource in supporting person-centredness in health and social care. *Nursing Philosophy*, *23*, e12398.
Kristensson Uggla, B. (2014). *Homo capax*. Daidalos.
Kristensson Uggla, B. (2022). What makes us human? Exploring the significance of ricoeur's ethical configuration of personhood between naturalism and phenomenology in health care. *Nursing Philosophy*, *23*, e12385.
Leplege, A., Gzil, F., Cammelli, M., Lefeve, C., Pachoud, B., & Ville, I. (2007). Person-centredness: Conceptual and historical perspectives. *Disability and rehabilitation*, *29*(20–21), 1555–1565. https://doi.org/10.1080/09638280701618661
Mårtensson, L., & Hensing, G. (2012). Health literacy—a heterogeneous phenomenon: A literature review. *Scandinavian Journal of Caring Sciences*, *26*(1), 151–160.
Martin, C. (2004). *From other to self: Learning as interactional change*. (Diss.). Pedagogiska institutionen, Uppsala Universitet.
Martin, C. (2009). Lärande som förändrat deltagande. In M. Hansson Scherman, & U. Runesson (Eds.), *Den lärande patienten* (pp. 63–86). Studentlitteratur.
Martinsen, K. (2000). *Øyet og kallet*. Fagbokforlaget.
Martinsen, K. (2005). *Samtalen, skjønnet og evidensen*. Akribe.
Merleau-Ponty, M. (1995). *Phenomenology of perception*. Routledge.
Miller, W. R., & Rollnick, S. (2013). *Motiverande samtal: att hjälpa människor till förändring* (4:esvenska uppl). Natur & kultur.
Motschnig-Pitrik, R., & Nykl, L. (2014). *Person-centred communication: Theory, skills and practice*. Open University Press.
Norberg, A., Bergsten, M., & Lundman, B. (2001). A model of consolation. *Nursing Ethics*, *8*(6), 544–553.
Nyström, M. (2003). Ett liv på egna villkor: vård och omsorg vid psykiska funktionshinder. Stockholm: Natur & Kultur.
Öhlén, J. (2001). Lindrat lidande: att vara i en fristad: berättelser från palliativ vård (2. uppl.). Diss. Göteborgs Universitet 2000. Nya Doxa.
Öhlén, J., Carlsson, G., Jepsen, A., Lindberg, I., & Friberg, F. (2016). Enabling sense-making for patients receiving outpatient palliative treatment: A participatory action research driven model for person-centered communication. *Palliative & Supportive Care*, *14*(3), 212–224.
Öhlén, J., & Friberg, F. (2019). Personcentrering—samtal och kommunikation [Person-centeredness—dialogues and communication. In Björn Fossum (Ed.), *Kommunikation—samtal och bemötande i vården [Communication—dialogues and approaches in healthcare* (pp. 157–184). Studentlitteratur. (in Swedish).
Österlind, J., & Henoch, I. (2021). The 6S-model for person-centred palliative care: A theoretical framework. *Nursing Philosophy*, *22*(2), e12334.
Peplau, H. E. (1952). *Interpersonal relations in nursing: A conceptual frame of reference for psychodynamic nursing*. G. P. Putnam's Sons.
Perris, C. (1986). *Kognitiv terapi i teori och praktik*. Natur och kultur.
Pettersson, M. E., Öhlén, J., Friberg, F., Hydén, L. C., Wallengren, C., Sarenmalm, E. K., & Carlsson, E. (2018). Prepared for surgery—communication in nurses' pre-operative consultations with patients undergoing surgery for colorectal cancer after a person-centred intervention. *Journal of Clinical Nursing*, *27*, 2904–2916.
Reddy, M. (1993). The conduit metaphor: A case of frame conflict in our language about language. In A Ortony (Ed.), *Methaphor and thought* (pp. 164–204). Cambridge University Press.
Ricœur, P. (1992). *Oneself as another*. University of Chicago Press.
Rogers, C. (1961). *On becoming a person: A therapist's view of psychotherapy*. Houghton Mifflin Company.
Santamäki Fischer, R., & Dahlqvist, V. (2014). In F. Friberg & J. Öhlén (Eds.), *Omvårdnadens grunder. Perspektiv och förhållningssätt* (2nd ed., pp. 297–321). Studentlitteratur.
Schutz, A. (1997). *The phenomenology of the social world*. Northwestern University Press.
Smith, C. (2010). *What is person*. University of Chicago Press.
Smith, F. (2016). *Patient education materials from a person-centred perspective: Coping and co-design in colorectal cancer care* (Diss.). Göteborgs Universitet.
Smith, J. B., Willis, E. M., & Hopkins-Walsh, J. (2022). What does person-centred care mean, if you weren't considered a person anyway: An engagement with person-centred care and Black, queer, feminist, and posthuman approaches. *Nursing Philosophy*, *23*, e12401.
Tieu, M., Mudd, A., Conroy, T., Pinero de Plaza, A., & Kitson, A. (2022). The trouble with personhood and person-centred care. *Nursing Philosophy*, *23*, e12381.
Travelbee, J. (1971). *Interpersonal aspects of nursing* (2nd ed.). Davis.
Wenger, E. (1998). *Communities of practice: Learning, meaning, and identity*. Cambridge University Press.
Wiklund Gustin, L. (2012). *KBT i omvårdnadsarbetet: om meningsskapande i gemenskap*. Studentlitteratur.
Wiklund Gustin, L. (2014). Lidande – en del av människans liv. In F. Friberg, & J. Öhlén (Eds.), *Omvårdnadens grunder. Perspektiv och förhållningssätt* (2nd ed., pp. 269–295). Studentlitteratur.
Zoffmann, V., Harder, I., & Kirkevold, M. (2008). A person-centered communication and reflection model: Sharing decision-making in chronic care. *Qualitative Health Research*, *18*(5), 670–685.
Zoffmann, V., & Kirkevold, M. (2012). Realizing empowerment in difficult diabetes care: A guided self-determination intervention. *Qualitative Health Research*, *22*(1), 103–118.
Zoffmann, V., & Lauritzen, T. (2006). Guided self-determination improves life skills with type 1 diabetes and A1C in randomized controlled trial. *Patient Education and Counseling*, *64*, 78–86.

How to cite this article: Öhlén, J., & Friberg, F. (2023). Person-centred conversations in nursing and health: A theoretical analysis based on perspectives on communication. *Nursing Philosophy*, e12432. https://doi.org/10.1111/nup.12432