

Body work and body meanings in patient-centered care: Health care professionals and patients with disabilities in Italian hospitals

Greta Elisabetta Brizio • Chiara Paolino

Background: This study integrates patient-centered care (PCC) research and body work studies to understand how a focus on physical and sensorial aspects in the relationship between health care professionals (HPs) and patients contribute to the implementation of PCC.

Purpose: To understand how HPs' body work practices contribute to the implementation of PCC, we investigate the meanings HPs ascribe to their and to patients' bodies. The goal is to grasp how these practices and meanings, rooted in unexplored sensorial perceptions, account for the emergence of a relationship of mutual acknowledgment between HPs and patients.

Methodology: Thirty-nine in-depth interviews were carried out with HPs, who interact with patients with disabilities in Italian hospitals.

Results: HPs engage in different body work practices: adopting a diagnostic gaze and an empathetic gaze, touching, and playing. The *diagnostic gaze* concurs to create a feeling of promptness between HPs and patients, but also a stronger distance with respect to other practices. The *empathetic gaze*, *touching*, and *playing* are associated with feelings of shared vulnerability and resilience. These shared perceptions and emotions build a common ground and shape a relationship focused on patients' involvement.

Practice Implications: *Voicing and feedback sessions* can be arranged to listen to how HPs interpret their own and patients' bodies. *An organizational culture acknowledging emotions* should be promoted to sponsor among HPs the consideration of the sensorial aspects of their connection with patients. *The value of bricolage* should be observed, where the HPs feel free to readjust tools, spaces, and routines. *Sensitivity training exercises* should be arranged to understand the interactions with patients with disabilities.

Key words: Body work, disability, health care professionals, meanings, patients' involvement, PCC

The World Health Organization reports that patients with disabilities are more likely to experience worse general health conditions than other patients—on the one hand, because of the possible comorbidities associated with disability, and on the other, for the numerous barriers to accessing primary and specialist care. Patients with disabilities are more than twice as likely to report finding health care providers' skills inadequate to meet their needs, four times more likely to report being treated badly, and nearly three times more likely to report being denied care (Hughes, 2000). When considering patients with disabilities, the implementation of patient-centered care (PCC) is particularly crucial, especially when examining its relational components; the emotional and physical comfort it implies; and the focus

on patients' needs, values, and preferences (Kuipers et al., 2021; Lotan & Ells, 2010).

PCC, as an overarching framework, focuses on patients' whole well-being by emphasizing the relevance of patients' contexts, relationships, values, preferences, and needs to be considered and included in the relationship of care (Alidina et al., 2021). There is research about the organizational aspects that might favor or inhibit the implementation of PCC (Clark et al., 2023; Engle et al., 2021; Machta et al., 2019). Such studies have focused on the macro-level dynamics that work as enablers of a more relational, holistic, and empowering approach to patients. The microdynamics between health care professionals (HPs) and patients, which contribute to understanding how PCC can be effectively implemented, have hardly been investigated. In particular, the contribution to PCC's implementation of the physical perceptions and related feelings and emotions, exchanged in the relationship between HPs and patients, warrants further research. The physical, emotional, body-related aspects of the interactions between HPs and patients are important, because they can constitute the medium for more direct and intuitive communication and for a greater integration of the patients in the provision of their care (Davies et al., 2023; Martinez et al., 2023). The sensorial and physical

Greta Elisabetta Brizio, PhD, is Research Fellow, Department of Business & Management Science, Università Cattolica del Sacro Cuore, Milan, Italy.

Chiara Paolino, PhD, is Associate Professor of Organization Theory and HR Management, Department of Business & Management Science, Università Cattolica del Sacro Cuore, Milan, Italy. E-mail: chiara.paolino@unicatt.it.

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components of the HP–patient relationship are critical to PCC, because they contribute to accounting for how HPs reflect on themselves and engage in the relationship with their patients through the consideration of their own and their patients' bodies. The relevance to PCC of a focus on bodies relies on the opportunities to grasp how and when HPs and patients are in a relation of acknowledgment and involvement. Such a perspective can be conceived as a valuable theoretical and empirical ground to understand how PCC can be based on a relationship of mutual respect and reciprocal recognition of fragility and humanity between HPs and patients (Christensen et al., 2023; Harris, 2016).

These physical and sensorial aspects are even more important when PCC is implemented to patients with disabilities, whose communication modes could be entirely different from those adopted in the usual HP–patient relationship (Lotan & Ells, 2010; Taggart et al., 2011). When interacting with patients with disabilities, perceptions about bodies could shape new ways of involving patients in the production of care by revealing original ways of establishing a connection with the patient.

To analyze how these more body-based aspects of the HP–patient relationship could contribute to interacting with patients, in this study we integrate body work literature in the health care and care fields (Twigg, 2006) into the PCC framework (Alidina et al., 2021). Body work can be defined as the active work of changing bodies; it can be performed on one's own body or on others' bodies; body work is associated with the perceptions and the feelings that it generates. Body work practices are connected to the meanings professionals assign to themselves and to the individuals they work with and on (Gale, 2011). In the health care context, the practices, for instance, of assessing, diagnosing, handling, treating, manipulating, and monitoring bodies are conceived as body work practices (Twigg, 2006). As such, they can be beneficial for comprehending how HPs produce meanings about their own and patients' bodies and how they shape such different ways of interacting and involving patients in their own care (Hansen & Kamp, 2018).

The literature about body work practices in health care emphasizes how body work might obstruct patients' involvement, especially when considering vulnerable bodies and those in vulnerable categories who cannot communicate their needs and choices in a conventional way (Hughes, 2000). However, there are also studies illustrating how body work practices might create an opportunity for more positive and more involving relationships (Brown et al., 2011; Gale, 2011; Hansen & Kamp, 2018). Notwithstanding the relevance of these studies, especially for patients with disabilities, extant research has not yet explored how body work practices shape the meanings that health professionals generate both for their own bodies and those of patients. In addition, it has not yet analyzed how these meanings create certain ways of interacting with patients by eliciting different approaches to considering patients' needs, preferences, and values.

To contribute to addressing these gaps, our research questions are as follows: How do able-bodied HPs engage in body work practices, such as gazing, touching, and playing, when they are confronted with patients with disabilities? What kind of meanings do HPs generate regarding their own bodies

and those of patients? How are these meanings related to a process of acknowledgment of both HPs' and patients' roles and of patients' involvement in the delivery of care?

We explored our research questions through a qualitative study based on 39 in-depth interviews involving HPs working in all the DAMA (Disabled Advanced Medical Assistance) units in Italian hospitals. The first DAMA unit was funded in Milano in Ospedale San Paolo, and nowadays, the DAMA units are departments and clinics located within public hospitals in different Italian cities. The DAMA units' mission is to provide a new way of treating patients with disabilities, adopting a multidisciplinary, relational PCC approach to the patients themselves. The DAMA units are focused on the care of patients with disabilities who cannot articulate their health status in traditional verbal or written language, as they have either a cognitive and/or a physical inability to speak and move in a standard way. This Italian experience is particularly fruitful for investigating how body work can contribute to implement PCC with patients with disabilities. For several years, care for patients with disabilities in Italy was dominated by the medical approach: Patients were identified with their disabilities, with their bodies merely regarded as the space hosting a disease, without the opportunity for the disabled patients to be considered in terms of their overall well-being, or for the contributions that their needs and preferences could provide to the production of their own care. HPs, when dealing with patients with disabilities, have long been identified and have identified themselves as professionals intervening to correct, fix, and heal the patient. It is only in the last 20 years that a more holistic and patient-centered approach has started taking hold in the Italian context (Berliri & Panocchia, 2014; Malaguti, 2010). The DAMA experience offers a suitable setting to understand how PCC can be structured toward disabilities by comprising a full consideration of body-related emotions, perceptions, and feelings, a consideration that acknowledges both patients and HPs in a relationship of mutual regard.

The article proceeds as follows: First, we illustrate how the literature on PCC and body work can be integrated to address the identified gaps, and we focus in particular on three body work practices analyzed in both these streams of literature: gazing, touching, and playing. Our methodological approach then follows, with a description of the data collection and data analysis. In the findings section, we illustrate how the HPs engage in their own gazing, touching, and playing when interacting with patients with disabilities; we illustrate the meanings that the body-related experiences elicit and how they interrelate with the typology of involvement that the HPs develop with the patients. Finally, we discuss our findings, contributions, and the practical implications of our study.

Theoretical Background

PCC literature has focused on analyzing the components of this approach to care (Alidina et al., 2021; Clark et al., 2023); these components range from the organizational characteristics and practices that may favor the centrality of the patients, to the organization of the diagnostic and communication flows enabling this approach, to the objective, even

demographic, features of patients and HPs that might benefit or impair the PCC (Kuipers et al., 2021). PCC is ultimately focused on patients' integration into the definition and delivery of their care and on the goal of pursuing well-being throughout the entire caring process (Martinez et al., 2023). The literature has focused extensively on the organizational aspects that support the implementation of PCC (Engle et al., 2021). However, the mechanisms and the experiences that facilitate PCC's deployment at the level of the HP-patient relationship have barely been studied. Focusing on this level is fundamental to grasping the dynamics of PCC implementation in order to understand its impacts on the personal and professional contexts that HPs and patients share and to drawing implications for the whole organizational environment.

Extant research on PCC at the micro level has focused on the decision-making processes through which HPs build PCC, the learning process that HPs and patients share (Alidina et al., 2021), the way in which information is processed in this relationship (Salge et al., 2018; Taggart et al., 2011), and the demographic and objective features of patients and HPs that can enable PCC (Khullar et al., 2022; Sieck et al., 2023). Although these cognitive and objective features are fundamental, the physical and emotional aspects of this interaction deserve to be further investigated to widen our understanding about how to develop PCC. Physical and sensorial experiences favor, indeed, the grasping of new ways of communicating and sharing and of holding back and suppressing emotions, feelings, and thoughts in a care-based relationship (Twigg, 2006). As such, these experiences could inform us about the more sensorial reactions elicited in a relationship of care and about their consequences for patients' involvement, consequences that cannot be observed by looking solely at organizational structures, practices, and cognitive processes.

The literature on body work in health care is a fertile ground to integrate with PCC literature, as it provides a more micro and sensorial perspective. Body work studies have illustrated how, through physical acts such as observing, touching, and playing, HPs can build meanings about patients' bodies (Brown et al., 2011). These meanings interrelate with the ways HPs interact with their patients, resulting in different degrees of involvement of the patients themselves in the production of care. On the one hand, body practices, such as touching, talking, and moving with the patient, have been shown to induce HPs to generate meanings about themselves, as helpers of the patient, and of the patients, as a source of information to organize the care. On the other hand, however, body practices, such as looking at the body of a patient as it is reproduced on a scan, have been shown to generate a concept of the HPs as an observer, an investigator of the patient, which is instead regarded by the HPs as a more passive actor (Måseide, 2011).

Notwithstanding the relevance of past research connecting body practices and how patients can be involved, it has not yet been investigated how body practices are related to sensorial and emotional experiences, which elicit meanings regarding HPs' and patients' bodies and which shape patients' involvement. The exploration of this relationship is vital to understanding how PCC might be implemented when we look at

how thoughts emerge about both the patients' and HPs' bodies through the sensorial and physical experience of their encounter (Hansen & Kamp, 2018).

This perspective is even more important when considering how PCC can be implemented to patients with disabilities, for example, those who might not communicate in conventional ways because of their different opportunities to speak, hear, and move (Lotan & Eells, 2010). Studies on body work and individuals with disabilities have focused on how looking, assessing, and touching individuals with disabilities rely on the notion of the disabled body as miserable, vulnerable, and fragile (Shildrick, 2019). In the health care sector, studies focused on PCC and patients with disabilities have illustrated the importance of HPs increasing patients' awareness, information, and education so as to enhance preventive care (Taggart et al., 2011). The extant literature has also highlighted the need for HPs to change their mode of communication and to make it more flexible, so as to adapt to different cases and create new forms of patient empowerment and involvement (Lotan & Eells, 2010). However, these studies have never focused on how the consideration of body practices and on how such experiences could be conducive to new strategies that actually involve patients with disabilities in their own care. This is important; if we consider that some studies have suggested that, on the one hand, the body practice of clinically observing the body of a patient with disabilities might generate a vertical relationship, wherein patients have less of an opportunity to establish a reciprocal relationship with HPs. On the other hand, when the gaze is returned by the patient, it has been shown that this practice expresses the desire and the need for a different interaction that involves both parties and bodies, disabled and able-bodied ones (Hughes, 2000). This implies that bodies, the body practices and the meanings that they generate, could be crucial to understanding how to enhance the involvement of the patient with disabilities and how to multiply the opportunities to increase their emotional and physical comfort and participation.

We have underscored the relevance of body work practices and the meanings they generate as regard both HPs' and patients' bodies to empower the participation of patients with disabilities in the development of their care. Now, we will analyze several studies on those body practices in health care sectors that are vital to grasping the HP-patient relationship, together with their potential and their gaps, for a better understanding of PCC implementation in this setting. The body practices are gazing (Foucault, 1963; Juhila et al., 2022; Källestedt et al., 2023; Nagington et al., 2021; Suijker, 2023; Turnbull & Reich, 2023), touching (Christensen et al., 2023; Cocksedge et al., 2013; Gleeson & Higgins, 2009; Kelly et al., 2018), and playing (Finlay et al., 2008; Hardy, 2020; Scholl & Ragan, 2003).

Gazing

The practice of gazing in the health care sector and its power to explain how bodies are involved in the relationship between HPs and patients were first theorized through the concept of the clinical gaze (Foucault, 1963). In his seminal

work, Foucault claimed that the gaze toward the patient was a way for professionals to exert a disciplining power meant to build effective knowledge about patients' diseases and to provide efficient care. The consequent relationship is not conceived as a reciprocal exchange: Patients are positioned and approached so as to be medically observed and healed. Through the clinical gaze, the patient's participation is not conceived as being instrumental to the actual purpose of the medical relationship, which revolves around the knowledge that HPs build through their own autonomous reflection. In this light, patients' bodies are identified with the disease or the issue the patient presents; if patients are empowered to do something through this approach, it is self-education about their disease and self-discipline (Källestedt et al., 2023; Linander et al., 2017; Suijker, 2023). More recent studies have unveiled other aspects of the gaze in order to understand the HP-patient link and how patients can be more involved and express themselves when presented with the gaze of the HPs. Although some studies have contributed by emphasizing the disciplining power of the gaze (Juhila et al., 2022), others have illustrated that gazing could be a more involving practice, where gazing is beneficial to reading any movements of the body as a source of information with which to develop care (Nagington et al., 2021). These studies have allowed us to consider different modes of gazing and different implications for the conceptualization of patients' more peripheral (or more central) role in the delivery of care. However, extant research has not yet analyzed the meanings generated in the HPs-patients interaction through body work and how these meanings may have implications for patients' participation. In addition, extant research has focused more on cognitive processes (e.g., information gathering, knowledge construction) that gazing at the patients elicits when delivering PCC (Turnbull & Reich, 2023). In the current research, we aim to understand how meanings about both HPs' and patients' bodies are constructed through different typologies of gazing and the emotional and sensorial experiences that are involved in the process of centering care around the patient when the bodies are considered.

Touching

The practice of touching in health care has been discussed within the framework of PCC in terms of the power of touching to represent a nonverbal technique that can stimulate information exchange, pick up on cues produced by patients, and shift from a more passive and technical approach to an attentive listening to patients (Cocksedge et al., 2013; Kelly et al., 2018). As a body practice, touching shows the potential to unveil a more attentive, patient-centered listening and exchange, because it stimulates one's own and others' acknowledgment through the activation of both the touching and the touched body. In addition, touching might elicit the feeling of physically being in a social, not solely medical, context (Harris, 2016).

In health care management, touching has been theorized in different ways, originally with a distinction between "procedural touching," which implies the touch needed to carry out a technical diagnosis, and "expressive touching," meant

to convey empathy, affection, and care toward the patient. Other categorizations of touching have been developed over time, considering how it might shape a more vertical (or involving) relationship with the patient. These classifications have contributed to understanding how the contact between patients' and HPs' bodies through touching could be vital to framing the structure and outcomes of medical care. Some studies have emphasized the power of technical or abusive touching in governing the relationship with patients and delimiting their space to express themselves (Edwards, 1998). Others, however, have focused on more affective modes of touching and have illustrated its effectiveness in involving the patient and exchanging cues and information (Cocksedge et al., 2013). In particular, when considering patients with disabilities, research has shown the reactions patients express and has demonstrated their feelings of being left out: When touching is absent or very hardly employed, patients miss the experience of being fully recognized in their relationship with the HP, engendering their feelings of social acceptance, making them feel out of place, and threatening their motivation to participate (Christensen et al., 2023; Gleeson & Higgins, 2009). With respect to touching, our goal is to contribute to the extant literature by understanding how certain touching modes could be linked to the meanings built by HPs both in terms of their own body and those of the patients. We aim to illustrate how touching contribute to shaping a more participative approach to care, not by focusing on a further classification of touching itself but by understanding the meanings, the sensorial perceptions and emotions it might generate by implementing a patient-centered approach.

Playing

Playing and using humor with patients is vital to implementing PCC, if we consider the enjoyable emotional states through which this practice conveys thoughts and feelings in a nonthreatening manner, thereby easing communication and facilitating confidence and openness between the HP and the patient (Scholl & Ragan, 2003). Playing can foster inclusion and promote noninstrumental interactions in the relationship with patients (Finlay et al., 2008). As a body practice, playing involves the body of HPs and patients in different ways: by introducing new objects into the medical space to imitate a game setting, by using the medical equipment in an unconventional way to create a humorous interaction with the patients, and by involving HPs' and patients' bodies in laughter and entertaining themselves. However, playing and humor have been also studied in terms of their capacity to distance the patients, when the games and jokes enacted by HPs, though meant to empower patients, do not fully consider the patients' participation. Sometimes playing might infantilize the patient or encourage their participation, but only on the terms and rules of the HPs and therefore at the expense of the patient's autonomy (Finlay et al., 2008). This is especially true when patients with disabilities are involved in an interaction based on playing and humor, because both the opportunity to feel empowered and to be involved in a "teacher-child" relationship have been documented (Jean, 2015). Through the analysis of the bodies of both the

professional and the patient, as well as the meanings ascribed to them when playing, it is possible to grasp when this body practice can define a relationship with patients based on exchange and involvement.

Method

Context of Analysis: The DAMA Units in Italy

The evolution of the health care sector with respect to disabilities in Italy reveals the dominance of the medical approach to disability up to the 2000s. The emphasis on rehabilitation was related solely to the assumed disabilities of the patient, not to the whole person. Scant importance was attributed to preventive screening (Berliri & Panocchia, 2014; Malaguti, 2010). In such a context, patients with disabilities were considered as being in need of medical care related solely to their disabilities. The change, progression, and evolution their health could undergo were ignored. Thus, their systematic access to preventive care was compromised. In the 2000s, rules and guidelines to simplify and to improve the access of patients with disabilities to health care were established in order to guarantee a more patient-centric approach. These improvements were made possible because of the ratification of the UN Convention on the Rights of Persons With Disabilities, the constitution of the Italian Committee for the Protection of People With Disabilities (Comitato Italiano per la Protezione delle Persone con Disabilità), and the creation of the Charter of Rights for People With Disabilities (Carta dei Diritti delle Persone con Disabilità in Ospedale).

In accordance with the evolution and the general principles established at the European and national level, in 2000, at a public general hospital in Milano (Ospedale San Paolo), the DAMA project was created. This unit sought to provide care to patients with complex disabilities, who have extreme difficulties in communicating, moving, and collaborating to their care in a conventional manner. The first DAMA unit was founded by three Italian surgeons who had personally experienced the difficulties that patients with complex disabilities undergo when accessing health care services. At the time of this research, DAMA units existed in an additional seven Italian hospitals beyond the Milanese one. DAMAs are focused on severely disabled people with communication problems and aim to diagnose and treat all kinds of diseases in an integrated and advanced way. For this reason, the DAMA project involves doctors, nurses, and technicians of every specialization. DAMA units, because of their managerial and organizational model, are a fruitful setting to investigate how body work and PCC can be integrated and to explain how PCC can be implemented when looking at the micro level of HP–patient interactions. Indeed, the DAMA approach is transdisciplinary; it is focused on listening to and approaching the patient from multiple standpoints so as to organize their care by focusing on their needs and preferences. In addition, professionals in the DAMA units are not dedicated full time to this project: While working in the units with disabled patients, they are also employed in other departments of the hospital where the DAMA unit is

located. Thus, they are also exposed to more traditional practices within other departments of their hospitals. These characteristics provide an insightful setting in which to investigate our research questions, because in this new context, unedited ways to practice body work, such as gazing, touching, and playing, can be observed, generating diverse sensorial experiences and new opportunities for different ways of constituting the bodies and of interacting with patients with disabilities.

Data Collection and Data Analysis

Our research questions focus on capturing how HPs engage in body work practices, on the meanings they build through this sensorial experience with patients, and on how these meanings are related to the interactions they have with them. As these are our main questions, our research problem needs to be explored through process data: fine-grained qualitative data that allow the researchers to be immersed in the processes through which the studied phenomena occur (Langley, 1999; Langley et al., 2013). Process data, indeed, do not represent just practices or routines; they are related to thoughts, feelings, and emotions and can grasp how individuals interpret and generate meanings in their interactions (Isabella, 1990). These data are appropriately collected through interviews at the micro level to investigate the perceptions and cognitions of individuals sharing experiences (e.g., Sutton, 1997), as the case is in our research. Consistent with this methodological standpoint, we carried out 39 in-depth interviews with HPs working for all the eight DAMA units located in eight cities in Italy at the time of the research (ethics approval was not required for this study).

To identify the HPs, we started by contacting the DAMA unit in Milano, which was the first one to be founded and the one accounting for the most HPs working in it on a regular basis. Using the snowball or chain sampling approach, through these HPs in Milano we contacted HPs in all the other cities where at least one DAMA clinic exists. The snowball sampling technique was chosen for different reasons that are appropriate with respect to our research questions. Our investigation functions by drawing on thoughts, perceptions, and feelings in a professional community in which individuals share a common context and processes. Snowball sampling is able to guarantee access to a good number of informants in close clusters as professional groups, particularly when they share a singular condition in terms of their status in their field and the kind of knowledge they represent and share. In this regard, the DAMA HPs can be considered pioneers in Italy in terms of their approach to patients with disabilities, and they share a distinctive approach that somehow represents a form of social capital underpinning their activities. Because of these features, snowball sampling is suitable in our case to enable us to contact professionals who share this professional and relational context.

Table 1 summarizes the interviewees' characteristics in terms of their gender, profession, and the cities where their DAMA unit is located.

The interviews lasted on average 50 minutes; the shortest interviews lasted 32 minutes, whereas the longest was about 2 hours; the interviews were held between December 2020 and

TABLE 1: Sample description

Gender composition of the sample	38% male, 62% female
Number of DAMA units involved and cities	8 units: in Milano, Firenze, Mantova, Empoli, Terni, Bolzano, Bari, Roma
Professions	30 doctors, 5 nurses, 2 physiotherapists, 1 dental assistant, 1 technician

October 2021. The interviews were conducted on the phone jointly by the first and second authors, and they were conducted in Italian, recorded, and then transcribed. The technique of phone interviews was adopted for various reasons. Phone interviews, nowadays, are frequently used in social and medical research. They enable researchers to involve people who are in different geographic areas and to preserve privacy of the interviewees, thereby enabling the researcher to deal with delicate and personal issues. However, the literature highlights that phone interviews can also present some biases. To overcome these difficulties, the authors implemented various strategies: The interviewees were welcomed in the call in a relaxed and friendly environment; furthermore, during the interviews, feedback was provided through an appropriate tone of voice by both the interviewers to make the interviewee feel comfortable and at ease. The interviews were scheduled according to the preferences of the interviewee, trying to find the best moment for them to talk, and by demonstrating the researchers' complete willingness to reschedule.

The interview protocol focused on investigating the following areas: how DAMA professionals enact body work with their patients, how they conceive and talk about their own bodies and the body of the patient, and how they interact with the patients in the production of medical care. The topic of the body and body work was explored by asking the interviewees to recall episodes of interaction with patients with disabilities and to focus on the bodies, feelings, thoughts, and perceptions related to their relationship with the patients. Consent to be interviewed and recorded for the research purpose was explicitly requested at the beginning of the process; in addition, the authors explained that anonymity would be maintained throughout the research and that HPs could interrupt or withdraw from the interview whenever they wanted to. All the informants consented to be interviewed, to be recorded, and to stay throughout the interview questions. After being transcribed, the interviews were translated into English according to the following process: The first author, who was closer to the research setting, translated first. This choice was driven by the intrinsic nature of the research goal, which requires context-based knowledge. Then, the translation was discussed with the second author. Both authors are used to writing and speaking in English, though they are not native English speakers. The translation was read also by a native speaker in both Italian and English.

Consistent with our goals and data collection process, our data analysis approach revolved around the comparison of small units of data (e.g., episodes, practices, physical perceptions, feelings, thoughts) to generate bigger categories and relationships among them (e.g., qualifying body work practices, and the meanings and the interactions associated with them).

The categories, their qualification, and related subdimensions were gradually generated by the authors by comparing continuously the smaller units of data, checking for common themes and connections among them, and engaging in a continuous exchange between the themes and the guiding theories, so as to arrive at more abstract concepts (Langley et al., 2013). In the first phase of data analysis, the interview transcripts were explored by each author separately, with a continuous iteration between the text and the literature, to enable the preliminary concepts to emerge. This phase was supported by audio and written research notes that the authors had exchanged after each interview to discuss the interview process, content, and eventually the possible preliminary themes and streams of literature that could resonate with the emerging topics. In this first phase of coding, the emerged themes referred to the concepts of "ability," "immobility," "fragility," "hopes," "recovery," and "future" and to the conceptual areas of "attention," "eyes," "hands," "emotions," "senses," "fixing," "healing," "fun," "sharing," and "participation." The comparison among the data units and between the data and the literature led the authors to regroup the themes around practices in the areas of "gazing," "touching," and "playing," by qualifying them for their distinctive features with respect to the extant literature. These distinctive features led to the more nuanced themes of "empathy" and "humor," which are markedly different to those of "technical excellence," "fixing," and the "prompt intervention" on the patient. In addition, the thematic areas of "physical capacities," "physical vulnerability," and "recovery" emerged.

In the second stage, the authors engaged more with the most resonant and fertile topics, underscoring the issues with a theoretical link and the most innovative and intense themes (Gioia et al., 2012). Such comparisons and theoretical aggregations led the authors to associate the area of "gazing" with that of "diagnosis," of "performing bodies," and of "a more detached interaction" (around 28% of respondents had contents coded to these codes and relationships). In addition, "gazing" was associated with other areas, both in terms of practices and in terms of its own qualifications, turning into an association among "empathy," "touching," "shared fragility," and "mutual acknowledgment" between HPs and patients (around 38% of respondents had contents coded to these areas). A final pattern emerged that connected "playing" and "deep sensorial experiences," together with the categories of "recovery," "resilience," and "healing" (around 34% of respondents had contents coded to these areas). The different steps of data analysis led to our findings as described below.

As our focus is on bodies and on the interaction between able and disabled bodies, we are aware that the identities of

the two authors could have an influence on the data collection and the data analysis process. The first author is a young, female, White, middle-class individual with disabilities, whereas the second author is a middle-aged, female, White, middle-class, able-bodied one; the disabled–abled identity of the authors could affect the way each of them phrased their questions to the interviewees, as well as their reactions to the answers of the interviewees themselves. The interpretation of the memories and experiences of the interviewees could have been shaped by the first author’s emotional, personal, and educational background of someone with a sensory disability (Cunliffe, 2003), as well as by the experiences of the second author. Research in health care management and in disability studies has an important emotional impact on any scholar; scholars with disabilities could risk being overly involved and self-referential or, conversely, being extremely rational and detached, so as to show impartiality. In our case, the author with sensorial disabilities tried to overcome these risks by not exploring the research problems through studies and a context that were too close to her own disability. At the same time, the able-bodied scholar could have applied her own prejudices and stereotypes about disability and disability in health care more generally; she tried to mitigate this by immersing herself in the literature and the data analysis through a deep exploration of the history of disabilities studies in health care organizations and through a continuous iteration between the data and the literature. The constant dialogue between the authors supported this attempt to maintain a strong balance in data collection and interpretation.

Findings

The Bodies That Can Do and the Bodies That Cannot Do: The Diagnostic Gaze and the Delivery of Care

Through our interviews, evidence emerged illustrating that HPS, in their interactions with patients with disabilities, can develop meanings describing their own and their patients’ body in terms of what they “can” and “cannot do.” These meanings were observed to emerge when HPs described their engagement with a peculiar gaze they developed toward the patients’ bodies. We labeled this gaze as *diagnostic*. Different from Foucault’s clinical gaze (Foucault, 1963; Holmes, 2012; Linander et al., 2017), the diagnostic gaze emerged in our findings as a body work practice through which HPs focus extremely attentively on patients with disabilities, building on the cues that their bodies provide, without dismissing them or just assuming that they could not communicate effectively what they were suffering from. Through the diagnostic gaze, the HP takes the time to carefully observe, so that the observation can transmit all the information about the patients, even their emotional states. Nonetheless, the diagnostic gaze also emerges as a body work, in which the HP thinks about and executes the care, without relying extensively on the patient’s participation. Diagnostically gazing enables the HPs to feel empowered to act in the interest of the patient, without the need to collect other cues from them beyond a profound observation.

The meanings that HPs construct about their own and patients’ bodies when diagnostically gazing are important

to account for how patients are involved in the production of their own care in this typology of interaction. In our analysis, when diagnostically gazing, HPs develop meanings about their own bodies focused on the activities that their bodies can perform, relying on a feeling of relief at being able to do things. Thus, in this typology of interaction with the patients, the HPs somehow transfer the diagnostic gazing to themselves, emphasizing what their body can do. In this light, the two bodies are thought about as the one that can deliver the care (the HP’s body) and the other as the one that receives it (the patient’s body). With respect to PCC, although diagnostic gazing ensures emotional and physical comfort to patients because it does not look at them solely clinically, it cannot elicit the full participation of the patient: It is more focused on HPs’ intervening, correctly and promptly, after having reflected autonomously.

In the following quotes, we can see what the diagnostic gaze is: In the words of the HPs, they *look at* the patient and they *execute*; they go beyond the traditional collection of technical information through their observation. Indeed, for instance, we see this quote about the care and the attentiveness HPs use to position a pillow. At the same time, the energy of the HPs’ actions and their competence to complete their tasks do not allow for a full, deep connection with the patient (e.g., patients *have to be moved, to be seated*—actions have to be performed on them to intervene and run the examination appropriately).

Once we had to manage a problem with the posture of the patients. We went and got eight pillows, which is not easy when you are asking for a single patient. Then we had to position the pillows in a particular way, helped by the description by the family of the patient. Pillows in the shape of an inverted pyramid under his head, two behind his back, one between his legs, two under his feet to prevent the heels getting ulcerated during the test. We do not ask the patient anything, we look and execute, we do not ask about the whys of the procedure, we trust the parents and what we see. (HP #19)

When observing the patient in this way, the HPs develop a sense of their own bodies that mirrors the same gaze they use with patients: They describe themselves in terms of actions, the number of things they can do. In this light, to perform (or to be unable to perform) activities qualifies the perceptions HPs have of their own bodies and of their physical, sensorial life. In the following quote, we can see how being able to do things such as walking and driving is confronted with the need to be fed and washed. The thought of being able to do things produces a feeling of emotional comfort in the HPs and eventually an urge to deliver the care to make the patients able to do things as well:

When you see people your age in a wheelchair, or needing to be fed, washed, changed by someone else and you are thinking about the fact that you could not go on holiday, then you have a second thought: I

may have a small physical problem, but at least I walk, I drive my car, I go to concerts and to the stadium. (HP #35)

Another quote reinforces this connection between diagnostically gazing and generating meaning that creates a sort of distance between how HPs conceive themselves and the patients. In the following quote, we read about an HP that, after having diagnostically observed a patient, faces a challenging moment in which the patient's body seems not to permit a traditional examination. The need to execute the medical examination and the urge to intervene lead the HP to think and act to perform an ultrasound scan. The HP looks at the body, collects his cues, and thinks autonomously about how to provide support in the most effective way.

With this patient, it was impossible to carry out the ultrasound as usual...he could not lie down because the shape of his body was extremely compromised with respect to the usual position that we ask for during an ultrasound. I had to find a new way to perform the ultrasound while he was seated on a chair, and it went wonderfully. (HP #36)

The Fragile Body and Involvement in the Care: Empathetic Gazing and Touching to Understand the Patient

Our findings illustrated that HPs also developed meanings about their own and patients' bodies of shared fragility, a fragility that defines a common ground for HPs and patients in the delivery of care. These meanings emerged when the HPs described their approach to patients through the body work practices that we encoded as *empathetic gaze* and *touching*. The empathetic gaze implies an engagement with looking at the patients, in a way that transcends both the traditional clinical gaze and the diagnostic gaze previously described. The empathetic gaze is not intended by professionals merely to perform the best execution of care: It is enacted to establish a relationship of identification with the patient. The empathetic gaze is not meant to be immediately vital for the diagnosis, but rather to start a relationship, wherein the look can somehow be reciprocated by the patients through their body.

With respect to technical touching (Watson, 1975), empathetic touching emphasizes the need to approach the diagnosis, first, by touching the patients through affective gestures, which are considered necessary to enter in a relationship of reciprocal acknowledgment with the patient. Through these empathetic body practices, HPs are led to think about their bodies as spaces of intrinsic fragility that they share with the patient with disabilities. Sharing this fragility emerges as a feeling that encourages HPs to listen to and integrate the patient in the delivery of care, as if they were in a relationship of mutual exchange. With respect to PCC, the empathetic gaze and touching enable them to increase the involvement of the patient through a more comprehensive knowledge (physical, emotional, and affective) of their conditions and a search for a reciprocal recognition in the management of their care.

In the following two quotes, the empathetic gaze and touching can be understood, together with the urgency they create as regard initiating a participative relationship with the patient. In the first one, we can see that the HP is still looking but not completely trusting this practice: An actual relationship with the patient occurs when the HP understands that the look is reciprocated and that this mutual acknowledgment can lead him to understand more about the patient (e.g., "I looked at her and we looked at each other...I understood"). In the second one, the clinical practices of touching are described as gestures adopted to let the patient feel that they and the HP are together, with both present in the diagnosis and in the care (e.g., "I take blood pressure, I listen to her heart...I am hearing you").

A 40-year-old lady arrived at the center to get the vaccination. I had been informed that she had a very serious condition, she was tetraplegic. She got in with her eyes closed so I thought she was in a state of coma, also on the basis of what her mother told me on the phone. Then, while I was writing, her mother talked to her and so I realized the lady had turned her head towards me and she was looking at me. I did not realize it immediately; I was in shock since I understood I was not paying attention. Then I looked at her and we looked at each other with such an intensity I understood she wanted to tell me something! (HP #23)

As psychiatrists, we do not focus that much on the body, but as a psychiatrist in the DAMA unit, I have to visit the body! Very often the patient is not able to communicate with me in the traditional way. So, I visit her body, I take her blood pressure, I listen to her heart. I use the tools and the procedures an internist would use much better than me for his own diagnosis. For these reasons, my gestures tell the patient: Here I consider your body and I am hearing you! (HP #38)

When HPs engage in this body work, the meanings they build about their own bodies refer to their fragility and the changes they have gone through. With respect to the meanings that emerge with the diagnostic gaze, HPs emphasize the feeling of the delicateness of their own body, framing their talk around the idea of the body as breakable and evolving. In doing this, they emphasize a feeling of sharing with patients with disabilities. The HPs share the background of the patient because they feel they identify with patients' personal experience of vulnerability. The contact with patients with disabilities has an important emotional impact that recalls intense personal memories and experiences that connect the HP with the patient. This is the case with the quotes of two HPs, who, thinking about the interaction with the disabled body, talk about private traumatic experiences and about their vulnerability.

I was about to die...serious things happened to me in my life and that nobody never really understood: a very serious disease, an intensive surgery that

compromised my appearance in some way. I was not disfigured, but for a while I had lived with a body that I could not feel as my own anymore (HP #38)

The fact that some of our patients are stressed make me think about the fact that I need to rest more, that that the medical test I am running for them would also be good for me, because I never spare myself. (HP #5)

While considering their own body's fragility, professionals consider patients' bodies as places to be acknowledged and listened to in a collaborative and integrated way. When engaging in empathetic gazing and touching, the HPs think and act to imagine and feel what their patients feel. In the following two quotes, the HPs stress the urgency "to understand" and "to learn from the patient" (HP #21); they expend energy trying to guess and to share the embarrassment and the fear of the patient when lying down in an uncomfortable position on the doctor's bed. Thus, the HP adopts hugging in order to both increase the patient's comfort and to conduct the examination (HP #31):

I always stop in front of a decisive obstacle, and I ask myself, where is the patient here? Am I considering that this is his examination and not mine? If I have to secure a diagnosis, because it is vital to go further with the care, of course I will do my best to finish the visit and all the exams. But if I focus and understand that what I am doing is more damaging than beneficial for the patient, I have to stop and learn from the patient, who has the freedom to express himself in the ways he can. (HP #21)

There was this lady, she had a serious contusion to the gluteus. There was no way to persuade her to lie down for the echography. But there was such an understanding with this young lady that we managed to organize something different for her, a unique situation in which to conduct the examination. I sat down on the clinic bed instead of her; she was hugging me and feeling comfortable, and while she was in this hugging position, the technician could conduct the echography on her back. (HP #31).

The Hoping Body and Co-Care With the Patient: Playing and Sensing With the Patient

The analysis of our interviews illustrates that, when engaging in playing as a body work practice, HPs develop meanings about their bodies around the concepts of hope and recovery, meanings that they develop on patients' bodies too. With respect to the fragile body, the meanings that emerge in this case go beyond a feeling of empathy because of a shared vulnerability. In this case, HPs share a perception of resilience and opportunities to change with the patients. Through playing, HPs live an interaction of continuous exchange with

the patients, their medical instruments and spaces, which become almost capable of activity and transformability. By playing with the patients, HPs engage in role-play, transform themselves, and joke, and thereby, they construct an experience with the patient: Feelings and perceptions become sufficiently intimate to allow a stronger collaboration. With respect to PCC, the acknowledgment and involvement of the patient is at its greatest, with respect to the other body practices. The HP and the patient walk together along the care journey, exchanging feelings, memories, and perceptions. The organizational environment and the medical instruments become interactive elements capable of generating and transmitting emotions and new meanings.

In the following quote, we can see an example of playing and of how it shapes a connection between the HP and the patient, enabled by the fact that the HP plays with his role and instruments.

I did an ultrasound on a little child who was two years old. I was the first one able to conduct an echography since this child usually cried so much, and was so nervous that it was impossible to do the examination. Very likely she had Asperger's syndrome, but she had not been yet diagnosed. However, the child was standing on the bed rather than lying down, and I gave to her a probe for the ultrasound, a fake one, so that she could play with it. She started playing with the probe and she was playing at conducting an ultrasound on my neck, while I started the actual ultrasound on her abdomen. We were mirroring our gestures; we were not conducting a test, we were playing together. (Professional #9)

When we examined more intensely the meanings that HPs build on their own and patients' bodies when engaging in this type of body work, a narrative emerged about their bodies as being able to recover from their own fragilities and uncertainties. HPs recognize disability as a common condition in patients and professionals, because it could affect anybody at any time in life, from the occurrence of an accident, dementia, or aging. The meanings constructed around the professional body express a feeling of resilience, of a continuous adaptability, stemming from the clear thought that disability is not a peculiar condition, but something intrinsic to our lives and bodies. This is exemplified in the quotes of the following interviewees:

Disability is constitutive of everyone's life. We might have a stroke or Alzheimer's. The awareness that this is part of our life is important in developing empathy towards not only disabled patients, but towards everyone, since once in a lifetime, each of us has experienced disability or vulnerability. Thus, I ask myself how I would like people to behave with me in those occasions, what kind of treatment I would like to have. (HP #25)

Disability is part of everyone's life, and it is important. Meeting disabled patients is important to understanding that we could all be in this state, and that it is nevertheless possible to live our lives in any case. (HP #6)

When playing with the medical spaces, instruments, and patients, HPs recognize their own opportunity to recover and that disability is a condition of human beings. This practice and these meanings were connected to a view of patients' bodies as "integrated," deeply interrelated, and intertwined with the HPs and the care they provide. In the following quote, the interviewee illustrates a synesthetic perception of the experience of the relationship with the disabled patient. The fragment focuses on the strong evocative power of smells and their intrinsic ability to create connections; share memories; and recall people, events, and places. The HP and the patient are connected through these sensorial experiences. They are not separated subjects with preestablished roles; they are somehow recovering and feeling more comfort together.

With that patient, I understood that the only way to get his attention and collaboration was to work with his sense of smell and let him smell certain kinds of scents. Only by creating this scented environment did we manage to run a blood test on him. Of course, we started by letting him stay practically hugged to his mother, but this was not enough to get his arm and to get him relaxed enough for us to take a blood sample without hurting him. Only when he smelled something different did he stop and let his arm go, meaning the nurse could take the blood sample easily. He was completely focused on smelling the air (...) this patient reminded me of an experience I had as a child. When I was a little girl, I was sick very often and the doctor was a regular presence in our family. So, I remembered that, when visiting me, she used two linen handkerchiefs, one for my back and the other for my chest, since she had to use her ears, as the phonendoscope did not exist at that time. When she listened to my chest, I could distinctly smell the scent of her hair, perfectly combed, and this smell came to my mind so vividly when I worked with this child. (HP #12)

Discussion

PCC is a fundamental perspective to both study and favor equal and effective access to medical care, particularly for patients with disabilities (Lotan & Ells, 2010; Salge et al., 2018; Taggart et al., 2011), whose needs, choices, and preferences have often been neglected (Shildrick, 2019; Twigg, 2006). This study focuses on the relationship between HPs and patients with disabilities in order to understand how PCC can be implemented at the micro level to enhance patients' participation and consideration in the management of their care. This study illustrates that engaging in empathetic gazing and touching and in playing with patients with disabilities produces meanings surrounding HPs' and patients' bodies that stimulate a mutual acknowledgment and a deep understanding between the HPs and patients. Through these body practices, HPs identify their intrinsic fragility and their resilience as a common ground they share with patients with disabilities. Recognizing these common physical and sensorial experiences, HPs develop a strong closeness to the patients, and

they engage in collecting cues from physical movements and sensorial information, such as sounds and smells, that would otherwise have been overlooked. These additional cues allow for a strengthened consideration of the patients in the generation of the diagnosis and of their care.

This study also identifies a practice, known as diagnostically gazing, that stimulates more traditional thoughts and feelings about HPs' abilities to heal and to intervene and about patients' opportunities to participate. While gazing diagnostically in order to attentively collect information to autonomously plan the care to be delivered to the patients, HPs develop meanings about what they cannot or can do. In such a way, HPs maintain a certain distance between them and the patients, who are observed more than involved. Through this kind of practice, the urgency to act and to use their competence to care is stronger for HPs than the opportunities to elicit and to attend to further cues that the patients might offer.

This study contributes to PCC by integrating it with body work studies and, thereby, by focusing on more micro-level dynamics. This focus reveals the importance of considering the physical, sensorial, and emotional components of the HP-patient relationship. Extant research on PCC has clarified how communication practices, organizational climate, the design of the flow of care activities, patients' education, and learning processes enhance patients' autonomy and participation. However, how the physical and sensorial experience and meanings HPs and patients share has not thus far been analyzed in order to understand how to support HPs and patients in engaging in better patient-centered care. As noted above, our study illustrates that the body practice of diagnostic gazing can support an effective and prompt intervention as regard patients with disabilities. At the same time, it might reinforce traditional relational patterns, where the HP looks for cues to structure their care, relying on the technical functioning of the bodies. Although this practice might effectively work in cases of emergency and time constraints, in a normal situation it might limit the information patients can communicate and the feeling of reciprocity that PCC should create (Juhila et al., 2022; Suijker, 2023).

This study also illustrates that time, space, and medical instruments can help the practice of empathetic gazing and touching and of playing and joking, all of which can support HPs and patients. Supporting these body practices allows HPs and patients to engage in a stronger reciprocal acknowledgment and, in such a way, in more personalized care (Davies et al., 2023; Martinez et al., 2023).

This study contributes also to a stronger integration of the literature on gazing, touching, and playing as individual body practices (Hansen & Kamp, 2018; Twigg, 2006) into health care management literature. With respect to the seminal work by Foucault about gazing and others following this tradition (Foucault, 1963; Turnbull & Reich, 2023), our study identifies different typologies of gazing by unveiling how they variously produce meanings about both HPs and patients and how they generate a different attention to patients' participation in their care. Different ways of gazing shape meanings about the bodies as sources of information about what an individual can or cannot do, and they can also acknowledge the

fragility of the bodies and a shared sense of continuous evolution between HPs and patients.

In addition, our findings illustrate the importance of the meanings that these body practices create; we have shown, for instance, that both empathetic gazing and empathetic touching produce a feeling of shared fragility that enhance the consideration of patients' involvement (Christensen et al., 2023; Kelly et al., 2018) by emphasizing the need to focus on the reactions and thoughts these empathetic body practices elicit in a care-based relationship.

When considering playing, this study contributes to the extant literature by illustrating that it represents the body practice best able to elicit the greatest range of sensorial connections between HPs and patients (Hardy, 2020). Because it involves bodies, medical instruments, and organizational spaces in a more profound way, our findings illustrate that, through playing, HPs and patients come to share more complex and articulate feelings. Through this practice, patients are acknowledged as a source of information about their needs, emotions, and preferences in a particularly deep way.

With respect to the literature focused on PCC and patients with disabilities, this study contributes by showing that PCC illustrates important specificities in this context. These specificities revolve around the need to prioritize an organizational environment, one which is able to support and to enhance the role of physical, sensorial, and emotional experiences between HPs and patients, beyond the important cognitive issues of favoring patients' education, awareness, and communication (Taggart et al., 2011).

Although it contributes in various ways to extant research, our study is not exempt from limitations. We have investigated our research questions without distinguishing between different categories of HPs. We believe that our data, our setting, and the literature on PCC and body work make our approach a plausible one, when considering that the body work literature has emphasized how the distinction between doctors and nurses, for instance, can be considered outdated, and when considering that contemporary health care organizational contexts illustrate less significant differences in terms of status, power, and direct contact with bodies across professional categories. However, we believe that, particularly as regard the disabled body, future research could further investigate how different HPs make sense of their own bodies and of disabled ones, highlighting the specific meaning-making process that a psychiatrist could attach to bodies with respect to a gynecologist or an oncologist. These differences are not meaningful in our analysis, but a further focus on doctors' specialties could illustrate more nuanced patterns of the relationship between body work and meanings assigned to the involved bodies and might also illustrate the different nuances of patients' involvement and participation in the delivery of care. In addition, we did not distinguish between typologies of disabilities and of bodies. This was not a focus of the current research, nor did it emerge through our findings; however, future research, by relying more on the literature on body appearances, could develop this.

Although we could not retrieve a recurring and different way through which female professionals articulate their body

work and conceive their own and patients' bodies, a contradicting finding emerged about the conception of the abled body, which was narrated slightly more frequently and powerfully by male professionals than female ones. Future studies could build on this contradicting evidence to study gendered patterns of integration and rejection between the disabled body and the body of the professionals.

In our research process, we have focused on HPs and how they conceive of their bodies and the bodies of the patients and how this is linked to the interaction they establish with disabled patients in the delivery of care. We have focused our data collection strategies on the professionals by interviewing them. Our approach to data collection has been consistent with our research goals and strategy of inquiry, which would not require direct observation in order to make meanings and patterns emerge (Langley, 1999). However, the opportunity to triangulate our findings by collecting data from patients and their caregivers could usefully be carried out, as could promoting the patients' views more prominently in the generation of the findings. Finally, the number of interviews we collected from the DAMA Milano unit is much greater than that of any other unit: This proportion mirrors the stage of development of the DAMA unit in the various Italian cities at the time of the research. This approach enabled us to represent all the units, while respecting their actual organizational identity in terms of size and number of HPs working full time in the unit.

Practice Implications

Our study generates practice implications for how health care organizations listen to and deal with the relevance and legitimacy of focusing on the physical and emotional experiences HPs build with patients, when they enact the body work practices of gazing, touching, and playing. Creating some space and time within health care organizations to develop sensitivity toward these aspects can generate an approach to PCC, which is able to build a stronger relationship of participation and reciprocity between HPs and patients with disabilities. As our study is focused on the more micro-level aspects of PCC, we draw practice implications about how human resource management practices and organizational processes can be designed to favor the implementation of body work practices that create a stronger involvement of the patient.

First, *voicing mechanisms and feedback sessions* (through qualitative activities, such as meetings and focus groups, and quantitative activities, such as surveys) can be arranged to listen to how HPs express and think about their emotions, the physical experiences of their patients, and their work environment. These voicing mechanisms and feedback sessions should also be structured to understand HPs' preferred approach to patients in terms of body practices, so as to foresee the most widespread patterns of interaction with patients and the implications for patients' involvement. These mechanisms could help HPs to understand, for instance, that diagnostic gazing is more likely to be coupled with thoughts and emotions that create a certain distance between HPs and patients, whereas empathetic practices, such as playing, are connected to feelings of hope, resilience, and a stronger recognition of patients' roles.

At the same time, these voicing mechanisms could work as a “thermometer” for health care organizations to grasp the extent to which sensorial and physical aspects are acknowledged by HPs as an integral part of their professional identities.

An *organizational culture* favoring the acknowledgment of both HPs’ and patients’ physical and *emotional vulnerability and encouraging the importance of emotional and sensorial experiences* should be promoted among HPs. Although emotions and more physical aspects of organizational culture seem to be more recognized nowadays by both research and practice, our findings show the importance for health care organizations to emphasize these aspects by illustrating the positive values of being aware of the importance of the body not only for diagnostic and care purposes but also in terms of organizing more inclusive interactions between patients and professionals. Encouraging this kind of organizational culture can direct the attention of HPs toward more engaging body practices and toward considering legitimate to look for a mutual sensorial and emotional recognition with patients. These organizational values can be stated and practiced by the most visible leaders in hospitals and medical centers, implemented through a shared leadership model and supported through training activities meant to promote sensitivity to the relevance of sharing our own fragility, resilience, and a recognition of the similarities between HPs and patients with disabilities.

With respect to organizational culture, health care organizations should implement also the *organizational values of bricolage*, which is the capability to rearrange a routine with the resources at hand. Our findings illustrate how playing and touching could be implemented using traditional medical instruments and routines in a new way to pursue not just a diagnostic goal but also a greater closeness and involvement with the patients. In addition, these findings indicate how these body practices might work through a recombination of health care instruments and spaces to provide more personalized care for the patients.

Finally, *sensitivity training exercises* should be arranged for professionals, so as to understand more specifically how their interactions with patients with disabilities might generate a notion of disability that limit the agency of both HPs and patients. These training sessions should be directed to spread greater sensitivity toward a deep understanding about how working with patients’ and HPs’ senses, medical instruments, and organizational space in a creative way can generate a greater involvement of individuals in producing their own care.

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