

## **How could discourse theories of identity formation critically engage patient-centred care in older adults?**

### **Abstract**

**Purpose** – The purpose of this paper is to explore how discourse theories can contribute to the concept of identity formation within a patient- or person-centred care (PCC) orientation, to enable more critical engagement with PCC in older people.

**Design / methodology / approach** – Conceptual paper

**Findings** – This paper concludes that the discourse literature has important insights for understanding identity formation in older people as operationalized in the context of PCC in three particular ways:

- 1) Accounting for multiplicity in patients' identity
- 2) Exploring 'the devolution of responsibility' to address shifts in performing identities in clinical encounters
- 3) Attending to a 'crisis of positioning' to engage empowerment discourse within a PCC philosophy

**Originality/value** – Whilst a notion of patient identity is at the heart of PCC, the concept remains inconsistent and underdeveloped. This is particularly problematic for the quality of care in older adults, as PCC has become increasingly synonymous with care of older people.

Discourse theories of identity formation can be used to critically engage with identity within the

context of PCC, so as to develop more nuanced understandings of ‘the person’ or ‘the patient’, with the potential to improve research into care for aging and older adults.

**Keywords** Patient-centred care, person-centred care, discourse, identity, empowerment, care of older people

**Paper type** Conceptual paper

## Introduction

Patient- or person-centred care (PCC) is a long-standing, commonly used concept in primary and secondary care (e.g. McCracken *et al.*, 1983; Stewart, 2001; Mead and Bower, 2000; McCormack and McCance, 2006). PCC aims to address problems caused by the separation of the person as patient into mental and physical components (Salmon and Hall, 2003), and in many ways embodies attempts to improve the experience of healthcare by addressing overly disease- or system-focused approaches (Entwhistle and Watt, 2013). The origins of PCC can be traced to Kitwood's (1997a) concept of 'personhood' in the care of people with dementia, understood within an ethical frame as a status accorded to an individual by others, and constituted in "a living relationship with at least one other" (Kitwood, 1997b: 11). PCC and 'personhood' are key concepts of policy and practice in efforts to improve the care of people with dementia (e.g. NICE, 2006), older people generally (Department of Health, 2001), and other patient groups e.g. people with learning disabilities; or people in end-of-life-care (Health Education England, <https://www.hee.nhs.uk/our-work/person-centred-care>). 'Patient' is often used interchangeably with '[whole] person' (e.g. Kogan *et al.*, 2015; Dwamena *et al.*, 2012; Pulvirenti *et al.*, 2011; McCormack and McCance, 2006), but 'client' or 'consumer' (e.g. Pulvirenti *et al.*, 2011) are often used, and PCC generally emphasizes the importance of attending to patients' subjective experiences of illness (McCormack, 2003), individual characteristics, preferences and needs (Dubbin, Chang and Shim, 2013; Jayadevappa, 2017), and promotes patients' active participation (Epstein and Street, 2011). While PCC has become increasingly regarded as synonymous with best-quality care for older people (Edvardsson *et al.*, 2010; Kogan *et al.*, 2015; McCormack *et al.*, 2010), especially relevant in addressing multi-morbidity (Kogan *et al.*, 2015; Jayadevappa, 2017), and co-ordination of services for older adults with complex needs (Sendall

*et al.*, 2016), it remains “abstract and vague” (Edvardsson *et al.*, 2010: 1). For example, Entwistle and Watt (2013) and Epstein and Street (2011) suggest that the term PCC can become confused or misleading, and enacted in ways that are “superficial and unconvincing” (Epstein and Street, 2011: 101) with health care providers tending to conceptualize PCC in terms of ‘processes’, which can be packaged and trained in order to produce “demonstrable improvements in health and/or reduces the costs to health services of achieving such improvements” (Entwistle and Watt, 2013: 31).

The discourse of the empowered patient taking an active role has become prominent in health care research and practice (Kreindler, 2013; Salmon and Hall, 2003). Whilst the concept of discourse is contested within the field, discourse theory generally assumes that the meaning of objects and actions are conferred by historically specific systems of rules, or “orders of discourse” that constitute their meaning and significance (Howarth and Stavrakakis, 2000: 3). Thus, ‘discourse’ here may be understood as systems of meaningful practices that work to form the identities of objects and subjects (Howarth and Stavrakakis, 2000). As such, issues of identity formation, and the production of ideologies and logics through which these are structured are central objects of investigation for discourse theorists. The identity of the ‘empowered patient’ for example is constituted by ‘orders of discourse’, be they neoliberal (‘consumerist’) or public health risk (‘self-management’), which produce its meaning and significance. Such discourses are key to constructing ways of thinking about the world, and importantly, also entail assumptions about what is knowable, appropriate and desirable (Crowther, 2000). How identities and practices are formed and performed relates to dominant discourses, which are themselves not static, but rather continually evolve as “systems of possibility which create knowledge” (Crowther, 2000: 480).

In terms of ageing and the older person's identity, choice, autonomy and control may be strongly idealized in the discourses which shape and constitute PCC practices, as conceptualised within an active, healthy and productive 'third age' (Gilleard and Higgs, 2013). However, later life has become "a larger more varied space within individual lives and within society, one indirect consequence [of which] has been to push the darker side of ageing into the shadows...the fourth age represents old age as failure" (Higgs and Gilleard, 2016a: 2). As these authors argue, the fourth age "operates as a set of often unstated but powerful assumptions concerning the dependencies and indignities of 'real' old age" (Gilleard and Higgs, 2013: 369). In more recent developments researchers and practitioners have sought to understand and enact the social repositioning of people with dementia in ways that are re-shaping opportunities for active involvement in communities of care, thus resisting "the despair of the fourth age" (Poland and Birt, 2016: 771). Moving into the fourth age may involve acceptance of increasing frailty, uncertainty and ambiguity – liminal states (see Birt *et al.*, 2017; West *et al.*, 2017) – but there is also a recognition that alternative conceptual frameworks exist, which provide for a discourse of agency and interdependence (Birt *et al.*, 2017).

In line with the ambition of putting people at the centre of their own health care, 'personhood' or 'patient identity' is undoubtedly a key concept (Pulvirenti *et al.*, 2011; Ferguson *et al.*, 2013), variously expressed in terms of biography and personal narrative (e.g. Kitwood, 1997a), or a sense of self, beliefs and values (e.g. Gershater and Forbes, 2013; Mead and Bower, 2000; McCormack and McCance, 2006), but is one which remains relatively under-conceptualized (Dubbin *et al.*, 2013; Edvardsson *et al.*, 2010; Jesus *et al.*, 2016; Kogan *et al.*, 2015) and unevenly enacted across different professional groups and contexts (Kitson *et al.*, 2013). Higgs and Gilleard (2016a) argue that Kitwood's position that "personhood is an attribute of

relationships, not of capabilities” (p.24), fails to address key components of personhood, namely “agency and autonomy, consciousness and memory, self-hood and personal identity” (Higgs and Gilleard, 2016b: 774). Literature from the field of discourse studies has highlighted important recent changes in the meaning and operationalization of the concept of ‘identity’. The loss of stability and certainty in social life that has resulted from rapid reconstitutions, and associated conduct, in interpersonal, social and organizational spheres (see Caldas-Coulthard and Iedema, 2008) has entailed an ‘identity crisis’, as actors must negotiate increasingly ambiguous scopes of responsibility and involvement across a range of social landscapes, from workplace organization, to education and health care. We suggest that insights offered into the notion of ‘identity’ from discourse scholarship have important implications for the operational concept of ‘patient identity’ in the field of PCC, particularly with regards to PCC in the care of older people.

In this paper we first consider three key ways in which PCC configures patient identity in the care of aging and older adults, highlighting how ambiguities inscribed in the concept have troubling implications that appear to undermine the very goals that PCC claims to espouse. We explore: troubles arising from a particular and restricted view – a unitary imagining – of patient identity in PCC; the ways in which power structures in the clinical encounter are made invisible; and identity crises associated with ‘empowerment’. We go on to discuss discourse theories of identity formation, selected for their promising theoretical potential for engaging with PCC in older adults, as well as potential pitfalls of using discourse theorization of identity in engaging PCC in older adult care. We conclude by considering directions for empirical research in PCC using discourse theory, and suggest how discourse theories of identity formation might be used to practically engage with identity for aging and older adults.

### *Multiplicity of patients' identity in PCC for older people*

The PCC literature has tended to present a unitary imagining of patient identity, comprising a particular and restricted view, with consequent risk of deterministic qualities. Kogan *et al.*, (2015) found that the current system of medical care fails to address the individual preferences and diverse needs of older adults with chronic illnesses and functional limitations. Inconsistent conceptualizations of patient identity are apparent, with studies tending to privilege either agentive or structural factors in their assumptions about patients' identity (e.g. Kitson *et al.*, 2013). Pulvirenti *et al.* (2011) for example, show how individualist assumptions are embedded in PCC's concept of patient identity, asserting that "individual patients are characterized as simultaneously and uniformly uninformed, but (with the right information) capable of autonomy" (p.309). These authors conclude that the current concept of patient identity fails to address structural factors and the social context in which self-management takes place (see also Henwood *et al.*, 2003). On the other hand, de Boer *et al.* (2013) note that Mead and Bower (2000) distinguish five key dimensions of PCC (a bio-psychosocial perspective; the doctor as person; the patient as person; sharing power and responsibility; therapeutic alliance), all of which are seen to emerge within the doctor-patient relationship. In this way, it seems that current PCC literature has been variously seen to rely too heavily on a concept of identity that sees 'patient identity' as either emerging directly from the clinical encounter, or being pre-constituted and then brought to bear in this encounter.

Issues of agency and the ethical principles of autonomy (Mendick *et al.*, 2010; Varelius, 2006) become increasingly complicated when faced with the application of PCC to adults with dementia, where deficits in memory, attention, language use and executive function may impact on an individual's agency, awareness and reasoning (Higgs and Gilleard, 2016b). In care for

people with dementia, the concept of person-centredness is being increasingly advocated in clinical practice as a way to acknowledge the ‘personhood’ of patients in all aspects of their care (e.g. Edvardsson *et al.*, 2008). McCormack (2003) presents a conceptual framework for person-centeredness that is based on a notion of “authentic-consciousness” (p.204). As PCC and old-age care become increasingly synonymous, we must consider the applicability of ‘authentic consciousness’ that is inferred in imagining of identity in PCC, and the utility of this concept. Is it possible that the concept of autonomy embedded in PCC, based on individualism and independence becomes untenable in the context of health care for older people (McCormack, 2001)? Higgs and Gilleard (2016b) for example, have highlighted the complexity of the relationship between personhood and dementia care, arguing for the importance of considering the social processes which constitute the fourth age, as well as the interpersonal processes of care. Current configurations of patient identity in PCC for older people fail to address how identity emerges from a myriad of discourses both in and beyond the clinical encounter, and in so doing risks a deterministic account of patient identity, as well as failing to address issues of autonomy and ethics that may be seen to emerge particularly in the care of older adults with dementia.

#### *Power structures in the clinical encounter*

PCC fundamentally changes the nature of the patient-practitioner encounter (Pulvirenti *et al.*, 2011), aiming to foster patient participation in an interactive partnership, with patients framed as “respected and autonomous individuals...with needs and values” (Kitson *et al.*, 2013: 15). This implies a critical restructuring of power in the context of clinical care, moving from patient as passive ‘recipient’, to fostering and promoting an active patient identity by facilitating increased patient autonomy in decision-making (Pulvirenti *et al.*, 2011). However, research has shown that



these aspirations have often failed to translate into practice, and that both practitioner and patient behaviours constitute more than transactional practices (Mendick *et al.*, 2010; Henwood *et al.*, 2003). In Kogan *et al.*'s (2015) systematic review the authors found that a large area of concern for recipients of PCC was patient-clinician communication and decision-making. In an analysis of patients' online essays, articles and blog posts, the authors found that patients were revealing a failure of PCC to adequately prepare them to make decisions about their health care that they felt confident about; one woman described her own difficulties with clinician communication as: "I didn't know how to speak to the doctors with the words that would get them, as I thought of it, 'on my side.'" (p. 4). In a study of factors facilitating and/or inhibiting the emergence of the 'informed patient', Henwood *et al.* (2003) found that participants feared being seen to challenge the doctor, and were concerned not to overstep the boundary between 'patient' and 'expert', while Mendick *et al.* (2010) argue that respecting patients' autonomy does not necessarily safeguard their interests. For a variety of reasons, older adults may be uncomfortable breaching the paternalistic health care model and assuming control over the management of their care, not least the tensions that may arise from years of having been socialized to never question their physician (Teh *et al.*, 2009). Some concern has been expressed about the way in which PCC tools and models entail clinical practices through which patient responses are guided, and their responses situated (Gardner and Cribb, 2016; Kogan *et al.*, 2015). In this way, the patients' 'power to' is "a consequence of the therapists' degree of 'power over' them" (Gardner and Cribb, 2016: 1055). This may be seen to demonstrate a one-way model of communication that Dixon-Woods (2001) has argued creates 'information for compliance' in the patient-empowerment process, where responsibility shifts onto patients to do the 'right thing' (Fox and Reeves, 2014). In this way, the space allowed for 'patient identity' in PCC for older adults is

shaped in ways that constrain the agency it purports to enable, and may serve to make invisible crucial power inequalities between patient and professional by “configuring a particular patient voice” (Gardner and Cribb, 2016: 1052).

### *Empowerment and crises of identity*

A specific danger of typological accounts of patient identity becomes clear when we consider the expectations and responsibilities that are embedded in the identity of the ‘empowered’ patient. While patient empowerment has been identified as a policy imperative of PCC (Henwood *et al.*, 2003), the current concept of empowerment utilized in PCC discourse is uncritical (Pulvirenti *et al.*, 2011). Indeed, there is little understanding of the extent to which older adults accept the mantle of being the “source of control” over their own care (Teh *et al.*, 2009: 522). Fundamental links between ‘empowerment’ and ‘responsibility’ call into question the patient-centered aims of PCC. Whilst an ‘informed patient’ discourse assumes that individuals wish to take more responsibility for their health care, Henwood *et al.* (2003) found that a significant minority of participants in their study of factors facilitating and/or inhibiting the emergence of the ‘informed patient’ were reluctant to take on the responsibilities implied by this discourse. In a study of older people’s experiences of patient-centered treatment for chronic pain, Teh *et al.* (2009) found that respondents were reluctant to voice their opinions, because of their concern to be a “good patient” (p.525). Assumptions about the self-manager (Pulvirenti *et al.*, 2011) implied by the PCC goal of empowerment, require patients to shift from being seekers of health care to becoming informed consumers of clinical services (Dubbin *et al.*, 2013). The responsibilities implied by an ‘empowered patient’ identity may produce tensions caused by ‘information for choice’, obscuring a potential conflict between lay and professional knowledge in the clinical encounter (Henwood *et al.*, 2003). In this way, we must consider how identity crises may be

produced by PCC empowerment discourses, framing patients as they do to take increasing responsibility for their own health-management, in opposition to a paternalistic model possibly more familiar to many older people (Teh *et al.*, 2009).

Scholars have acknowledged that patient identity has been under-conceptualized in the PCC literature, and there have been calls for further research to understand identity and the effects of labels in health care interactions (Gershater and Forbes 2013). Through their study of patient-centred medicine, Gardner and Cribb (2016) highlight how PCC interactions actually entail instrumental power dynamics, which under close scrutiny are asymmetrically distributed and more complex than those promoted by advocates of PCC. These authors emphasize the need for tools to ensure that “patient-centered interactions are not elided by discourses that herald and overestimate the egalitarian aspects of patient-centeredness and patient-empowerment” (p.1055).

In this review, we have attempted to demonstrate some crucial shortcomings in the conceptualization of patient identity in PCC for older adults through its unitary imagining of patient identity, lack of critical attention to power dynamics embedded in the clinical encounter, and an uncritical pursuit of patient ‘empowerment’. Next, we turn to how discourse theories of identity formation provide a compelling entry point through which to engage with patient identity as it is operationalized in PCC for older people.

### **Potential contributions from the field of discourse studies**

Recent literature from the field of discourse studies has sought to provide conceptual tools to address ‘identity politics’ arising from the need for identity performances to shift rapidly and evolve in ways that address so-called ‘liquid modernity’ (Bauman, 2000), a term which “serve[s] to characterize the rapidly reconstituting nature of interpersonal, social and organizational

spheres and associated conducts, and to express the idea that social life is losing stability and certainty as to who we can be and what we can do and say” (Iedema and Caldas-Coulthard, 2008: 1). These observations have distinct resonance with the manner in which PCC reconfigures patient identity in ways that require patients to negotiate increasingly ambiguous scopes of responsibility and involvement. In necessitating patients to shift from being seekers to informed consumers of healthcare, PCC thus implies a fundamental shift in power relations and in the boundaries of medical responsibility (Gardner and Cribb, 2016; Salmon and Hall, 2003), where identities of both health care workers and the nature of patienthood are re-configured (Charles-Jones *et al.*, 2003). Concurrent with the loss of stability embodied in Bauman’s “liquid modernity” (2000), such shifts from ‘power over’ to ‘power to’ (Gardner & Cribb, 2016) in PCC patient identity imply uneven and unpredictable expectations of conduct, as patients must negotiate oscillations between ‘rights’ and ‘responsibilities’ inscribed in their new role. The rights entailed by the growing autonomy of the patient as ‘expert’ are mirrored by more ambiguous and risky responsibilities, with regard to the extent to which patients will be considered accountable for their own healthcare. Here we will argue that discourse theory: provides useful conceptual tools to address the crisis of identity enactment arising from a state of ‘liquid modernity’; has promising implications for critically engaging with patient identity in the context of PCC for older adults; and may help to move beyond unitary imaginings of patient identity and embedded notions of autonomy.

### *Enacting identity: a discursive perspective*

Enactments of identity by older patients – the ways in which identities are performed and expressed – are more complex than notions of patient identity arising from clinical encounters, or more overarching notions of ‘patient as person’ seem to allow (de Boer *et al.*, 2013; Lupton,

1997; Pulvirenti *et al.*, 2011; Nolan *et al.*, 2004). Current PCC configurations of such identities have been shown to divorce identity from social practices, neglecting its performative, situated and contingent nature, and proposing uncritical notions of autonomy. Whilst the PCC literature appears to be stuck in a “worn-out debate postulating a dualism between agency and structure” (Bergström and Knights, 2006: 352), discourse theorists have provided conceptual tools to move beyond this in productive ways. These are founded on understandings of who we are and what we do, which are not pre-coded, but which are constituted in our conduct in the here-and-now, through discursive practices (Garfinkel, 1967). Discourse-informed concepts enable us to consider identities not as matters of biography, internal feelings or personal narratives, but within a “contested public terrain” (Lemke 2008: 32), where identity is a public phenomenon, constructed through social and embodied conduct (Benwell and Stokoe, 2006). This position echoes calls by Higgs and Gilleard (2016b), Birt *et al.* (2017) and others to attend to the social processes of identity formation, and enables us to move beyond structure/agency debates, to an understanding of identity formed and performed through a dialectical interaction between human agency and organizational discourse, rather than the effect of one on the other. Lemke (2008), for example argues that, while the notion of identity has inherited features such as ‘personality’, ‘selfhood’, ‘agency’ from earlier discourses, contemporary notions of identity must embrace a “multiplicity and hybridity of social identities” (Lemke, 2008: 17). He proposes a ‘scale-differentiated’ approach, which would encompass a range of concepts from situated enactments of identity, to “notions of identity appropriate to larger institutional scales and lifespan development” (p.18). Such an approach may have important implications for understanding the failure of the PCC literature to address performances of professional-patient relationships within a wider context (Kitson *et al.*, 2013). Lemke’s (2008) situated, anti-essentialist approach to

identity suggests we cannot maintain that identity ‘in-the-moment’ or ‘in practice’ is identical with identity ‘across-events’ or ‘across-the-lifespan’. As we have discussed above in relation to liminality and a third age-fourth age dialectic these observations about ‘scale’ have important implications for reassessing the parameters of patient identity as used in PCC for older adults, where the existing literature has tended to favor either a conceptualisation of identity ‘in-the-moment’ of the clinical encounter (e.g. Mead and Bower, 2000) or ‘across-the-lifespan’ (e.g. Pulvirenti *et al.*, 2011). ‘Identity-across-time’, exemplified in the notion of liminality and liminal identity, where people are no longer able to return to a previous state and status but still resist “the unwanted status of ‘person with dementia’” (Birt *et al.*, 2017: 199) has particular relevance in the care of older adults living with dementia, where the core component of PCC may be founded on the continuation of self and ‘normality’ as experienced by people with dementia and family members (e.g. Edvardsson *et al.*, 2010). These authors, for example consider the way in which dementia significantly threatens constructions of identity and normality, and thus how PCC in this context must be focused on existential experiences of being a whole person, rather than being reduced to a patient, disease or task. We suggest that a scale-differentiated approach has positive theoretical and practical implications, for researchers and practitioners alike, to understand patient identity as mutually constituted by institutional discourse and patient, with ‘patient’ understood as a constellation of relational identities, both longer term, and situated in the specific context of the clinical encounter. For practitioners particularly, this might be taken up in careful attention to contextual elements, and how these might be harnessed in the PCC goal of promoting continuation of self and normality (Edvardsson *et al.*, 2010).

There are dangers too in typological accounts of identity, which must also be addressed. We must, for example, consider the ‘pathologizing’ effect of marking patients as deficient or

uninformed, with patients' agency mediated by the expertise of the more powerfully placed 'experts' (see Crowther, 2000). Discourse scholars have paid close attention to identity politics, not least Lemke (2008), who observes that the concept of identity is used as a term to mediate between socio-cultural practices and lived experience, but asserts that, as an essentially semiotic concept, 'identity' will ultimately favor the socio-cultural stance, being an analytical tool rather than a phenomenological reality (Lemke, 2008). He points to the power inherent in institutional configurations of identity, as they tend to over-simplify highly diverse human spaces by producing identity types that make invisible more subtle and complex forms of human self-presentation. These observations have meaningful resonance with Gardner and Cribb's (2016) argument that PCC "configure[s] a particular patient voice" (p.1052), as well as Nolan *et al.*'s (2004) concern that notions of independence and autonomy inherent in identity theorization in PCC underpin a 'heroic' model of aging that does not adequately capture the experiences of most older people.

#### *Discourse, identity performance and the clinical encounter*

PCC scholars have highlighted the fundamental changes in the nature of the clinical encounter implied by PCC, reconfiguring the relationship between patient and practitioner (Gardner and Cribb, 2016; Gershater and Forbes, 2013; Kitson *et al.*, 2013; Pulvirenti *et al.*, 2011; Charles-Jones *et al.*, 2003). Patients are being asked to shift from directive to performative ways of being, from "seekers of health care to informed consumers of medical services" (Dubbin *et al.*, 2013: 3). Patients may exercise an increasing influence on the course and outcome of clinical encounters (Salmon and Hall, 2003), while in the emerging context of consumer health informatics, PCC also entails an identity shift for health care professionals, moving from authority figure to facilitator (Ferguson, 1997). Such shifts in identity performances in clinical

settings might be helpfully understood in a wider context of bottom-up participation, where contemporary organizational structures tend to de-emphasized previously rigid hierarchical distinctions between management and workers (Rhodes *et al.*, 2008). This has resulted in significantly more turbulent negotiations of identity in organizational and institutional settings, as choices are constrained in ever more complex and multileveled ways. These insights resonate strongly with the discourse of PCC in the care of older patients, which looks to configure growing patient autonomy in the decision-making process (Pulvirenti *et al.*, 2011), and increasing levels of informedness and expertise (Henwood *et al.*, 2003). Just as workers must negotiate an increasingly ambiguous scope of responsibility and involvement, with identities fashioned through discourses of empowerment, belonging and individualization (Garrick and Solomon, 2001), so must patients engage with assumptions of self-management implied in the configuration of the patient-practitioner relationship in PCC discourse, where the autonomy and self-organization of the individual subject (patient) has become a central resource for the (health care) organization.

By putting individuals at the forefront of their own health care, patients are being asked to accept ever-increasing responsibility for knowledge and decision-making, internalizing the power structures of the medical setting. It is in the discursive fabric of the medical encounter that we can see a crisis of positioning, where individuals – clinicians and patients – struggle to locate themselves in new discourses that emphasize performative rather than directive ways of being. The “hybrid discourse” (Rhodes *et al.*, 2008: 243) espoused by PCC incurs significant turbulence in performing identity work in the medical encounter, particularly for older adults. The longevity of the paternalistic clinical model, as well as issues of autonomy and independence that are particularly complex in the application of PCC to older adults in the context of the physical and



social changes inherent in dementia may induce troubling identity tensions. West *et al.*, (2017) for example, show how in the context of frailty and cognitive decline residents' complaints may be considered as particular ways of enacting identity, which represent transitional states that require particular support from staff – for example to build new relationships, or to come to terms with altered capabilities.

### *Identity and empowerment discourse*

Empowerment has been identified as central to the PCC agenda (see Pulvirenti *et al.*, 2011). However calls for patient 'empowerment' are best understood as part of wider socio-political trends, such as the valorization of individual choice and consumerism (Gardner and Cribb, 2016). There is a normative assumption that people want to operate as health care consumers, which is embedded in PCC (Henwood *et al.*, 2003). Critically, the increased insight, understanding and confidence implied by an empowerment discourse goes hand-in-hand with increased responsibilities. A PCC empowerment discourse that characterizes patients as capable of self-management, and that strives for this goal in turn entails unmarked assumptions about the patient as increasingly responsible for the decisions and conduct that this creates. Discourses of empowerment create new expectations of and for the patient. The PCC goal of overturning paternalistic medical discourses to promote active, self-managing patients creates new pressures on the individual as responsible for finding their own learning trajectories, and configures a combination of forces within and beyond the individual in ways that parallel modern trends in education, for example stressing that the "learner accept ever-increasing responsibilities for decisions associated with the learning process" (Banz, 2008: 46). Indeed, some argue that the relative failure of modern health care to address the needs of older adults with chronic illnesses has arisen from the promotion of an individualistic view of the world in which independence and

individualism are championed (Nolan *et al.*, 2004). Rhodes *et al.*, (2008) explore the crisis that has been incurred by discourses of empowerment in an organizational setting, demonstrating how finding a place in a restructured organization creates uncertainties for workers as they try to locate themselves in terms of power and accountability, while being aware that their roles do not fit in the organizational hierarchy. It is in “the new appeal [to] ‘*own responsibility*’” (van Zon, 2013: 113, original italics) that PCC discourses of empowerment risk incurring a crisis of positioning for patients, forced to occupy an ambiguous structural position, caught in a double bind between their old role as subjects of powerful, disciplinary institutions, and their new role as consumers of services (Fisher, 2009).

The problem, identified by Fisher (2009) is that any opposition to flexibility and decentralization risks being self-defeating, since calls for centralization and rigidity are not likely to rouse support. In this way, critical engagement with empowerment discourse in PCC for older adults is particularly imperative, as the democratising goals of empowerment make it a slippery narrative with which to critically engage. This problem is compounded by the relative vulnerability of the aged population, particularly those in liminal states or living with dementia. We suggest that the manner in which discourse theories of identity in the context of ‘bottom-up participation’ have effectively engaged with empowerment narratives offers promising insights into patient identity in the context of the PCC empowerment rhetoric for older adults. The use of discursive analysis to examine the intersections, effects and contradictions between organizational narratives of empowerment and the positioning of their subjects would certainly seem to go some way to address Gardner and Cribb’s (2016) call for tools to address the complex micro-power dynamics of PCC interactions, and provide important conceptual tools to consider the increasing

responsibilities for decisions and conduct that assumptions about the self-managing patient create.

### *Challenges to using discourse theorization of identity*

The potential for application of discourse theories of identity formation to PCC in older people is significant, but not without challenges. Discourse theorists have been criticized for ignoring the materiality of the ‘real world’, as well as the role of the body in interactions and identity construction (Benwell and Stokoe, 2006). The issue of materiality is of particular relevance to notions of patient identity, with the body typically a focal point of the subjective experience of ageing in the medical encounter. It is widely recognized in social studies of medicine that the material properties of the pathologized body correspondingly have material agencies, as objects rather than subjects (Krmpotich *et al.*, 2010). In this way, it is important that the application of discourse theories to PCC are complemented by research and conceptual tools that acknowledge the centrality of the body in PCC encounters, and indeed the embodiment of identity<sup>1</sup>.

Furthermore, in spite of attempts to bridge discourses, and move beyond understandings of identity as the effect of one discourse on another, discourse identity theories have often been split along either ‘essentialist’ or ‘constructionist’ lines (Benwell and Stokoe, 2006). Any application of discourse theories of identity to engage with PCC in older people must pay careful attention to the dangers of privileging one discourse over another, and by doing so falling into an unproductive trap of determinism. Indeed, the Foucauldian theories, which have greatly influenced many of the discourse scholars cited in this paper, have been accused of being ultimately deterministic. Whilst discourse theories provide the conceptual tools to address the

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<sup>1</sup> Though it may also be noted that relevant discussions of materiality may also be found in the field of discourse literature, with many scholars arguing that the material world is in itself a ‘discourse’ (see Howarth, 2000).

interaction between organizational discourse and patient agency, if misapplied they will fail to move beyond a structure/agency debate.

## **Conclusion**

Undoubtedly, ‘patient identity’ is a concept that needs expansion in research and application of PCC in older adults. In this paper we have attempted to demonstrate the potential for literature from critical discursive fields to engage with this. Specifically, we have discussed insights from discourse theories relating to: nuanced and multi-faceted theories of identity, which could be used to address the widespread operationalization of limited, unitary imaginings of identity in PCC for older adults; the examination of ‘devolution of responsibility’ in organizational settings to address shifts in identity performance incurred by PCC in the patient-practitioner encounter; the notion of a ‘crisis of positioning’ incurred by restructured hierarchies, which has considerable implications for engaging with the discourse of empowerment, at the heart of PCC. For researchers, the potential for uptake of these insights follows from the idea that describing the rules that condition a particular discourse will provide the means to delineate research objects, in order to “foreground possibilities foreclosed by... dominant logics” (Howarth, 2005: 319). This means in practice a process of description, reflective understanding and explanation through investigations of the objects and actions that comprise PCC as it is constituted by ideologies that structure certain possibilities, whilst simultaneously excluding others. Through tracing the contingent and historical constructions of discourses (Howarth and Stavrakakis, 2000) researchers both start from, and challenge the political circumstances within which such constructions emerge and operate (Howarth, 2005). Here, we have attempted to demonstrate the imperative for applying these tools to the subjects, objects and practices formed in PCC

discourse, with the goal of challenging the structuring forces that are at risk of “receding into invisibility” (Fisher, 2009: 66).

For policy makers and practitioners, the uptake of an agenda that attends to ideologies that structure PCC in a particular way might entail applying more nuanced and socially constructed understandings of ‘identity’ as it comes to bear in the care of older adults, and an understanding that listening through this frame “has implications for how well-being is understood” (West, *et al* 2016: 1894). For example, Edvardsson *et al.*’s (2010) conclusion in relation to consumers ‘experiencing’ and staff ‘providing’ PCC entails assumptions that call into question both the agency of the older person, and the co-constructed nature of PCC. Following Lemke’s ‘scale-differentiated approach’, practitioners might consider how deploying relational understandings of identity might be used to promote continuation of self and normality for older adults moving from third-age, through liminal states, to fourth-age. How might ‘identity-across-time’ be better maintained by the adaption of contextual elements that inform ‘identity in the moment’? This would include attending to support for embodied identity through maintenance of familiar items of clothing, for example (see Twigg and Buce, 2013). These alternative ways to frame the co-construction of health and social care in PCC may be considered to have significant potential for the development of personalized care environments, and for development of more adequate and nuanced understandings of the patient-as-person and expert in conditions of multi-morbidity, moving between the various ‘collectives’ of professional care (see Horton *et al.*, 2017).

The need to address dynamic phenomena, such as fragmentation of the self, identity development and restructuring (Hou-Song, 2012), and the embedding of decisions in social and institutional contexts (Mendick *et al.*, 2010; Varelius, 2006) is clearly warranted. Certainly in the context of PCC for older people, identity politics cannot be ignored. We hope that these

reflections might be taken forward by researchers and healthcare practitioners alike to mobilize more dynamic explorations of positioning, belonging and identity formation in PCC for older adults.

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