Patient Story Production as Strategic Communication: A Critical Analysis of Healthcare Brand Storytelling

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Abstract

This study examines how practitioners at leading U.S. academic health centers produce patient stories as strategic communication assets. Through interviews with 12 practitioners at 10 organizations, the study reveals professionalized production systems where tensions—between authentic representation and organizational objectives, patient agency and organizational control—shape practice. Practitioners navigate these contradictions through a dual-purpose philosophy, maintaining distance from business objectives while producing stories that serve them. Transformation narratives position patients as protagonists while blending emotional experience with outcome content for persuasive impact. The Patient Story Production Framework demonstrates how organizations coordinate exemplar selection, character development, content curation, and multichannel distribution to achieve strategic outcomes while reconciling contradictions. Critical analysis exposes physician-driven gatekeeping of patient experiences, selective representation of positive outcomes, commodification of experiences as marketing assets, and service line prioritization perpetuating healthcare inequity. The study extends strategic communication theory by revealing how organizations achieve alignment across competing institutional logics through structural separation and legitimizing strategies, offering insights for credence goods contexts.

Introduction

Patient stories have become a cornerstone of healthcare strategic communication, with all 22 organizations on the 2023-24 U.S. News Best Hospitals Honor Roll featuring them prominently across owned, earned, and paid media channels (Harder, 2023). These stories showcase patients who overcome health challenges through healthcare intervention, emphasizing transformation and positive outcomes while serving objectives such as patient acquisition, fundraising, and brand differentiation (Martel et al., 2022; McLeod, 2022, 2023; Patet, 2018). Healthcare services present unique strategic communication challenges as credence goods—services whose quality remains difficult to evaluate even after consumption due to information asymmetry and outcome complexity (Angerer et al., 2023; Schenker et al., 2014). This amplifies strategic communication's persuasive influence by increasing consumer dependence on organizational information. Patient stories transform intangible healthcare services into tangible, emotionally resonant narratives. Yet beneath apparent authenticity lies a sophisticated production system managing tensions between genuine patient experiences and strategic objectives, navigating the legitimacy-reputation balance requiring being "special in an ordinary way" (Blomgren et al., 2016) and means-ends dilemmas about commodifying patient experiences. This raises critical questions about representation, power, and ethics in healthcare communication.

Existing research has documented patient story content but not the production processes transforming patient experiences into strategic assets. Studies have analyzed how patient stories frame experiences supporting organizational legitimacy (McLeod, 2022, 2023), critiqued their role in reproducing organizational power dynamics (Martel et al., 2022), and explored practitioner motivations (Patet, 2018). However, this research examines finished products rather than production systems. Scholars have not explained how practitioners navigate contradictions

between authentic patient voices and strategic objectives—including selective representation of positive outcomes, commodification of experiences as marketing assets, and orchestration of story elements for persuasive impact—while maintaining professional legitimacy. This gap limits understanding of how strategic communicators coordinate meaning-making across competing institutional logics (van Ruler, 2018) while managing ethical tensions, and it prevents recognition of how healthcare organizations have professionalized the human interest economy and challenged brand storytelling boundaries.

This study addresses these gaps by integrating three theoretical frameworks. Thorbjørnsrud and Ytreberg's (2020) Human Interest Economy framework explains systematic management of patient exemplars as strategic resources. Mills and John's (2021) brand storytelling model reveals narrative construction through character, plot, and purpose. Shaffer et al.'s (2018) Narrative Immersion Model illuminates strategic purpose and content selection. Integration reveals how healthcare organizations engage in coordinated meaning-making—systematically aligning exemplar selection, character development, content curation, and distribution—while extending each framework's theoretical boundaries. The study introduces the Patient Story Production Framework demonstrating how coordination achieves strategic outcomes while managing inherent tensions—creating stories simultaneously genuine and orchestrated, achieving "alignment" between communication and organizational strategy (Volk & Zerfass, 2018).

Through constructionist-critical analysis of interviews with 12 healthcare strategic communication practitioners, this study uncovers systematic patient story production practices. Findings reveal a dual-purpose philosophy where practitioners maintain professional distance from business objectives while producing content serving those objectives, systematic exemplar

selection filtering experiences through organizational priorities, and transformation storylines positioning patients as protagonists overcoming adversity through healthcare intervention. The production system encompasses strategic content blending, selective disclosure excluding negative outcomes, and multi-channel distribution. Critical analysis exposes power asymmetries in physician-driven selection creating triple filtering mechanisms, ethical concerns about distorted exemplification excluding negative outcomes, commodification of patient experiences as marketing assets, and contributions to healthcare inequity through emphasis on profitable service lines while marginalizing routine care.

These findings extend strategic communication theory by demonstrating how organizations coordinate meaning-making across competing institutional logics—medical professionalism versus market orientation—while managing ethical tensions through legitimizing strategies. The contributions extend beyond healthcare to credence goods contexts where organizations balance authentic representation with strategic objectives. By revealing how practitioners navigate tensions through embedded processes where managing contradictions becomes routine organizational work, the study offers insights for financial services, higher education, and professional services demonstrating intangible value through narrative evidence. The critical implications—selective representation, experience commodification, and equity concerns—demand consideration as healthcare communication becomes central to organizational strategy. The integrated framework provides understanding of how strategic communication operates in complex environments where traditional promotional approaches face legitimacy challenges, contributing to discussions about authenticity, power, and ethics as van Ruler (2018) advocates for recognizing communication's constitutive role in organizational strategies.

Literature Review

Patient story production requires theoretical integration, as stories navigate tensions between authentic representation and organizational messaging, individual experiences and brand promises, emotional resonance and strategic objectives. No single framework explains how practitioners produce these stories while managing contradictions. This study integrates three frameworks examining how practitioners coordinate meaning-making while managing tensions in patient story production as strategic communication.

The Human Interest Economy Framework

Thorbjørnsrud and Ytreberg's (2020) Human Interest Economy framework explains how organizations leverage personal stories as resources. These stories "bring a human face or an emotional angle to the presentation of an event, issue, or problem" (Thorbjørnsrud & Ytreberg, 2020, p. 1095). Developed through research on health organization-media interactions, the framework conceptualizes a "structured and strategic system in which emotionally compelling personal stories are treated as scarce and valuable commodities" (p. 1094). Organizations compete to supply media-friendly patient exemplars—ordinary people whose experiences illustrate broader issues—while journalists seek engaging stories. Key mechanisms include information subsidies (ready-made content), strategic processes (identification, preparation, presentation of exemplars), and media hierarchies privileging certain storylines. Central is the means-ends dilemma: tension between viewing patients as autonomous individuals versus strategic means. Organizations develop legitimizing strategies framing participation as serving both individual and organizational goals. While addressing organization-media relationships, the authors acknowledge organizations increasingly bypass journalism through owned media, gaining control over framing, selection, and presentation. However, they provide limited operational detail, describing informal practices like "case registers" and "career performers"

without explaining how organizations coordinate these practices or resolve the means-ends dilemma. Their framework identifies legitimizing strategies—like framing participation as helping others—but not how organizations coordinate these practices or resolve the means-ends dilemma operationally. The framework reveals exemplar management but not systematic production processes or story construction techniques.

Brand Storytelling Framework

Mills and John's (2021) brand storytelling framework, developed through consumer goods analysis, explains how organizations construct stories to build relationships and communicate value. They define brand storytelling as "a strategic brand narrative comprising critical elements of plot and character with the purpose of representing the brand in a meaningful way to consumers" (p. 37). The framework identifies three elements: Purpose represents "the intended consumer outcome conveyed explicitly or implicitly by the brand story" (p. 43), engineered to influence perceptions and behaviors. Character encompasses "the actors, agents or role-players within the brand story that face and overcome challenges" (p. 43). Mills and John (2021) suggest either consumers or brands can occupy the protagonist role depending on purpose, assuming positioning flexibility rather than contextual constraints. Plot describes "a structured unfolding of actions or events that evolves in a sequential manner suggesting a benefit from the use of the brand" (p. 43), creating coherent stories demonstrating value through causal connections. Mills and John (2021) identify authenticity and emotional involvement as mechanisms for achieving purpose. The framework offers valuable tools for analyzing story construction where product benefits are observable and brand positioning unconstrained. However, applying this framework to healthcare reveals limitations. The framework does not address credence goods—where quality cannot be evaluated post-consumption—nor contexts where regulatory, ethical, or

trust requirements constrain positioning. Second, they delimit their model to brand storytelling, excluding corporate storytelling (internal stakeholder communication) and advertising applications. Mills and John (2021) identify these as boundary conditions requiring future research. Corporate storytelling focuses on demonstrating importance to internal stakeholders and employee bonding (Spear & Roper, 2013), while advertising is brand-initiated mediated communication designed to persuade (Kerr & Richards, 2021). This delimitation creates an opportunity to explore whether patient stories fulfill these excluded applications.

Narrative Immersion Model

Shaffer et al.'s (2018) Narrative Immersion Model provides healthcare-specific understanding of how story content influences audience engagement and decision-making. Developed from a medical decision-making perspective, the model focuses on stories supporting informed choice rather than persuasion. The model identifies three content types: Outcome content provides information about intervention results, including physical (symptom relief, survival) and psychological outcomes (peace of mind, regret). Experience content captures what undergoing healthcare feels like, providing emotional information helping audiences develop accurate expectations while creating connections. Process content describes how medical decisions are made, helping audiences understand decision-making approaches without necessarily persuading toward specific choices. The model treats these as distinct categories—outcome content persuades, experience content informs expectations, process content models decision-making—without theorizing synergistic functioning. While acknowledging outcome content includes physical and psychological outcomes, Shaffer et al. do not differentiate these subtypes or theorize different narrative functions.

The model proposes narrative effects depend on audience progression through engagement levels: interest (triggered by realism and relevance), involvement (enhanced by character-audience similarity), and immersion (facilitated by coherent plot structure and perspective-taking). While invaluable for understanding content types and engagement, the model does not address how organizations strategically select and blend content for persuasion, how narrative voices deliver different content types, or how content functions beyond informed choice. The model's assumption that narratives support autonomous choice rather than organizational objectives leaves unexplored how content operates in promotional contexts.

Supporting Strategic Communication Concepts

The frameworks require support from strategic communication scholarship addressing complex organizational contexts. Van Ruler's (2018) conceptualization of strategic communication as meaning construction—rather than transmission—illuminates how organizations coordinate across competing institutional logics: medical professionalism (emphasizing clinical outcomes) versus market logic (emphasizing consumer satisfaction) while maintaining patient voices. Hallahan et al.'s (2007) definition emphasizes strategic communication's intentional, goal-oriented nature. Blomgren et al.'s (2016) analysis reveals healthcare organizations must be simultaneously special (deserving trust) yet ordinary (accountable), a tension patient stories help reconcile. Ciszek and Lim's (2021) authenticity framework identifies five dimensions—credibility, integrity, symbolism, continuity, and representativeness—explaining how organizations construct perceived authenticity. Volk and Zerfass's (2018) alignment framework demonstrates managing competing demands through communication coordination. These concepts contextualize how patient stories function within organizational strategic communication efforts, addressing tensions inherent in healthcare communication.

Theoretical Integration and Gap Identification

While each framework offers insights, none alone explains patient story production. The Human Interest Economy illuminates exemplar management but not story construction; brand storytelling explains story elements but omits content; the Narrative Immersion Model categorizes content but not plot or character. This gap becomes significant given healthcare's credence good status, where quality remains difficult to evaluate post-consumption (Angerer et al., 2023; Berry & Seltman, 2007). Information asymmetry amplifies strategic communication's influence, making patient stories powerful vehicles for legitimacy and reputation. By integrating these frameworks, this study examines how practitioners navigate patient story production as strategic communication, exploring: (1) relationship between organizational objectives and practitioner meaning-making, (2) selection and development of patients as story subjects, (3) construction of story content and structure, and (4) deployment across communication channels. Integration reveals how healthcare organizations transform patient experiences into strategic assets addressing credence challenges while navigating ethical tensions. The synthesis provides a lens for examining how patient stories are produced through coordinated practices serving both patient and organizational interests, contributing to strategic communication scholarship.

Method

This study employs a constructionist-critical approach examining how practitioners produce patient stories as strategic communication. The constructionist dimension recognizes meaning emerges through social interaction, acknowledging patient stories are co-created through negotiations between patients, practitioners, and organizational objectives (Fairhurst & Grant, 2010). The critical dimension examines power relations, hidden assumptions, and systemic patterns shaping story production (Mumby, 2013). This dual approach enables examination of

both explicit practitioner accounts and implicit patterns revealing production processes. By combining constructionist attention to meaning-making with critical analysis of power dynamics, the study illuminates how practitioners navigate tensions between authentic representation and strategic objectives while producing patient stories.

Population, Sampling, and Participants

The study population consisted of strategic communication practitioners at U.S. academic health centers—organizations combining medical education, research, and patient care. Academic health centers were selected because they represent sophisticated healthcare communication operations with significant resources for strategic communication and established patient storytelling programs. All 22 healthcare centers on the 2023-24 U.S. News Best Hospitals Honor Roll (Harder, 2023) are academic health centers, and each maintains an active patient story program, indicating sector-wide adoption of this practice.

Purposive sampling targeted practitioners directly involved in patient story creation. Initial identification involved review of health center websites to locate patient stories and identify authors or producers. LinkedIn and professional directories confirmed practitioner roles and responsibilities. This approach ensured participants possessed direct experience with patient story production rather than general healthcare communication knowledge. Recruitment emails explained the study purpose, requirements, and compensation ($25 gift card), emphasizing that neither individual nor organizational identities would be published. The study was approved by the IRB at a large midwestern university. The study achieved participation from 12 practitioners representing 10 academic health centers (45% of Honor Roll organizations), with two organizations providing two participants each to capture different roles in story production. The sample demonstrated diversity across roles (six writers, six strategists), departmental affiliations

(marketing, communications, media affairs), and professional backgrounds (journalism, marketing, public relations). Eight participants reported five-plus years at their organization. The gender composition (11 women, one man) is consistent with healthcare marketing and communication demographics (Berlin et al., 2023; Navarro, 2024).

Data Collection Procedures

Semi-structured interviews enabled systematic exploration of patient story production while allowing participants to introduce unexpected themes. The interview guide, developed from theoretical frameworks, addressed key domains: story purpose and objectives, character selection and development, story construction techniques, content decisions, distribution strategies, and ethical considerations. Questions progressed from descriptive ("Can you walk me through the process of developing a patient story?") to analytical ("Do you think your goals differ from the organization's goals?") to potentially sensitive topics ("Do you consider patient stories advertising?"). This progression enabled participants to establish comfort discussing their work processes and perspectives before addressing questions about the promotional nature of patient stories and potential tensions between personal and organizational objectives.

Interviews occurred between October 2023 and February 2024 via Zoom, enabling nationwide participation while maintaining conversational intimacy. Recording enabled verbatim transcription while allowing the interviewer to focus on probing and follow-up questions. Interview duration ranged from 45 to 89 minutes (median: 66 minutes), with longer interviews reflecting participants' enthusiasm for discussing their work. Before recording, participants confirmed informed consent and asked questions about study purpose. Six participants accepted the offered compensation; others declined, citing organizational policies or personal preference.

Constructionist-Critical Analysis Process

Data analysis employed theoretical thematic analysis (Braun & Clarke, 2006) within a constructionist-critical framework, examining explicit practitioner accounts and implicit discourse patterns. Practitioners' accounts were viewed as socially produced through professional contexts potentially obscuring tensions and contradictions.

Analysis began with verbatim transcription, noting tone, emphasis, and paralinguistic features revealing discomfort or enthusiasm. Initial open coding assigned multiple descriptive codes to data segments while maintaining sensitivity to unexpected themes. Subsequent analytical phases were theory-driven, guided by the study's theoretical frameworks. Critical analysis examined themes for power relations, hidden assumptions, and semantic and latent patterns (Braun & Clarke, 2006). Semantic analysis captured explicit articulations; latent analysis interpreted underlying assumptions and tensions—particularly around authenticity, ethics, and boundaries between journalism and strategic communication. This involved reflecting upon what remained unsaid and whose interests were served. For instance, the finding that 80% of stories originate from physician referrals revealed power dynamics where medical authority determines which experiences achieve visibility. A second analytical phase examined coordination patterns across frameworks, revealing meta-theoretical insights about discourse coordination.

Reflexivity and Researcher Positioning

As a communication scholar with healthcare communication experience, I brought insider knowledge and critical distance to this research. My familiarity with healthcare communication enabled rapport with participants and understanding of terminology, while my academic position allowed critical examination of taken-for-granted practices. Throughout data collection and analysis, I maintained reflexive awareness of how my positioning might influence interpretation.

For instance, my critical orientation toward healthcare commodification required careful attention to participants' own complex negotiations of commercial and care logics. Memo-writing documented evolving interpretations and potential biases, creating an audit trail of analytical decisions. Participant quotes are presented extensively to allow readers to assess interpretations against practitioners' own words.

Findings

Patient story production operates as a professionalized strategic communication system coordinating five interconnected dimensions: strategic purpose and practitioner perspectives, exemplar management and character development, content construction, narrative structure, and multi-channel distribution. Organizations employ systematic practices managing inherent tensions between authentic representation and organizational objectives. These practices appeared consistently across all 10 health centers, indicating standardized approaches within elite academic medicine. Each dimension reveals formal procedures (selection criteria, review processes, distribution protocols) and embedded power dynamics (physician gatekeeping, selective disclosure, commodification logics).

Strategic Purpose and Practitioner Perspectives

The Advertising Paradox and Dual-Purpose Philosophy

Healthcare practitioners expressed discomfort when asked whether patient stories constitute advertising, revealing tensions between strategic objectives and professional identity that they resolve through a dual-purpose philosophy. When asked if patient stories were advertising, practitioners paused, laughed, or made pained expressions before acknowledging persuasive intent. "Oooh! ... In a way they are. I just ... I find that it makes it sound dirty. But yeah, we do use patient stories in advertising our institution" (P06, manager). This discomfort stems from

perceived conflicts between authentic storytelling and promotional objectives, with practitioners distinguishing patient stories as "organic" awareness tools rather than traditional advertising (P05, manager), though ultimately acknowledging: "From a lay standpoint, common sense answer, yes. Because very often these patients do agree to be in marketing campaigns after we've done stories on them" (P11, magazine editor).

This tension is resolved through a dual-purpose philosophy. Writers emphasized serving patient needs while acknowledging organizational goals, maintaining professional distance from business objectives: "Oh, they want people to come to the hospital. ... That's not my goal. Like, I don't care if more patients come to [the hospital] or not. I just wanna reflect a person's experience accurately" (P09, writer). Yet the same writer acknowledged, "I think if I do my job well, it totally satisfies what they need to do" (P09, writer). Strategists articulated similar dual purposes but emphasized organizational benefits:

> It sounds a little cold to, like, in a way you're using somebody else's story to try and get more people in. But if we can help somebody ... if there's more we can do to get patients in the door to see the right [doctors], that's what I wanna do. (P06, manager)

This dual-purpose philosophy—serving authentic patient expression and organizational objectives—functions as a legitimizing strategy justifying strategic use of patient experiences while resolving ethical conflicts.

Strategic Goals and Service Line Promotion

Practitioners identified multiple strategic objectives for patient stories, with service line promotion emerging as the dominant driver: "Ninety-five percent of the time when we bring the patient in for a story it is to support and highlight a service line" (P11, magazine editor). This market-oriented approach reflects resource allocation toward high-value services. "We're

looking at service areas where ... patients are more likely to be searching online... taking control of their healthcare and looking for options" (P06, manager). Beyond patient acquisition, practitioners identified complementary goals including financial donations, physician recruitment, and brand differentiation. "Through patient stories we demonstrate success. We demonstrate that we can tackle those really difficult cases, and patients can thrive as a result of our care" (P03, media affairs director). Physician referrals drive story selection, with one practitioner estimating "probably 80% comes through the clinician" (P11, magazine editor), creating a filtering mechanism aligning story selection with clinical priorities. This physician-driven process ensures patient stories support strategic service lines while maintaining clinical credibility, demonstrating how organizations coordinate stakeholders to produce stories serving predetermined objectives

Emotional Connection as Strategic Mechanism

Writers described emotional connection as the mechanism through which patient stories achieve strategic goals within the dual-purpose framework. Practitioners articulated this through emotional themes—hope, confidence, resilience, and connection—designed to create affective responses: "People want to feel things. ... People can see themselves in these stories, or they feel something. They cry because they're a parent, and they're reading a story about a little girl who had a heart transplant" (P07, writer). Another practitioner connected emotional response to strategic success: "If you feel connected, whether it's to that individual or to the organization, I think that's why it achieves an objective. ... It leaves you with a good feeling" (P09, writer). The emphasis on good feelings reveals how practitioners conceptualize emotional connection as essential for strategic outcomes. Writers emphasized universal themes transcending specific medical conditions: "The feeling, the emotion, the resilience, the overcoming, like those kinds of

emotional themes are the ones that I hope to convey" (P09, writer). This focus enables stories to resonate with diverse audiences while maintaining authentic patient voices. The deployment of emotion represents an approach to healthcare communication that addresses consumer anxieties while building positive brand associations through affective engagement.

Character Development as Exemplar Management

Systematic Selection of Patient Exemplars

Practitioners described organizational processes for identifying and selecting patients whose experiences align with strategic objectives. Two identification pathways emerged: physician referrals (constituting the majority, as established earlier) and organizational relationships. This physician-driven process creates a filtering mechanism where providers identify patients whose experiences support organizational priorities. The selection process involves multiple criteria. Practitioners emphasized positive outcomes: "Stories that turn out well ... The patient that got the treatment and then they're better—that's what makes a good story" (P12, writer). Beyond clinical success, selection criteria include patient satisfaction ("already expressed that they are a grateful patient" [P06, manager]), communication abilities ("they're honest and open in talking about things" [P12, writer]), comfort with public exposure ("they need to be OK and comfortable with their personal self being highlighted in this way" [P06, manager]), and diversity ("make sure we reflect the rainbow of people we serve" [P11, magazine editor]). Practitioners seek differentiating elements: "I think we look for the atypical [cases] because we're also looking at differentiators in our care" (P05, manager). This multi-criteria process ensures patient exemplars represent both successful clinical outcomes and positive brand attributes, operationalizing exemplar management by treating patient stories as strategic resources requiring careful curation.

Patient-as-Protagonist Through Co-Creation

Practitioners described positioning patients as protagonists through a co-creation philosophy: "It's kind of like a novel, you know, you've got the protagonist and their challenge" (P02, writer). The patient-centered approach serves strategic functions while addressing audience resistance to promotional content, reinforcing the dual-purpose philosophy established earlier.

Co-creation permeates story development:

> It's very much a partnership between me and the patient. I'm going to do my best to take your words, your story, and translate them into a story that communicates to people who don't know anything about your medical condition. ... But ultimately, it's their voice; it's their story. (P12, writer)

Practitioners emphasized developing patients as three-dimensional characters:

> He's not just Joe, 63 years old. He's Joe, who is an engineer and a grandfather of seven. ... As much as we can include in that story—of their life, of their pastimes, what were they doing before that they're not able to do now? (P05, manager)

This humanization creates relatable characters facilitating audience identification while demonstrating healthcare's impact on whole persons. Character development manifests emotionally: "I can't tell you how many times I interview people and they cry on the phone, even if they've had, like, a completely great outcome. But they're remembering what it was like when they didn't know [the outcome]" (P08, writer).

Co-creation manifests through practices ensuring patient agency. Formal consent establishes agreement, but practitioners described collaboration extending beyond regulatory requirements: "When we write something we send it to the patient for the patient's approval, for accuracy and comfort" (P11, magazine editor). Visual representation reinforces collaborative character development, with practitioners preferring naturalistic imagery: "We really try to get that

intimacy, that 'this is a real person' kind of feeling" (P02, writer). This approach transforms patients from medical cases into relatable protagonists whose journeys demonstrate organizational value, functioning as both ethical framework and strategic tool.

Healthcare Providers as Brand Representatives

While patients occupy protagonist roles through co-creation, healthcare providers function as supporting characters embodying brand attributes without overshadowing patient narratives. A writer noted the provider-patient relationship as crucial:

> The relationship between the provider and the patient is something I always ask about and we include in the patient story ... because it exemplifies that compassionate care [and] that they know the patient and have a relationship with the patient. (P01, writer)

This relationship validates clinical expertise while showcasing interpersonal care. Practitioners identified three brand attributes providers embody: expertise through explanations of complex procedures, compassion through emotional support, and innovation through problem-solving that makes patients "feel safe, hopeful, and confident in making the decision to get treatment with us" (P02, writer). However, practitioners noted limitations: "Doctors can be less compelling characters because people expect them to advocate for medical care" (P03, media affairs director). This positioning of providers as supporting characters represents story construction maintaining clinical credibility while prioritizing patient perspectives.

Content Construction Patterns

Strategic Blending of Content Types

Practitioners combine emotional experience content with outcome content—physical and psychological—creating stories balancing affective engagement with evidential support for healthcare quality. Experience content helps audiences understand the emotional journey:

“Healthcare can be alienating, it can seem cold and clinical, and there’s just something about a human story that can help make those things feel more comfortable and accessible” (P08, writer). Experience content dominates story beginnings, establishing emotional context: “You have to show them how bad it got if you wanna be able to show how good it got. ... If we’re gonna be able to feel with the patient, then we need that emotional scope in the story” (P09, writer). This experiential foundation creates emotional investment before introducing outcome information. Practitioners weave outcome content throughout stories, emphasizing both physical and psychological transformation. Physical outcomes appear in descriptions of symptom relief, functional improvements, and survival. Practitioners emphasized psychological transformation as essential, focusing on life impacts extending beyond medical recovery: “What helped you stay strong during your treatment? How did friends or family support you? When were you most worried? When did you start to feel hopeful?” (P02, writer). These questions elicit content about psychological journeys complementing physical outcomes: “The nut of the story is always they get something back. They retrieve something that was lost—with our help” (P02, writer).
This transformation focus accommodates diverse medical situations, including chronic conditions without cures: “We have been doing some more stories recently on... patients with chronic conditions. I think those stories are important to tell because not every story is necessarily going to be a cure” (P05, manager). Practitioners valued universal psychological themes: “God willing, we’ll never have to be so sick like that. But we all have to summon resilience in our lives for any number of challenges ... the resilience, the overcoming, like those kinds of emotional themes” (P09, writer). This strategic content blending addresses healthcare’s credence good challenge by making service quality tangible through emotional and evidential dimensions.

Minimal Inclusion of Process Content

While practitioners emphasized experience and outcome content, process content about medical decision-making received minimal attention. A manager described process content as demonstrating organizational differentiation:

> That's a priority to be in there because it's that complex care narrative again... 'I've gone to all these places, and here's where I had an answer.' And then also making sure to include... that the ultimate treatment option that was suggested by the physician the patient had equal parts in that conversation and that decision making. (P05, manager)

This frames process content as evidence of clinical sophistication and patient-centered care. Process details depend on individual cases, though overall receive less emphasis than other content types: "We would want to show that this person had options ... I would say that the decision making process is probably the least that I end up including" (P09, writer). This hierarchy—emotional experience and outcomes dominating while decision-making processes receive less attention—suggests strategic choices about which content types serve organizational objectives.

Selective Disclosure and Narrative Control

Content selection involves decisions about inclusion and exclusion, revealing narrative control mechanisms. Practitioners acknowledged selecting only stories with positive outcomes: "We focus on the benefits and the positive outcomes of a service. We don't usually talk about some of the risks unless it was relevant to their case" (P01, writer). A magazine editor (P10) echoed: "We're not going to go into risks of the procedure ... That's not our job. That's a newspaper's job or a health magazine's job." While describing selection of details as patient-driven—"We're really mindful of letting the background and the details really drive the narrative of the piece"

(P05, manager)—the focus on "stories that turn out well" (P12, writer) and omission of risk information filters the range of patient experiences represented. Practitioners described sending stories to patients for approval to ensure comfort with sensitive content. While framed as collaboration, these review processes enable organizational content of story content. Technical information appears selectively to establish expertise without overwhelming audiences: "I go really light with the complicated stuff because, you know, these are just regular people picking [up the story], and I know I'll lose them if I get into super technical stuff" (P07, writer). This selective disclosure—determining which experiences, outcomes, and details to include—demonstrates how organizations exercise editorial control while maintaining stories that feel authentic.

Plot Structures and Transformation Narratives

Transformation Journey Framework

Practitioners described employing a three-part transformation structure positioning healthcare intervention as the catalyst for positive change:

> Basically, I write in three parts. What happened to you? What [our health center] did for you, step by step, and that's when we get in and talk with the doctors and the care team. And then what life's like for you now. (P02, writer)

This temporal organization creates causal connections between healthcare interventions and patient outcomes. By establishing a "before" state of illness, the narrative creates dramatic tension the healthcare intervention resolves. The "during" phase showcases organizational capabilities—clinical expertise, compassionate care, and emotions of "what it's like." The "after" state demonstrates physical and psychological outcomes. "People go through changes. You know, there's definitely a before, during, and after in these people's lives. They're not the same"

(P02, writer). This transformation arc positions the healthcare organization as the change agent: "If we're gonna be able to feel with the patient, then we need that emotional scope" (P09, writer).

The triumph narrative accommodates various medical contexts while maintaining messaging about organizational effectiveness. For acute conditions, stories emphasize dramatic recoveries. For chronic conditions, triumph appears through improved quality of life: "Extending quality of life is equally as important a story to tell" (P05, manager). When cures are not achieved, patient exemplars are "still in a mindset where they're grateful for the fact that maybe whatever treatment that they're doing now to manage their condition is giving them quality of life" (P05, manager). Structural decisions serve the story's message: "The nut of the story is always they get something back" (P02, writer).

Journalistic Adaptation and Structural Flexibility

Many practitioners described adapting journalistic techniques to construct stories within the transformation framework: "You have your opening, you have your nut graph, then you sort of get into the chronology, and then you have your kicker [ending], and like pretty much, if you look at all my stories, that's what it is" (P08, writer). The "nut graph"—a paragraph summarizing the story—helps audiences understand narrative trajectory while establishing expectations for positive outcomes. Writers emphasized strategic placement of openings and closings: "I think mostly about the lede and the kicker. Like as I'm getting going, how do I want to start? Then I'm thinking about how I want to end it" (P09, writer). Opening techniques include dramatic moments ("a dramatic opening that's gonna pull you in" [P08, writer]), relatable details ("I look for something in that person's life that makes the person relatable" [P07, writer]), or quotes ("Good quotes up high" [P07, writer]).

Despite structural consistency, practitioners emphasized flexibility: “We’re really mindful of letting the background and the details really drive the narrative of the piece. So, it’s not like we sort of have a singular approach” (P05, manager). This includes varying chronological presentation: “I would play with the time sometimes ... we could start at the end. Or, you know, like we could start right when she got the diagnosis, or we could start when she’s already recovering” (P09, writer).

This flexibility accommodates different medical scenarios. Stories about diagnostic journeys emphasize the “before” phase. Emergency interventions compress the timeline while maintaining the three-part structure. Chronic condition stories stretch the “during” phase showing ongoing management. Practitioners also incorporate elements enhancing engagement: “I like twists ... So, like you’re going along and then something happens, and you’re like, ‘Oh wow!’ ” (P09, writer). This balance between journalistic structure and flexibility demonstrates how storytelling practices serve organizational objectives while maintaining narrative effectiveness across diverse patient experiences.

Distribution Strategies and Multi-Media Formats

Strategic Implementation of the Human Interest Story

As previous sections illustrate, practitioners describe patient stories as human interest stories (Thorbjørnsrud & Ytreberg, 2020), and this journalistic format enables channel versatility, with stories functioning across paid, earned, shared, and owned (PESO) media (Dietrich, 2020). “If we decide that in order to build volume, we need a consumer-focused marketing campaign, one of the strongest things that we can do is create patient stories, whether it’s in video format or written format” (P06, manager). The human interest story’s familiarity to audiences and adaptability across media types reveals how healthcare organizations have professionalized

exemplar management, systematically deploying patient narratives as strategic assets across integrated communication channels.

Owned Media Foundation and Internal Deployment

Stories originate on organizational websites before being repurposed across other owned channels: “They go on the website first... and then we will share it on social media and in some of our newsletters” (P01, writer). This owned media foundation establishes narrative control and search engine optimization (SEO) value while serving both external and internal audiences. Internal distribution fulfills corporate storytelling functions, building employee engagement: “I think [patient stories] are huge to the organization, to the employees and the staff to see these and realize that ... this organization that you work for has changed this person’s life” (P06, manager). Stories appear on intranets and are shared in staff meetings, making organizational mission tangible: “There is a bigger picture in all that we’re doing, and it’s not just coming out of the mouths of our leadership” (P06, manager). This dual deployment—external marketing and internal culture-building—demonstrates how patient stories fulfill both brand and corporate storytelling functions through owned media.

Shared Media Amplification

Organizations encourage redistribution through social channels and affiliates: “It goes through social media, and then people are welcome to share it. We like that—hospitals can share it; practices can share it... As long as they credit [us], we’re glad for them to reprint our articles” (P04, writer). Visual content drives social engagement: “We are in an age where photos are more interesting to people than copy... in the Instagram world, it’s so important to have the photo” (P07, writer). Editors systematically push stories to social teams, amplifying reach through organic sharing that extends story visibility beyond organizational channels.

Earned Media Through Information Subsidies

Patient stories function as information subsidies for journalists, with practitioners creating ready-to-publish packages:

> I give them the whole story. I make it so easy ... if you have video, if you have photos to share, if you show them like, 'Hey, I'm prepared. I have what you need. You really don't have to do much. Just do the interviews, and that's it.' I think that really gives places some incentive to pick it up. (P03, media affairs director)

This practice ensures message control:

> The more we can spoon feed, the more likely we are to get attention ... Now we find that even the big prestigious papers will basically pull from releases almost word for word. And we as an institution, we like that because it helps control the message. (P04, writer)

While not every patient story receives media relations support—"we won't promote every patient story through media relations" (P01, writer)—high-profile cases can achieve national coverage, with one story becoming "a 'Today Show' piece, and then on nightly news" (P05, manager). This selective earned media strategy demonstrates professionalized management of patient exemplars as newsworthy assets and the increasing prevalence of information subsidies.

Selective Paid Media Distribution

Paid media deployment remains selective, primarily through social advertising or campaign integration. "We do paid social but not for every patient story" (P01, writer). When stories align with active campaigns, organizations "integrate [them] into that paid effort ... paid Facebook, Instagram... If it's related to the [search engine marketing] campaign, we may put the video front center on that landing page" (P06). Direct paid support for individual stories is "relatively rare … I couldn't tell you the last time one of the stories had paid behind it" (P05, manager). This

selective paid deployment fulfills advertising functions while maintaining the perception of organic, authentic storytelling.

Discussion

Theoretical Contributions

This study demonstrates how patient story production exemplifies Hallahan et al.'s (2007) strategic communication definition—purposeful communication advancing organizational missions. However, findings reveal this purposefulness operates through complex indirection—practitioners achieve objectives by maintaining distance from them, suggesting credence goods contexts require sophisticated tension management.

Professionalizing the Human Interest Economy Framework

This study extends Thorbjørnsrud and Ytreberg's (2020) Human Interest Economy framework by revealing how healthcare organizations systematized exemplar management beyond the informal practices they documented, evolving into sophisticated implementation strategies across media types. Healthcare organizations developed comprehensive lifecycle management systems treating patient exemplars as renewable assets, following patients post-publication for updates—an evolution from informal case registers to formalized asset management. This professionalization includes specialized roles, standardized workflows, and explicit evaluation criteria transforming exemplar management into a strategic discipline. The dual-purpose philosophy represents a legitimizing strategy extending beyond simple means-ends resolution. By maintaining professional distance from business objectives while acknowledging strategic alignment, practitioners developed strategic authenticity through deliberate role separation and identity management. This suggests the Human Interest Economy evolved from organization-media exchange to a comprehensive production system where healthcare organizations manage

their own human interest economies. This operationalizes Ciszek and Lim's (2021) authenticity dimensions—achieving credibility through genuine representation while preserving integrity through transparent strategic acknowledgment.

Adapting Brand Storytelling Theory to Credence Goods

Applying Mills and John's (2021) brand storytelling framework to healthcare reveals theoretical extensions and adaptations for credence goods contexts. Positioning patients as protagonists rather than brand heroes responds to healthcare's trust requirements and challenges Mills and John's assertion that either can be central characters (p. 43). The supporting role appears obligatory in credence goods, suggesting positioning strategies differ from consumer goods.

This study demonstrates Mills and John's (2021) framework extends to boundary conditions they excluded—corporate storytelling and advertising. Patient stories fulfill corporate storytelling through internal use illustrating missions and values (Spear & Roper, 2013) while functioning as advertising through multichannel campaigns achieving persuasive intent (Kerr & Richards, 2021). Patient stories achieve this boundary-spanning through dual-purpose philosophy and professional distance—tension management mechanisms absent in Mills and John's consumer goods contexts, suggesting brand storytelling can fulfill multiple applications when supported by legitimizing strategies.

The transformation journey structure (before-during-after) represents healthcare-specific plot adaptation addressing Mills and John's "suggesting a benefit" (p. 43). This enables healthcare organizations to be simultaneously "special in an ordinary way" (Blomgren et al., 2016)—extraordinary medical intervention becoming relatable through the patient's authentic journey. While consumer goods demonstrate benefits through direct product interaction, healthcare services require narrative mediation to make intangible outcomes tangible and believable. The

co-creation philosophy extends Mills and John's (2021) authenticity mechanism by revealing how organizations operationalize authenticity through systematic collaboration processes. This suggests authenticity in credence goods requires procedural manifestation—formal consent processes, patient review procedures, shared editorial control—rather than emerging solely from narrative tone or content. These findings indicate brand storytelling theory requires sector-specific modifications accounting for trust requirements, regulatory constraints, and ethical considerations particular to service contexts.

Applying the Narrative Immersion Model to Strategic Contexts

Applying Shaffer et al.'s (2018) Narrative Immersion Model to strategic communication reveals how objectives influence content selection beyond the model's scope. Findings reveal a content hierarchy—outcome content dominates, experience provides emotional context, process appears minimally—driven by persuasive effectiveness rather than informational completeness. Patient perspectives deliver experience and psychological outcome content, while providers deliver physical outcome and limited process content—strategic voice distribution maximizing credibility. The original model treated content as story characteristics, not strategic choices distributed across characters. Systematic blending of experience and outcome content to create "emotional scope" challenges the model's treatment of content types as distinct categories. Findings reveal integration where experience creates emotional investment necessary for outcome content's persuasive impact—answering Shaffer et al.'s (2018) call for examining how content types work together. Findings also reveal a crucial distinction within outcome content that Shaffer et al. (2018) acknowledged but did not theorize. While the model mentioned physical and psychological outcomes without differentiation, practitioners clearly distinguish these as serving different narrative functions. Physical outcomes provide evidence of medical

effectiveness, while psychological outcomes deliver transformation themes transcending specific conditions. This distinction matters particularly for chronic conditions where physical cure is not possible but psychological transformation—adaptation, acceptance, renewed purpose—remains achievable. Even with dramatic physical recoveries, practitioners emphasized psychological journey creates emotional resonance: stories must show not just survival but transformation. This suggests reconceptualizing Shaffer et al.'s (2018) outcome content as two distinct subtypes: physical outcomes providing clinical evidence, psychological outcomes creating universal transformation themes facilitating emotional engagement regardless of medical condition.

Toward an Integrated Theory of Strategic Healthcare Storytelling

This study reveals patient story production as a sophisticated strategic communication system requiring theoretical integration. The phenomenon represents "coordinated meaning-making"—organizations systematically aligning exemplar selection, character development, content curation, plot structure, and distribution to create coherent strategic messages while maintaining apparent authenticity. This involves managing tensions between medical professionalism and market orientation, patient autonomy and organizational utility, authentic representation and strategic messaging. Practitioners maintaining professional distance from business objectives while serving them exemplifies Van Ruler's (2018) reflective meaning construction. Practitioners do not transmit organizational messages but actively construct meaning by negotiating between medical professionalism and market orientation—constitutive communication that builds rather than represents organizational reality. The Patient Story Production Framework (Figure 1) illustrates how theoretical foundations converge through coordinated meaning-making, with production processes and tension management strategies

achieving strategic outcomes while critical implications undergird the system.

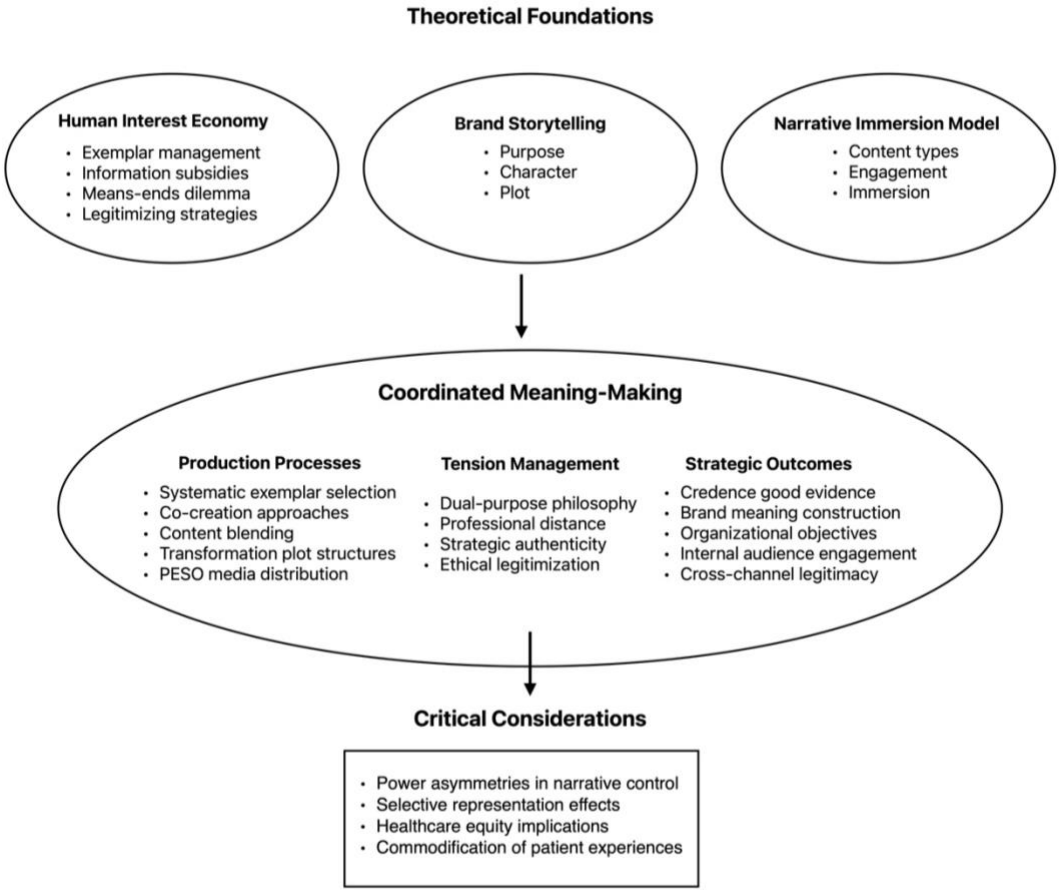

Figure 1. Patient Story Production Framework

The Patient Story Production Framework demonstrates that strategic outcomes extend beyond simple message transmission. Organizations achieve multiple simultaneous goals—patient acquisition, fundraising, and brand differentiation—while enhancing legitimacy through the synergistic effects of paid, earned, shared, and owned (PESO) media channels. Internal benefits include employee engagement and cultural cohesion, as stories make organizational values tangible. This multi-stakeholder value creation demonstrates Volk and Zerfass's (2018) alignment framework, where strategic communication coordinates competing demands across

diverse audiences—patients seeking care, employees needing purpose, donors wanting impact, and media requiring newsworthy content—through unified narrative assets. Critically, patient stories provide the credence good evidence that consumers cannot obtain through direct experience, addressing healthcare's fundamental information asymmetry. This suggests strategic communication in healthcare contexts requires what Van Ruler (2018) calls "reflective communication management," where practitioners continuously negotiate meaning across multiple stakeholder groups with different expectations and values. The integrated framework emerging from this study contributes to strategic communication theory by demonstrating how organizations manage complex, multi-level communication challenges through systematic production processes. Rather than simple message transmission, patient story production involves orchestrated meaning construction that addresses credence good challenges, navigates ethical tensions, and serves multiple organizational objectives simultaneously. This theoretical contribution extends our understanding of how strategic communication functions in complex organizational environments where traditional promotional approaches face legitimacy challenges.

Critical Analysis of Patient Story Production

Power Dynamics and Narrative Control

Patient story production reveals complex power dynamics. While practitioners emphasize co-creation and patient agency, analysis reveals asymmetric power relationships favoring organizational control. The physician-driven referral system creates triple filtering: Physicians select patients with positive outcomes, demonstrated satisfaction, and cases aligning with service line priorities. This predetermines which experiences become visible and which remain untold. This embodies Foucault's (1979) "disciplinary power"—benign procedures shape discourse

possibilities. Emphasizing grateful patients reveals organizational power operating through selection rather than coercion, choosing naturally aligned voices. Even co-creation occurs within parameters established by the organization. Patients influence how their stories are told but not the type of story—success and transformation. Practitioners maintaining professional distance while producing content serving business objectives suggests ideological functioning where power operates through positioning rather than mandate. Practitioners preserve identity and ethical comfort by dissociating from commercial objectives while producing commercial value. This represents sophisticated hegemonic functioning where power relations appear as professional autonomy while ultimately serving organizational interests.

The Ethics of Selective Representation

Exclusive focus on "stories that turn out well" (P12) raises ethical questions about representation, informed consent, and potential harm. Selective representation creates "distorted exemplification" (Zillmann, 1999, p. 85), where featured cases misrepresent typical experiences. Excluding negative outcomes means only success stories achieve visibility. This distortion becomes problematic given healthcare's credence good nature—consumers cannot independently evaluate quality and rely heavily on organizational representations. Information asymmetry amplifies selective representation's influence. Patients encountering only transformation stories may develop unrealistic expectations, leading to inadequate risk assessment or failure to consider alternatives. Ethical implications extend to public health. Consistently presenting healthcare interventions as universally successful may contribute to overutilization, unrealistic expectations about medicine's capabilities, and inadequate awareness of negative outcomes. Multiple review processes—patient approval, physician verification, organizational clearance—suggest awareness of ethical sensitivities; however, those processes primarily ensure comfort with

disclosure rather than representativeness. This questions whether current ethical frameworks address the cumulative effect of positive healthcare stories on public understanding.

Commodification of Patient Experience

Transforming patient experiences into strategic communication assets represents commodification. Patient stories become valuable resources within the human interest economy (Thorbjørnsrud & Ytreberg, 2020), where narratives possess exchange value. Lifecycle management—following patients for updates, refreshing stories, repurposing content—treats experiences as renewable resources managed for maximum return. This transforms intimate healthcare experiences into standardized narrative products packaged, distributed, and measured for strategic impact. That 95% of stories support clinical service lines (P11) explicitly positions patient experiences as means rather than ends. Although practitioners emphasize patient agency through co-creation, patient experiences become valuable only when aligned with organizational objectives. Can patients provide informed consent when full strategic utilization—future repurposing, campaign integration, competitive positioning—may not be clear? Emotional vulnerability may compromise patients' ability to critically evaluate sharing requests. Commodification may contribute to healthcare neoliberalization, where market logics penetrate domains previously governed by care ethics.

Implications for Healthcare Equity and Access

Strategic focus on service line promotion raises equity and resource allocation questions. Prioritizing stories promoting high-margin specialty services—complex surgeries, innovative treatments, quaternary care—may contribute to access disparities. Emphasis on differentiators potentially diverts resources from routine but essential primary and preventive care serving larger populations but generating less revenue. Patient exemplar selection criteria may perpetuate

representation inequities. Patients who are "honest and open" (P12) and "comfortable with their personal self being highlighted" (P06) may disproportionately represent certain demographic groups while excluding others whose cultural backgrounds, language barriers, or privacy concerns reduce participation. This selective representation reinforces healthcare disparities by making certain populations visible while rendering others invisible. Sophisticated multimedia production requires substantial investment that might otherwise support patient care. Employing specialized writers, videographers, and strategists directs organizational resources toward story production rather than clinical services. While organizations justify investments through patient acquisition and fundraising returns, opportunity costs for community health initiatives or charity care remain unexplored.

Implications for Strategic Communication Practice

Navigating Authenticity in Strategic Contexts

The dual-purpose philosophy offers insights beyond healthcare. Practitioners maintaining authentic patient representation while serving organizational objectives demonstrate authenticity and strategic intent need not be mutually exclusive but require sophisticated structural and procedural mechanisms. Role separation—writers focused on patient truth, strategists on business objectives—enables productive tension preserving authenticity while achieving strategic goals. Strategic communicators should consider role differentiation as structural solution to authenticity challenges rather than seeking complete alignment. Co-creation processes provide procedural models for maintaining authenticity. By involving stakeholders as genuine collaborators rather than sources, organizations produce strategic content that feels authentic because it emerges from genuine collaboration. However, this requires relinquishing narrative control and accepting that stakeholder voices may not perfectly align with messaging.

Practitioners creating "emotional scope" through careful content blending suggests authenticity emerges not from avoiding strategic intent but from grounding messages in genuine human experiences. Emotional truth can carry strategic messages more effectively than direct promotional content, particularly where audience skepticism toward marketing is high.

Ethical Frameworks for Strategic Health Communication

Tensions in story production highlight the need for robust ethical frameworks specifically addressing healthcare strategic communication. Current guidelines focus on accuracy and consent but inadequately address cumulative effects of positive representation, long-term story management, and experience commodification. Organizations should implement representative storytelling standards ensuring varied experiences achieve representation, including complicated cases, partial successes, and chronic conditions. While transformation narratives serve strategic purposes, exclusive focus on dramatic success stories may harm individual decision-making and public health understanding. Transparency about story selection and production could help audiences evaluate patient stories. Organizations might consider disclosure statements acknowledging featured stories represent selected experiences chosen for alignment with organizational priorities, similar to financial disclosure requirements. This transparency need not undermine strategic effectiveness but could enhance credibility by acknowledging patient stories' constructed nature. Lifecycle management raises questions about ongoing consent and narrative control. Organizations should develop clear policies about story updating, repurposing, and retirement respecting patient autonomy while enabling strategic utilization, including consent renewal and clear utilization endpoints.

Strategic Communication in Credence Goods Contexts

Findings offer insights for credence goods contexts including financial services, education, legal services, and professional services. Patient-as-protagonist positioning could translate to contexts where practitioner expertise must be demonstrated without appearing self-promotional. Centering client experiences while positioning professionals as knowledgeable guides builds trust while demonstrating competence. The transformation narrative structure provides a template for making intangible service outcomes concrete and emotionally resonant. Establishing clear before-during-after progressions helps potential clients envision their own transformation journeys, making abstract service benefits tangible through narrative structure. Strategic blending of emotional experience and concrete outcome content addresses credence goods' fundamental challenge—inability to independently assess quality. Combining emotional resonance with specific, measurable outcomes creates compelling stories that feel authentic and evidential. This approach may be particularly valuable in professional services where technical competence must be balanced with interpersonal trust.

Toward Ethical and Effective Patient Storytelling

Recommendations for Practice

Several recommendations emerge for healthcare organizations balancing strategic objectives with ethical obligations. First, organizations should implement representative storytelling standards ensuring patient stories represent the full spectrum of healthcare experiences, including complex cases with mixed outcomes, chronic condition management, and realistic recovery portrayals. While positive stories give hope, exclusive focus on optimal outcomes creates unrealistic expectations and may harm informed decision-making. Second, transparency about production processes could enhance credibility by explaining how patient exemplars are identified and stories developed and distributed, helping audiences understand both authentic

patient voice and organizational shaping. Third, patient storytelling should include formal ethics review similar to research protocols, evaluating not just individual story accuracy but cumulative representation effects and potential impacts on healthcare decision-making. Ethics committees could assess whether story portfolios accurately represent service line outcomes and patient populations. Such oversight mechanisms resemble calls for increased regulation of medical advertising (cf. Schenker et al., 2014; Schwartz & Woloshin, 2019). Fourth, organizations should develop guidelines about story lifecycle management, including consent renewal protocols, updating procedures for evolving conditions, and retirement timelines respecting patient privacy while enabling strategic utilization. Finally, investment in patient storytelling should be balanced with health literacy initiatives helping consumers critically evaluate healthcare communication and understand the constructed nature of marketing communications, even those featuring authentic patient voices.

Limitations and Future Research Directions

This study has limitations that bound its claims. Focus on elite academic health centers may not represent patient story production at less-resourced organizations. The practitioner perspective privileges organizational accounts while excluding patient and audience voices. The interview method captures reported practices and conscious reflections but cannot access actual production processes or unconscious influences. Practitioners who agreed to participate may be more reflective than those who declined. The critical stance may emphasize problematic aspects while underrepresenting genuine care many practitioners demonstrate. Data collection at one point cannot capture evolution of practices or impact of emerging technologies on patient story production. The U.S. healthcare system varies from other countries, limiting generalizability to global contexts.

Study limitations suggest multiple research paths. Studies eliciting patient perspectives could show how story participation influences patients' lives and their relationship with health centers. Studies testing patient story effects could show how consumers interpret and use patient stories in decision-making. Ethnographic observation of actual production processes—from selection meetings through development to approval—could reveal dynamics invisible in interview accounts. Comparative analysis across healthcare settings—community hospitals, safety-net institutions, for-profit systems—could show whether resource constraints or organizational missions alter production practices. Cross-national research could illustrate how regulatory environment and cultural context shape production. Studies on the "negative space"—stories not told—could reveal which patient populations, conditions, and outcomes remain invisible, informing more equitable communication strategies. Studies tracking practice evolution could capture how technological disruption, particularly artificial intelligence, might transform production, i.e., could AI-generated composite stories address ethical concerns about individual exploitation while maintaining effectiveness? These investigations would advance understanding of strategic communication in credence goods contexts while addressing questions about representation, power, and ethics in healthcare communication.

Conclusion

This study reveals patient story production as a strategic communication system navigating inherent contradictions between authentic representation and organizational control. By integrating three theoretical frameworks, the Patient Story Production Framework demonstrates how healthcare organizations coordinate meaning-making across competing institutional logics through structural separation and legitimizing strategies. This coordination addresses the fundamental challenge of credence goods: making intangible service quality tangible through

narrative evidence while maintaining professional legitimacy. However, systematic production creates consequential ethical tensions. Physician-driven gatekeeping, selective representation of positive outcomes, and commodification of patient experiences perpetuate information asymmetries and healthcare inequities. The prevalence of these practices across all elite academic health centers—and their normalization within healthcare strategic communication—demands critical attention. For strategic communication in healthcare and other credence goods contexts, authenticity and strategic intent need not be oppositional but require robust ethical frameworks ensuring representation, transparency, and accountability. The question is not whether organizations should tell patient stories, but whose stories get told and whose interests they ultimately serve.

References

Angerer, S., Glätzle-Rützler, D., Mimra, W., Rittmannsberger, T., & Waibel, C. (2023). *The value of rating systems in healthcare credence goods markets* (SSRN Scholarly Paper No. 3965318). https://doi.org/10.2139/ssrn.3965318

Berlin, G., Robinson, N., & Sharma, M. (2023). *Women in the healthcare industry: An update*. McKinsey. https://www.mckinsey.com/industries/healthcare/our-insights/women-in-healthcare-and-life-sciences-the-ongoing-stress-of-covid-19

Berry, L. L., & Seltman, K. D. (2007). Building a strong services brand: Lessons from Mayo Clinic. *Business Horizons*, *50*(3), 199–209. https://doi.org/10.1016/j.bushor.2007.01.005

Blomgren, M., Hedmo, T., & Waks, C. (2016). Being special in an ordinary way: Swedish hospitals' strategic web communication. *International Journal of Strategic Communication*, *10*(3), 177–194. https://doi.org/10.1080/1553118X.2016.1176569

Blumenthal, D., Campbell, E. G., & Weissman, J. S. (1997). The social missions of academic health centers. *New England Journal of Medicine*, *337*(21), 1550–1553.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Ciszek, E., & Lim, H. S. (2021). Perceived brand authenticity and LGBTQ publics: How LGBTQ practitioners understand authenticity. *International Journal of Strategic Communication*, *15*(5), 395–409. https://doi.org/10.1080/1553118X.2021.1988954

Dietrich, G. (2020, September 8). What is the PESO model? [Spin Sucks]. https://spinsucks.com/communication/peso-model-breakdown/

Fairhurst, G. T., & Grant, D. (2010). The social construction of leadership: A sailing guide. *Management Communication Quarterly*, *24*(2), 171–210. https://doi.org/10.1177/0893318909359697

Foucault, M. (1979). *Discipline and punish: The birth of the prison. (Trans A. Sheridan)* (pp. ix, 333). Vintage.

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. In *Field methods* (1st ed., Vol. 18, pp. 59–82). Sage.

Hallahan, K., Holtzhausen, D., van Ruler, B., Verčič, D., & Sriramesh, K. (2007). Defining strategic communication. *International Journal of Strategic Communication*, *1*(1), 3–35. https://doi.org/10.1080/15531180701285244

Harder, B. (2023, August 1). *America's best hospitals: The 2023-2024 honor roll and overview*. US News & World Report. https://health.usnews.com/health-care/best-hospitals/articles/best-hospitals-honor-roll-and-overview

Kemp, E., Min, K. S., & Joint, E. (2015). Selling hope: The role of affect-laden health care advertising in consumer decision making. *Journal of Marketing Theory and Practice*, *23*(4), 434–454. https://doi.org/10.1080/10696679.2015.1049688

Kerr, G., & Richards, J. (2021). Redefining advertising in research and practice. *International Journal of Advertising*, *40*(2), 175–198. https://doi.org/10.1080/02650487.2020.1769407

Kocher, B., & Wachter, R. M. (2023). Why is it so hard for academic medical centers to succeed in value-based care? *Health Affairs Scholar*, *1*(1), qxad002. https://doi.org/10.1093/haschl/qxad002

Lindlof, T. R., & Taylor, B. C. (2002). Producing data II: Qualitative interviewing. In *Qualitative Communication Research Methods* (2nd edition, pp. 170–216). SAGE Publications, Inc.

Martel, S. L., Strang, M., Singh, N., Shariff, S., & Marwaha, S. (2022). Co-authoring the "person" in person-centred care: A critical narrative analysis of patient stories on healthcare organization websites. In C. Elliott & J. Greenberg (Eds.), *Communication and Health: Media, Marketing and Risk* (pp. 191–207). Springer. https://doi.org/10.1007/978-981-16-4290-6_10

McLeod, M. (2023). Happy endings: An analysis of "kicker quotes" in cancer patient narratives used to promote cancer care centers. *The International Journal of Health, Wellness, and Society*, *14*(1), 15–36. https://doi.org/10.18848/2156-8960/CGP/v14i01/15-36

McLeod, M. L. (2022). Attitudes of gratitude: An analysis of 30 cancer narratives published by leading U.S. cancer care centers. *International Journal of Medical and Health Sciences*, *16*(6), 77–85.

Mills, A. J., & John, J. (2021). Brand stories: Bringing narrative theory to brand management. *Journal of Strategic Marketing*, *33*(1), 35–53. https://doi.org/10.1080/0965254X.2020.1853201

Mumby, D. K. (2013). *Organizational communication: A critical approach*. Sage.

Navarro, J. G. (2024). *Gender distribution of marketing and advertising professionals in the United States as of June 2023* (Advertising & Marketing). Statista. https://www.statista.com/statistics/1179002/gender-distribution-advertising-agencies-type-united-states/

Patet, S. (2018). *The stories they tell: How different children's hospitals are using patient stories on their websites*. University of Minnesota.

Schenker, Y., Arnold, R. M., & London, A. J. (2014). The ethics of advertising for health care services. *The American Journal of Bioethics*, *14*(3), 34–43. https://doi.org/10.1080/15265161.2013.879943

Schwartz, L. M., & Woloshin, S. (2019). Medical marketing in the United States, 1997-2016. *JAMA*, *321*(1), 80–96. https://doi.org/10.1001/jama.2018.19320

Shaffer, V. A., Focella, E. S., Hathaway, A., Scherer, L. D., & Zikmund-Fisher, B. J. (2018). On the usefulness of narratives: An interdisciplinary review and theoretical model. *Annals of Behavioral Medicine*, *52*(5), 429–442. https://doi.org/10.1093/abm/kax008

Spear, S., & Roper, S. (2016). Storytelling in organisations: Supporting or subverting corporate strategy? *Corporate Communications: An International Journal*, *21*(4), 516–532. https://doi.org/10.1108/CCIJ-02-2016-0020

Thorbjørnsrud, K., & Ytreberg, E. (2020). A human interest economy: The strategic value of turning ordinary people into exemplars in the news media. *Journalism Studies*, *21*(8), 1093–1108. https://doi.org/10.1080/1461670X.2020.1720520

van Ruler, B. (2018). Communication theory: An underrated pillar on which strategic communication rests. *International Journal of Strategic Communication*, *12*(4), 367–381. https://doi.org/10.1080/1553118X.2018.1452240

Volk, S. C., & Zerfass, A. (2018). Alignment: Explicating a key concept in strategic communication. *International Journal of Strategic Communication*, *12*(4), 433–451. https://doi.org/10.1080/1553118X.2018.1452742