Two models of ethical alignment through metacommunication in clinical situations

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Abstract

The literature about communication in patient-centered care typically focuses on physicians' alignment strategies. The goals of these strategies are diagnostic accuracy, effectiveness via compliance and patient-centeredness. Although the success of these strategies can to some extent be measured, the ethical standards by which they are evaluated are not sufficiently clear. This article presents two models of alignment through 'explicit' metacommunication, derived from two different ethical perspectives on patient-centeredness. The article first presents the concept of metacommunication and identifies two ethical perspectives that produce normative stands concerning patient-centeredness; *the logic of care* and *internal morality.* Second, the article presents two models of how metacommunication can contribute to the visibility and accomplishment of these two ethical perspectives in clinical alignment.

Keywords: Metacommunication; ethics of medicine; logic of care; alignment; physician-patient interactions; skills-based communication

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Democratic healthcare systems today prioritise patient-centeredness through the involvement of the patient in care and decision-making or at least the ongoing achievement of a shared understanding (Epstein *et al.* 2005; Stewart *et al*. 2003; Ishikawa *et al*. 2013), in short *alignment*. Evaluations of these efforts to involve patients as well as growing communication curricula in medical education in Western countries show on the one hand a great interest in implementing professional communicative strategies for this purpose. On the other hand they show a need for a continuous development of models and standards that can support practices of communication in the physician-patient meetings that enhances alignment as part of a patient-centered policy (Ishikawa *et al.* 2013; Street 2013; Street *et al.* 2012). However, the ethical standards by which communicative practices are evaluated are rarely sufficiently clear.

This article departs based on two insights: the first being that a skills-based communicative approach to patient-centeredness is indeed very useful for physicians engaged in diagnosing, comforting and healing human beings, which is why we would like to introduce the concept and skill of metacommunication; the other being that models by which to practise and evaluate the ethical qualities of communicative patient-centeredness would contribute to the maintenance of the close link between ethics and the medical professional practice. This illustrates at the same time that the qualities of communicative interactions are not value-free: communication is constitutive (Craig 1999) and produces normative positions (Ishikawa et al. 2013).

In the present article, we would like to present a communicative skills-based approach to patient-centered communication and two distinct ethical perspectives by which to evaluate

it, Mol's *logic of care* (2008) and Pellegrino's *internal morality* (2001). We work with the concept of metacommunication, because it is a generic and relation-producing feature of language that allows speakers to contextualize their communication in accordance with their particular personal and ethical approach to the situation and the interaction. Furthermore, the applicability of metacommunication is not restricted to a certain medical setting although it may shape the setting and the relation between communicating participants. Finally, the use of metacommunication is not restricted to any specific communication strategy either and can be a linguistic feature in different kinds of patient-physician communication, for instance in dialogic or narrative approaches. The two ethical perspectives discussed here are by no means exhaustive, but have been chosen for comparative reasons. They illustrate two different perspectives on the core concept of 'good', central mechanisms for securing the good of the patient and normative expectations of physicians.

Following an introduction to the field of patient-centeredness and the concept of metacommunication we will present the ethical perspectives of *the logic of care* and *internal morality.* The emerging communicative consequences of these perspectives will be highlighted, followed by two models of how metacommunication can contribute to the visibility and accomplishment of the logic of care and internal morality in clinical alignment.

1. A gap between communication skills and ethics in clinical situations?

Practising alignment as experienced by patients is a difficult task due to conflicting system demands on physicians, the inherent ambiguities of interpersonal communication and sometimes patient opposition towards mutual alignment with her physician (Villadsen and Pii 2012). A study of informed consent in cancer clinical trials in Australia (Brown *et al.* 2004) showed that the oncologists very seldom initiated shared decision-making; instead they implicitly stated their preferred treatment to the patient. Silverman *et al.* (2013) refer to

several other studies from different settings that document that patients' worries and agendas are only disclosed to a limited degree, which is why they call on physicians not to close alignment prematurely (2013: 36, 43, 177).

In the widely used Calgary-Cambridge Guide that teaches skills for communicating with patients (Silverman *et al.* 2013), the primary means for patient involvement and alignment is asking questions concerning the patient's view, expectations and experiences and incorporating patient expectations in the introduction and conclusion of the interview. More specifically, it is strongly recommended of the physician to continuously summarize, categorize, illustrate, encourage questions and to articulate the structure of the interview – what has been said and done and what will follow (Silverman *et al.* 2013). Many of these aspects are metacommunicative. However, the use and impact of metacommunication in clinical healthcare practices has not been an area of particular awareness or interest in previous medical communication research (see Sarangi and Gilstad 2014). Studies in metacommunication have primarily been conducted in areas such as human development and relationship (Robinson and Robinson 1983; Tannen 1987; Branco and Valsiner 2004; Fogel and Branco 2014); psychotherapy (Kiesler 1988; Safran and Reading 2008); play and (e-)learning (Mitchell 1991; McLean 1999; Sawyer 2003); and online communication (Hoppenbrouwers and Weigand 2000; Lanamäki and Päivärinta 2009). Only a few studies in medical and social counseling touch upon metacommunication as part of an observed or recommended communication strategy. For example, Nijnatten (2006) showed how metacommunication was used to manage conversations between family advisors and parents in accordance with institutional goals. The supervisors used metacommunication to evaluate the client's contribution to the conversation, to construct the course of the conversation and to select parts of the conversation as especially relevant in accordance with the professional agenda. Hence, metacommunication was used as a rather coercive method to achieve

institutional goals, while at the same time counteracting ample deliberation of the client's problems and perspectives (Nijnatten 2006: 348). In a study by Robins *et al.* (2011) metacommunication about the agenda and course of the clinical interview and examination was recommended as a suitable strategy for gaining *process transparency* leading to increased collaboration between physician and patient. According to Robins *et al.* (2011) the physician's use of metacommunication seemed to calm, educate and invite patients to take active part in the consultation, for instance, by asking questions and sharing personal concerns. A third study of relevance for physician-patient interaction is the research of Graugaard *et al.* (2011) about prognostic communication. Graugaard *et al.* (2011) suggest more explicit metacommunication before providing patients with a prognosis in order to gain more knowledge about patients' preferences and expectations.

The studies of Nijnatten (2006), Robin *et al.* (2011) and Graugaard *et al.* (2011) show the potential of metacommunication to be a tool to enforce the dynamics of a given communication strategy, whether it being a strategy of control or collaboration. When applied by professionals in an institutional context, metacommunication can be used either to determine and direct or to share and negotiate the course of an interaction, depending on the provider's communication strategy and capacity. Hence, the motives and effects of metacommunication can be placed along a continuum between two extremes – control and collaboration: the first striving for conversational progress and clarity; and the latter aiming at an explorative process by sharing multiple perspectives and understandings. As a means for contextualizing, driving and qualifying the conversational process through talking about talking, metacommunication becomes a primer of – or a catalyst to – the relational and conversational strategies adopted by the participants. However, these very useful skills-based approaches to patient-centered communication only implicitly address the nature of the relation between physician and patient, what we may define as a social contract. However,

the underlying notion is that the doctor in this way enables alignment with the patient and involvement that secures compliance and efficacy.

According to Ishikawa et al. (2013) there are four social contracts – related to goals, roles and values – underlying patient-centeredness. Communication is involved in producing each of the authors' theoretically informed classifications: *functionalism*, *conflict theory*, *utilitarianism* and *social constructionism*. Ishikawa et al. (2013) do not, however, specify how language actually produces social contracts and thus normative positions concerning the roles and relations of physicians and patients. Cameron (2004: 312) depicts metacommunication as a *genie* that, once out of the bottle, will serve and support any wish of its rescuer. Understanding it as a genie, we should be wise, however, to apply explicit metacommunication according to certain ethical standards, two of which we will introduce in the sections following a theoretical outline of metacommunication.

2. Metacommunication

Metacommunication can be understood as communication about communication (Wilmot 2009), or as a parallel meta-track of the conversation, where the participants can comment and commit to the act of communicating with each other. According to Watzlawick *et al.* (1967) metacommunication is first and foremost an act of relating, since "every communication has a content and a relationship aspect such that the latter classifies the former and is therefore a metacommunication" (p.54). As such, metacommunication concerns primarily aspects concerning relations, according to Watzlawick et al. (1967). Other theorists define a broader scope for metacommunication by seeing metacommunication as attempts to either ensure correct interpretations of one's own messages or to clarify the meaning of others' messages (Bateson 1999; Cameron 2004; Verschueren 2004). In this broader definition we may say that metacommunication produces or elicits the *latent content* of a

conversation, whether it refers to the topical or the relational aspects of the conversation (Tannen 1987).

Communicating about what, when, why and how information is being exchanged from one to another can serve as a means for collaboration, compliance and clarification, allowing the participants, for instance, to secure the transmission of messages (Would you mind repeating that? I'm not sure I understand your point), to stick to or change the subject (This is important, so let's talk a little more about it; There's something else I'd also like to talk about), to position themselves in relation to the other (It's not up to me to decide what's best for you; As your doctor, I recommend...), to think aloud (That makes me wonder, if… It sounds like, you think, that...) or to present intentions and expectations (I've invited you to this meeting, because... ; I hope, we can come to an agreement on…). Furthermore, metacommunication is a special mode or feature of communication that contextualizes or frames specific messages in order to guide a certain interpretation of them (Wilmot 2009), i.e. metacommunication higtlights certain content or relational aspects of an interaction on behalf of others. This point derives from the recognition that communicative signals are only signals, which, in order to be meaningful, must be interpreted by the other, that is, to be "trusted, distrusted, falsified, denied, amplified, corrected, and so forth" (Bateson 1999 [1971]: 178). Metacommunication is thus a guiding tool for contextualization and clarification, and according to van Leeuwen (2004) it is a tool that is especially called upon "in cases of special communicative needs or problems" (128).

3. Implicit and explicit metacommunication

Wilmot (2009) distinguishes between two modes of metacommunication, that is *implicit* and *explicit* metacommunication, the former being primarily non-verbal signals and cues accompanying and framing verbal utterances; and the latter being verbal comments referring

to other utterances, signals or cues. Implicit non-verbal metacommunication can be a smile, a nod, a hand-gesture or a specific tone of voice which guides the receiver's interpretation by implicitly framing the utterance. A smile on the face of the speaker can be interpreted as 'I'm amused by saying this' or maybe as 'I'm lying right now'. A nod can be interpreted as the meta-message 'I agree on what you just said' or 'I know what you mean', but it can also be a silent way of saying "Get on with it, I've heard it all before". Implicit metacommunication cannot be separated from interpersonal communication since it is a truistic part of the act of communicating (Stewart and Logan 1999). To interpret such subtle, often obscure and sometimes unconscious nonverbal, meta-communicating cues can be a difficult and ambiguous enterprise.

Explicit metacommunication which is verbal, on the other hand, consists of messages that explicate and contextualize previous or coming utterances. Explicit metacommunication expresses an extra effort to guide the other's interpretations of one's own messages, or to call for guidance when interpreting the other's messages. Hence, explicit metacommunication allows participants an insight into the other's intentions and perceptions (Wilmot 2009), that, as Tannen (1987) pointed out, would otherwise stay a latent part of the communication.

By defining metacommunication as both implicit, non-verbal cues and explicit, verbal utterances, Wilmot (1980; 2009) corrects what he finds is a too common misinterpretation of Watzlawick *et al.*'s (1967) notion of metacommunication as only implicit and non-verbal cues that transcend and shape the explicit, verbal utterances (Wilmot 1980: 63). Wilmot points to the fact that Watzlawick *et al.* (1967) themselves also stated examples of explicit metacommunication such as "This is an order" and "I am only joking", and he concludes that the definition of metacommunication cannot depend on its non-verbal or verbal character, but rather whether it, in Bateson's words, ""contextualizes" or "frames" messages to assist the participants in understanding the communication event" (Bateson 1951; 1972 in Wilmot

1980: 63). In the following we primarily refer to explicit, i.e. verbal, metacommunication, motivated by an intention of contextualizing and clarifying messages in order to enhance and align mutual understanding.

4. Two levels of reference in metacommunication

Moving from the situated functions and verbal and nonverbal character of metacommunication, we now move to what Wilmot (1980) suggests as *levels* of metacommunication, i.e. the identification of relevant contexts that metacommunication refers to and emerges from. Wilmot (1980) suggests two levels of reference: the *episodic* level and the *relationship* level of metacommunication (p.64). On the episodic level, meta-messages regard the conversational and relational aspects within the specific episode of communication as an expression of awareness "directed to the other's acts, the self, or the transaction between them", thereby addressing: "this is how I see you at this point in time for purposes of interpreting my messages" (Wilmot 1980: 64). On the relationship level, meta-messages regard episode-transcending relational aspects between the participants, such as friendship, animosity, family, partnership, competition etc., which have emerged over time, based on several, previous episodes (Wilmot 1980). As such, metacommunication on the relationship level requires an already existing personal relation between the participants, and expresses the speaker's overall personal attitude toward the other, stating: "This is how I see you and me in relation to one another" (Wilmot 1980: 63). In other words, metacommunication on the episodic level refers to the situated, personal encounter, its purpose, content and emerging relational aspects, whereas metacommunication on the relationship level refers to the relationship between the participants emerging from several encounters. This division of metacommunication into two levels of reference nuances the concept of metacommunication as a situationally and relationally productive, linguistic

feature within, on the one hand, the specific, personal encounter and, on the other hand, over time across specific, personal encounters. Only, Wilmot's division primarily regards the establishment of personal relations such as family, friends or enemies. For the purpose of analysing communication in professional contexts it would be fruitful to incorporate an institutional perspective in which participants occupy certain roles associated with certain rights and duties and thus also preceding attutudes and expectations concerning the other (Aubert 1979) . We will assume that metacommunication in professional contexts will be shaped by and shape institutional relations as well as the situated and interpersonal interaction. This is in accordance with the comprehensive field of studies in "institutional talk" (Heritage and Clayman 2010). When discussing physician-patient communication in the following, we therefore refer to the episodic level and the institutional relationship level of metacommunication.

In what follows we will suggest how to start building a bridge between metacommunicative skills and ethics in clinical situations. We will begin by presenting the ethical perspectives of *internal morality* and *the logic of care.* The emerging communicative consequences of these perspectives will consequently be highlighted, followed by two models of how metacommunication can contribute to the visibility and accomplishment of the logic of care and internal morality in clinical alignment.

5. The ethics of an internal morality for medicine

According to physician and bioethicist Edmund Pellegrino (2001), the clinical meeting with patients is "the physician's locus ethicus whose end is a right and good healing action and decision" (Pellegrino 2001: 563). This ethics is a morality connected distinctly to the medical profession, which is at the core a trusting relationship between a human struck by illness and a trustworthy, beneficent physician dedicated to the virtues of practical wisdom, compassion,

justice, fortitude, temperance, integrity and self-effacement (Sulmasy 2014). This is the internal morality for medicine. Taking each individual patient's current situation into consideration, the good healing action and decision must be guided by four hierarchically related spheres of "good" (Pellegrino 2001: 569-571). These spheres accommodate to each individual patient as well as to the medical profession, humanity and spirituality.

At the first, and lowest, level of this framework lies 'the medical good', which depends on the disciplinary knowledge and skills of the physician as medical expert, aiming at "the return of physiological function of mind and body, the relief of pain and suffering, by medication, surgical intervention, psychotherapy, etc." (Pellegrino 2001: 569). What the medical good is in the particular situation, is assessed by the physician, but must at the same time align with the next level, 'the patient's conception of good'. On this second level, the ethical reflections must be based on the patient's personal preferences, values and goals, depending on such individual factors as age, gender, occupation, stage in life, etc. Assessment of what is good for the specific patient can only be made by the patient him- or herself. In the ethical assessment of the overall situation, the individual perspective must, however, be aligned with the next level, 'the good for humans'. On this third level, the focus must be directed to ethical values common for all humans, such as Beauchamp and Childress' (2013) four principles of bioethics: autonomy, nonmaleficence, beneficence, and justice. At the fourth and final level lies 'the spiritual good', determined by the patient's spiritual beliefs, as the highest component of the good, to which the three other components must accommodate (Pellegrino 2001: 570).

Pellegrino (2001) emphasizes that this overall ethical framework of medicine outlining the good of the patient based on four components must not be perceived as a social construction and cannot be socially re-constructed or altered depending on, for example, time, place, societal development or the personal conviction of the individual physician. The

hierarchical relation between the medical, the personal, the human, and the spiritual sphere is fundamentally tied to the profession of medicine and must always guide the internal morality of clinical situations (Pellegrino 2001: 577). Nevertheless, what can be determined as the good of the patient in each particular situation is still situationally contingent, arising from the intersection between the physician's assessment of the medical good, the patient's conception of the personal good, conviction of the spiritual good, and the common moral grounds valid for all humans. Whether the ethical dimension is satisfactorily unfolded in the particular situation will depend on the physician's ability to address and assess ethical issues on the four different levels.

Kaldjian *et al.* (2005) present suggestions as to how the internal morality of the medical profession may be practised in actual meetings with patients. As a method of integrating ethical reflections in clinical practice, they suggest that ethical reasoning is explicitly and consciously incorporated into the process of clinical reasoning, instead of just being assumed as an intrinsic part of it. Reasoning within an Aristotelian telos-oriented framework targeted towards Pellegrino's definition of the internal morality of the medical profession, the authors state that an "accurate perception" (2005: 558) of the patient's needs must be based on dialogue (2005: 561). This will help the patients "choose wisely among available diagnostic and treatment options" (Kaldjian 2010: 558) and ensure that "clinical judgement not merely expresses the clinician's judgement" (Kaldjian 2010: 561, see also Kaldjian 2017). According to Kaldjian, dialogue takes place between physician and patient as well as through the personal deliberation of the physician, what we may define as internal dialogue. This obligation of the physician reflects, in our view, the basic phenomenological assumption of Pellegrino that illness as a lived experience and as "wounded humanity" calls for beneficent, unconditional help of the trained and skilled physician (Sulmasy, 2014: 107).

Seen from a communicational perspective, we believe that Pellegrino's framework as

a guideline for ethical medical practice requires that the physician is able and willing to communicate with the patient not only for diagnostic purposes, but in order to relate to and integrate the patient's personal and spiritual perspectives into the conversation and the medical decision-making. Hence, the physician's communication skills restrict and enable the ethical potential of the conversation. Since the ethics of medicine, according to Pellegrino (2001), is a professional, moral obligation, qualified communication suitable for evoking ethical reflection and reasoning must be imperative to the clinical practice as well. In our reading of Pellegrino we furthermore deduce an essentialist understanding of humans represented by the four non-negotiable spheres of good. In our view, this imposes some interrelated communicational limitations as well as possibilities for the beneficent physician vis-à-vis the patient. The first one is that of eliciting the good of the patient, according to the patient himself/herself, whereas the second one is that of perceiving the spiritual good of the patient. Communicatively, this implies a strategy of generating answers that reveal the unique subjectivity of every patient.

6. The logic of care

Attuning to the lifeworld of the individual patient without neglecting the medical duties of the professional physician is also a key element in Annemarie Mol's (2008) *logic of care*. The specific ethical dimension of this perspective comes with its radical call for a democratization of health expertise through collaboration between medical and lifeworld expertise. The argument is that care emerges when physician and patient alike are engaged in decision making in which the medical knowledge of the physician and the lifeworld knowledge of the patient are equal and should be considered accordingly. Whereas the ethics of internal morality ties the ethical perspective to the good of medicine, the patient, humanity and spirituality (Pellegrino 2001) and the professional's "practical wisdom" in eliciting the good

of the patient (Kaldjian 2010), Mol (2008) takes a different vantage point that we interpret as an ethics of intersubjectivity. Arguing for a logic of care, Mol (2008) analyses two logics in healthcare in Western democracies. One is a "logic of choice", which Mol describes as a linear time logic, when professionals in possession of non-negotiable knowledge initiate prescriptions to patients or objects in need of care, presenting choices that are bound up with different forms of risk. Consequently, the patient must make his/her own treatment decisions, based on the physician's references to a scientific, non-negotiable, and risk-assessed reality. This is basically what Ishikawa *et al.* (2013) name a functionalist, consumerist relation. On the other hand, the "logic of care" grows out of the proposition that health targets, first of all, are values; they are negotiated and personal facts. Secondly, people lead complex lives in which there may not be only one right decision, but ambiguous meanings, perhaps even conflicting meanings (Mol and Law 2004). This entails for the professional a close attention to the complexity of each individual patient's life as well as a close attention to the collaborative construction of meaning in clinical situations. Seen from our communicative perspective, the logic of care therefore presents a constructivist ontology in which meanings are continuously emerging through intersubjective processes. This implies a communicative strategy focused on exploring and challenging categorical knowledge and explicating the intersubjective processes of meaning-construction between physician and patient. Metacommunication as a logic of care would thus include the subjectivity of the physician in the communicative interaction as a strategy to construct the meaning of the good of the patient as well as to elicit the embodied life of the patient.

As seen, Pellegrino (2001) and Mol (2008) agree on the ethical importance of the concept of care and the patient-centered approach. Mol's realms, however, are the personal interactions, networks and embodied life in her contribution to a medical ethics. The caring practice unfolds when the healthcare professional *attunes* to the patient's reality and needs

through careful individuation, thus acknowledging the intersubjective relation between physician and patient as grounds for the negotiation of knowledge as personal and contingent. Consequently, in our reading of Mol (2008) a logic of care as an ethical imperative in healthcare implies a close attention to the communicative situation(s) in which physician meets patient, as is also the case for Pellegrino and Kaldjian, albeit slightly differently.

7. Explicit metacommunication as practising the ethics of internal morality and *logic of care*

As explained earlier, metacommunication is a feature of language that allows participants to explicate and produce institutional, relational and episodic qualities of a given situation by pointing to elements of the conversation itself. This final section of our article will present a model of how metacommunication can produce two different standards of ethics in clinical alignment. The two approaches, internal morality and logic of care, are but two examples of ethics in patient-centered care. They are of course far from being exhaustive in the field of patient-centered ethics. We have chosen them because they exhibit some differences that we find illustrative and informative concerning the point that metacommunication can serve the purposes of both perspectives.

In the model below we summarize and merge the relevant aspects of metacommunication and the two ethics. We combine Wilmot's (1980) two levels of metacommunication, the episodic and the relationship levels, in a way that allows us to distinguish between different dimensions and effects of metacommunication.

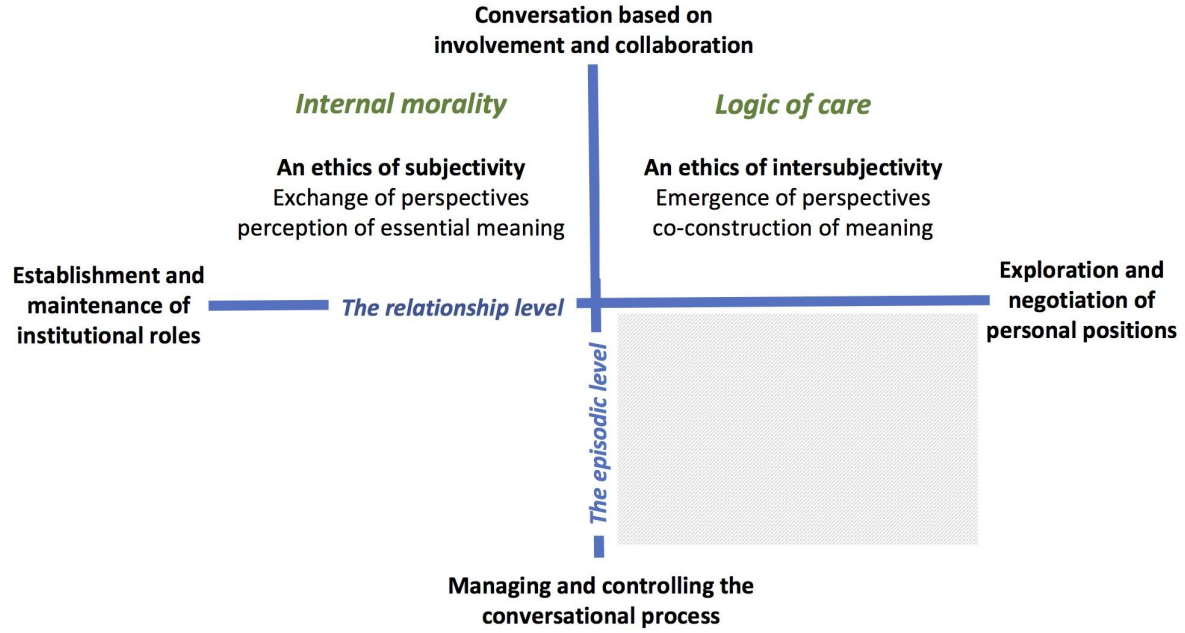

Fig. 1: Metacommunicative strategies in clinical situations

The vertical axis describes the use of metacommunication in reference to the specific course and content of the conversation, that is, the *what* and *how* of the situation, corresponding to the episodic level (Wilmot 1980). The horizontal axis reflects the use of metacommunication in regard to the relational aspect of the interaction within the professional, institutional context, the *who* of the situation, corresponding with Wilmot's (1980) relationship level, but based on an understanding of relationship as institutionally, not interpersonally, grounded. By distinguishing between and combining the use of metacommunication on the two different levels, the model illustrates different possible strategies in patient-centered communication ranging from extreme compulsion to extreme consideration towards the other.

In table 1 below, we move further towards a skills-based approach by summing up the most significant and discriminating characteristics of the two patient-centered, ethical perspectives and by including examples of relevant metacommunication that supports them.

	Internal morality	**Logic of care**
Situations of special communicative needs that call for metacommunication	If patient asks for treatment contrary to the good of humanity If patient distrusts the physician's beneficence If patient has conflicting convictions	If patient asks for neutral choices If patient expects physician to define universal facts If patient expects physician to place her in social, medical categories as impetus for treatment
Episodic metacommunication	Eliciting the real essence Ex.: *On behalf of what you said (...), I think we need to get closer to an understanding of what you really need.*	Emerging perspectives, constructions of meanings Ex.: *When you shake your head while telling me this, I become unsure of your commitment to this treatment.*
Institutional, relational metacommunication	Subjectivity Ex.: *What I am saying is that I am totally devoted to helping you out of your suffering. I'm not sure whether you trust me on this.*	Intersubjectivity Ex.: *It becomes clearer to me as we speak, that what might be the case...* *What I am saying is, in other words, that the treatment we choose for you, should be relevant and realistic according to how you live your life and those you share your life with.*
Content metacommunication	The values of the subject Eks.: *What I am asking about now is actually what your spiritual values are.* Human ontology Ex.: *What you are asking me to do is against my conviction about what's good for humanity*	The value-laden nature of medical knowledge Eks.: *When I say survival rate, I refer to the statistics of …* Human ontology Ex.: *If you are asking me to give you the exact same treatment as other young*

		women, I'm afraid you'll be disappointed. Because I will engage with you and your treatment according to how we work together on finding the right treatment for you in your life.

Table 1: The most significant and discriminating characteristics of the two patient-centered, ethical perspectives.

The upper row points to cases in which, according to the ethics of internal morality and logic of care, there is a special need for metacommunication according to ethical standards. As mentioned earlier, van Leeuwen's (2004) short definition of metacommunication is that it is a generic element of communication called upon in situations of special communicative needs or problems. The suggestions in the following rows of the table are thus our further development of ethically applied metacommunication according to the two different ethical perspectives and their most significant themes.

8. Conclusion and implications

In this article we have emphasized metacommunication as a particular feature of language that can be attributed with great generic power and ethical importance in communicative interaction in clinical situations. We have argued that metacommunication can be a catalyst to communicative strategies for physicians, because communication about communication effectively contextualizes, clarifies and emphasizes conversational elements, such as structure and content, as well as the character of the relationship between the professional and the other. By this, metacommunication also (re)produces certain relations between physician and patient – relations that are the embodiment of ethics. In the preceeding section we have

shown examples of how medical ethics can be explicated and produced with metacommunication, thus illustrating that ethics is indeed visible in language itself.

With our argument we have attempted to evoke more awareness and interest in the potentials of metacommunication as a particular, linguistic element in ethical, communicative practice in clinical situations. When applied deliberately and consciously, metacommunication can be a productive way of careful communicating and relating to patients. We have also attempted to fertilise the ground for further research into the linkages between language in interaction and different ethical perspectives within the very broad field of patient-centeredness that contains several normativities. Furthermore, we suggest increased analytic awareness of physicians' and other healthcare professionals' use of metacommunication and its impact on quality and outcomes of conversations in clinical situations in general and we hope to be able to contribute to that development in our future research.

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