

For The Record

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Through Patients' Eyes New and Not-so-New Health Communication Challenges and Opportunities

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Through Patients' Eyes

New and Not-so-New Health Communication Challenges and Opportunities

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Introduction

As the health professional community struggles to develop more integrated and cross-disciplinary approaches to medical education and practice, ironically, the healthcare consumer community has already become quite multidisciplinary in its use of health sources, services, and settings. Patients, families, and the general public choose quite comfortably from among a growing pool of traditional and alternative health resources and services provided by an expanding group of health and wellness advisors in a widening assortment of locales.

On the one hand, these options provide new opportunities and enhance patient empowerment. At the same time, they introduce formidable challenges for patients and also for health professionals with regard to the coordination of services and the assurance of safe, high-quality healthcare. The diversifying healthcare landscape accentuates the importance of communication for integrating and making appropriate use of the array of health services, sources, and settings. Unfortunately, some classic views of communication have limited value for these purposes because they focus primarily on the role of providers and their messages, and tend to understate the influence of healthcare consumers. Alternative conceptualizations of communication offer the possibility for focusing greater attention on the role of healthcare consumers and their increasingly central role in shaping health outcomes.

The Emergence of the Consumer Perspective

The shifting landscape in healthcare and the increasing attention to patient focus is reflective of a broader evolution in thinking about organizational quality and the relationship between providers and consumers in service organizations. Efforts to conceptualize and improve organizational *quality* and *effectiveness* have long been central to the work of scholars and professionals. Historically, much of this effort has focused on the *structures, functions, roles, and operational dynamics* of organizations. In the past two decades, however, across multiple sectors and settings, the emphasis on the role of *consumers* has increased. Consumers might once have been viewed simply as an assortment of individuals who uncritically react to available choices for goods and services. Contemporary perspectives, however, envision members of the consuming public as active agents with preferences that significantly influence not only organizational economics, but also conceptions of the quality of products and services, and of organizational effectiveness. In a physical sense, of course, consumers are external to the organization

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from which they acquire goods and services. However, the influence of their collective needs, expectations, satisfactions, and dissatisfactions—and the decisions that emanate from these—have led to system-oriented conceptualizations that situate consumers as internal components of organizations. In a systems-theoretic framework, producers and consumers are viewed as interacting and mutually influential. Because of this codependency, both consumer perceptions and behaviors—and those of producers—are seen as critical for assessing and advancing organizational excellence and quality.

Arguably the single most visible and influential model of this alternative way of thinking has been provided by the Malcolm Baldrige organizational framework, published in 1987, which identified “customer focus” as one of the seven critical determinants of organizational quality and performance.¹ For pragmatic reasons, widespread adoption of what came to be called “customer focus” occurred first in the business sector (Malcolm Baldrige Program, 2012). In 1999, another version of the Baldrige model was introduced that focused attention on the expectations, needs, and perceptions of students, parents, employers, and other stakeholders in characterizing and assessing the performance of schools.² An analogous Baldrige framework was implemented the same year for healthcare, and that model provided a comparably significant role for patients and other consumers in the assessment of quality in health systems. The Baldrige framework spurred interest in measuring and tracking consumer expectations and measuring satisfaction levels as a means of better understanding the perceptions and preferences of “customers.” Across all sectors, the increasing focus on consumers brought new ways of thinking, new approaches to assessment, and a number of organizational and management innovations addressing customer needs.³

The impact of what is often referred to as “consumerism” was particularly notable in healthcare, where the perspective amplified traditional concerns about the patient and his or her needs...the framework promoted a vision of patients as active, engaged, and influential healthcare decision makers and partners.

Consumer Focus in Healthcare

The impact of what is often referred to as “consumerism” was particularly notable in healthcare, where the perspective amplified traditional concerns about the patient and his or her needs. Attention to clinical dimensions of patient care had always been a central concern in medicine; the consumerism movement underscored the importance of patient focus from an economic and organizational effectiveness perspective (Reeder, 1972). In so doing, the new conceptualization promoted a shift away from a view of patients as passive, detached, dependent, and powerless consumers of services provided by expert and controlling healthcare providers. In its place, the framework promoted a vision of patients as active, engaged, and influential healthcare decision makers and partners. A growing emphasis on prevention and wellness, through regular checkups, and self-help activities, was emblematic of a paradigm shift that would lead to broadened concepts of patient empowerment in the years ahead (Reeder, 1972). In addition, this period marked the beginning of intensified efforts to listen to and better

understand “the voice of the consumer,” and to more clearly define and track patient-oriented outcomes.

One obvious way to better understand the consumer perspective on factors of importance to healthcare quality and effectiveness was to talk directly with patients. This approach had been utilized by a number of healthcare researchers, and that work provided a helpful foundation for further information-gathering focused on better understanding the patient perspective (e.g., Bertakis, 1977; Ellmer & Olbrisch, 1983; Greenfield, Kaplan, & Ware, 1985, 1986; Kaplan, Greenfield, & Ware, 1989; Omachonu, 1990; Pascoe, 1983; Reeder, 1972; Ruben, 1992a, 1992b, 2005; Waitzkin, 1984, 1986; Ware & Davies, 1983).

In my own research (Ruben, 1992a, 1995), I have sought to capture the consumer perspective by studying what patients say they most remember from their hospital stays and visits to health centers. The research involved nearly 4,000 patients at six different hospitals and healthcare settings. In these studies, patients were asked to do the following:

Think back to your stay at the hospital (or visit to the health center) and describe, in a sentence or two, your most memorable positive or negative experience. (This can be any experience related to the hospital [or center], its staff, or services.)

Patient responses were content analyzed and six themes were identified: “Most memorable experiences related to”: (1) clinical/technical facets of care; (2) administrative policies/procedures; (3) facilities/accommodations; (4) personal treatment/interpersonal communication by caregivers; (5) quality/quantity of information provided; and (6) other.

The most frequently remembered events, by a substantial margin across all healthcare institutions, were those associated with “personal treatment/interpersonal communication by caregivers.”

Participants’ narratives were then categorized based on these themes. Contrary to what might be expected, most patients did *not* report that their most memorable experiences related to the clinical or technical quality of the care they received. In five of the six healthcare settings studied, the “clinical/technical” category ranked second; in the case of the ambulatory healthcare center, the rank was third. Overall, “clinical/technical” aspects of care accounted for only

27.0% (304/1125) of reported experiences. Facilities/accommodations—which included food in the case of the hospitals—was even less predominant in patients’ recollections. The category “facilities/accommodations” ranked fourth overall, accounting for only 7.3% (82/1125) of the experiences reported.

The most frequently remembered events, by a substantial margin across all healthcare institutions, were those associated with “personal treatment/interpersonal communication by caregivers.” Across the six populations, reports with this theme accounted for 46.7% (525/1125) of all responses. “Policies/Procedures” accounted for 9.4% of the responses overall. “Quality/Quantity of information provided” ranked fifth at 5.8%, and “Other”—which included factors like cost and convenience—ranked sixth, at 3.9%.

Results from studies like this one, that focus on patient perceptions, do not provide reliable information about how patients were *actually* cared for. They do, however, reveal a great deal about how patients *perceive* they were treated, and perhaps more interestingly, about the *criteria they use* in evaluating the quality of care they receive. By implication, the study also tells us about probable sources of satisfaction and dissatisfaction among patients, helps us understand the basis upon which images of health and wellness services are formed, and provides insights into mind-sets that both reflect and shape attitudes that will likely guide future behavior.

With the exception of the small group of patients who possess medical expertise, judgments of clinical and provider quality will be inferential, based largely on the communication behavior of providers and by the information they provide and the (personal or impersonal) way they provide it.

Results from these studies also suggest that, often, when patients talk about the “quality of clinical or medical care,” they do so through the lens of personal treatment, communication, and information. With the exception of the small group of patients who possess medical expertise, judgments of clinical and provider quality will be inferential, based largely on the communication behavior of providers and by the information they provide and the (personal or impersonal) way they provide it.

The following narrative, representative of those reported in these studies, provides a number of insights that are helpful in understanding the dynamics of healthcare through patients’ eyes.

I made an appointment with the ENT to discuss a constant pulsating heartbeat sound I had had in my ear for several weeks that was driving me up the wall. I explained that I was hearing an incessant pounding of my heart in my ear, and that it was very difficult to concentrate on anything in the daytime, and even more difficult to get to sleep. After the exam, I was told that there probably wasn’t anything seriously wrong, that the problem might go away on its own or it might not, and that there really wasn’t anything that could be done to help me. The recommendation was to turn on a radio for background noise while I tried to fall asleep. A hearing test was administered and I was told to schedule another hearing test in three months—for reasons that weren’t explained. On my way out, I stopped to drop off my paperwork at the workstation, and a staff member handed me a piece of paper that appeared to be for a prescription of some kind. Puzzled, I asked the person if she knew what this was for, and she said she didn’t know—and looked at it, but said she couldn’t read it. At that moment the doctor I had seen appeared at the workstation next to me. I turned to ask him if he could explain what this was. The receptionist cut me off, and said: “Do not bother Doctor! If you’ll be seated in the waiting room, I will get that information for you.” The physician looked our way and said, “Oh, that’s for the MRI. I want to do that to confirm that there is no serious problem causing the pulsation.” This was the first I’d heard that I needed the MRI. I’ll be looking for another ENT practice.

While there don’t appear to be any major clinical or technical omissions or errors in this encounter, this was a very memorable event for the patient. From a patient perspective, situations such as these are often critical—shaping remembrances, creating stories that will be told and retold, molding attitudes toward healthcare providers and provider practices, and influencing future health-related behaviors. And, unfortunately, such situations seem to be fairly common.

As noted, memorable negative experiences often occur even when appropriate clinical procedures are followed. The fact is that patients are seldom aware of “appropriate clinical protocol,” and other “treatment” factors can be overshadowing. Thus, a breakdown in confidence, trust, and fidelity of information-sharing as well as compromised healthcare may occur, not for the lack of good intention on the part of the care provider, nor of first-rate medical skill, but rather for the lack of fully understanding—or fully demonstrating an understanding of—the patient perspective on the quality of care. As one patient put it, “When you’re a patient you’re very vulnerable; little things are so important in those situations.”⁴ Too often, what Mishler (1981) termed the “voice of medicine” draws solely on “the biomedical model.” This technical-instrumental approach “strips away social contexts of meaning on which a full and adequate understanding of patients and their illness depend” (Mishler, 1984, p. 192).

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In some respects, the remedy for these problems seemed quite straightforward, and various efforts were undertaken with the goal of heightening healthcare professionals’ sensitivities to the patient viewpoint, and by implementing educational programs that focus on improved patient relations and consumer service (e.g., Bowman & Ruben, 1986; Leebov, 1988; Ruben, 1985; Ruben & Bowman, 1986). These efforts have also often included patient and family satisfaction surveys, the creation of “Patient’s Bills of Rights,” and the publication of various guides and lists of recommended practices, such as the following checklist based on the work of Jeppson and Thomas (1994):

Does your physician exhibit these behaviors associated with patient-centered care?

1. Listens to all symptoms before making a diagnosis.
2. Is knowledgeable about the patient's condition; past and current status.
3. Is very knowledgeable about diagnosis and current treatments; staying up to date on current medications and recent research.
4. Encourages patients and family members to ask questions and participate in the care experience.
5. Gives options for solving problems and suggests ways in which the patient and family members can participate in care.
6. Collaborates with patient and family members in seeking additional solutions.
7. Volunteers information about agencies that provide additional services and knows how to access those services.
8. Uses familiar terminology or carefully defines new terms; checks that patient and family members understand.
9. Takes time and does not seem rushed.
10. Follows through on care and outcomes.

The need to address these issues in a more formalized manner has also been recognized, and in 2009, the National Alliance for Physician Competence published *A Guide to Good Medical Practice—USA*

(National Alliance for Physician Competence, 2009, p. 1). Six physician competency areas identified as essential to patient-centered care were listed in the *Guide*: (1) patient care; (2) medical knowledge and skills; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professional behavior; and (6) systems-based practice (National Alliance for Physician Competence, 2009, p. 2). The *Guide* was intended to advance, for the first time, a common language and agenda for physician education, accreditation, certification, and licensing, and to “support the development of a common view of professional responsibility among individual physicians” (National Alliance for Physician Competence, 2009, p. 1).

In 2011, the Picker Institute released a report entitled *Creating an Optimal Patient Experience* that provided a summary of these developments:

Over the last decade, increasing attention has been focused on the importance of measuring and improving the healthcare experience of patients and families. Spurred by the Institute of Medicine’s 2001 report on *Crossing the Quality Chasm*, and motivated further by the public reporting of HCAHPS and the evolving use of patient experience measures in accreditation and pay-for-performance programs, hospitals and healthcare systems are striving to become more patient- and family-centered. (Picker Institute, 2011, p. 3)

There have been varied efforts to articulate and address the need for more patient- and family-centered care. But, as indicated in the 2011 Picker Report, a substantial gap and many additional opportunities for improvement remain:

Despite growing levels of activity, the nation’s healthcare system still falls short of providing an optimal experience for patients and families. Data from national and international studies indicate that patients often rate hospitals and medical care providers highly, but report significant problems in gaining access to critical information, understanding their treatment options, getting clear explanations regarding medications, and receiving responsive, compassionate service from their care providers. The traditional approaches to improvement simply are not producing a patient-centered healthcare system. (Picker Institute Report, 2011, pp. 6–7)

Efforts continue toward improving what is now often being termed the *patient experience*. Fueled in part by the Affordable Care Act and plans to tie payments to value and quality of care, attention is increasingly being devoted more broadly to care coordination, communication with providers, empathy, and staff responsiveness.⁵

The Role of Communication: A Central Element in the Problem and the Solution

Of the various factors identified as impediments to patient focus—as well as in efforts to reduce those impediments—communication has been a primary consideration. Communication processes are acknowledged as essential not only to greater patient satisfaction, but also to more accurate patient reporting and disclosure, reduced uncertainty, greater engagement in decision-making, increased social support, more effective utilization of healthcare options and facilities, better adherence to treatment

regimens, improved clinical outcomes, and enhanced prevention and wellness (Arora, 2003; DiMatteo & DiNicola, 1982; Greenfield, Kaplan, & Ware, 1985, 1986; Hulka, Kupper, Cassel, & Mayo (1975); Kaplan, Greenfield, & Ware, 1989; Thompson, Robinson, & Brashers, 2011; Zolnierek & DiMatteo, 2009). Greater attention to communication with patients and their families also contributes to practice-building and to a reduction in patient complaints and litigation (Beckman, 1995; Nichols, 2003; Vukmir, 2004).

In its 2011 Report, the Picker Institute reported its conclusion that communication and care transitions were the two overarching themes that patients, families, providers, and experts all agreed were essential to quality patient-centered care.

Consistent with this conclusion are the numerous training programs, curricula, and certification requirements that have increasingly emphasized patient-centered communication. Beginning in 1999, six competency areas, three of which included communication skills, were introduced by the Accreditation Council for Graduate Medical Education (ACGME), and since 2004 medical students have been required to participate and be evaluated based on a clinical interaction with a fictionalized patient as a part of Step 2 of the United States Medical Licensing Examination (USMLE) (Brown & Bylund, 2008). This requirement was designed to promote patient focus and to address public expectations that physicians would be able to effectively demonstrate communication competencies in interactions with patients. Since its implementation deficiencies have been identified in approximately 3,400 medical students (First, 2013; Lehman & Guercio, 2013). The examination is also credited with promoting changes in clinical skills curricula and education (Gilliland, La Rochelle, Hawkins, Dillon, Mechaber, Dyrbye, Papp, & Durning, 2008).

The emphasis on communication and communication training has increased substantially over the years, yet according to the Picker Institute and others, these efforts have not led to the dramatic improvement in patient satisfaction and other patient-focus outcomes that have been anticipated.

In addition, accredited post-graduate training programs now must demonstrate that patient-centered skills—including communication—are taught and assessed (Brown & Bylund, 2008).

It is clear that the emphasis on communication and communication training has increased substantially over the years, yet according to the Picker Institute and others, these efforts have not led to the dramatic improvement in patient satisfaction and other patient-focus outcomes that have been anticipated.

Core Concepts of Health Communication

Sending and Receiving Messages: MS ≠ MR

Although the issues involved are numerous and complex, limitations in the way communication is sometimes conceptualized and in the manner in which those conceptualizations have been translated into practice may provide a partial explanation for the failure to realize desired outcomes.

Quoting from the Picker Institute Report:

Communication encompasses *the exchange and sharing of information* [italics added] among several key players of the healthcare team, including communications between patients/families and providers, as well as among providers collectively responsible for a patient's care. Communication is a foundation of effective patient-provider partnerships. It is a theme constant in any interaction a patient may have with the healthcare system. (2011, 6–7)

As much as “the exchange and sharing of information” is a familiar and customary way of describing communication,⁶ this portrayal oversimplifies and actually obscures some critical nuances of the process. The discipline of communication concerns itself with *the way people create, convey, select, and interpret the messages that inform and shape their lives* (Ruben, 2011). Most essential in the dynamics of health communication are the activities associated with *whether and how people sense, make sense of, and react to the messages in their environment*. Some messages are intentionally created; others are produced accidentally. Some messages are constructed to achieve specific goals or intentions; others may be created by their initiator with no specific purpose in mind. Some messages are created in the moment in face-to-face settings; others at remote times and places, and conveyed into a particular setting by means of print or electronic media (Ruben & Stewart, 2006).

The implication of this view of human communication is that at any moment in time an individual is being bombarded with messages of varying sorts, intentions, and origins—including even “intrapersonally” sourced reflective messages generated by the individual. All in some sense compete for one's attention (Ruben, 1975). The act of selecting a particular message, making sense of that message, and responding in specific ways is a complex, personal, and subjective process, and quite difficult to predict, let alone control—even in the case of what would seem to be very simple messages, with straightforward intentions. A profound consequence of this perspective is that outcomes of communication are not easily shaped or controlled by message senders, but rather are guided by the predispositions, susceptibilities, and take-into-accountabilities of the receivers (Thayer, 1968).

A profound consequence of this perspective is that outcomes of communication are not easily shaped or controlled by message senders, but rather are guided by the predispositions, susceptibilities, and take-into-accountabilities of the receivers.

The “information exchange and sharing” view reflects the presumption that, in communication, messages are created and transmitted in a linear and machine-like way, and then appropriated by a receiver who translates the message to mean exactly what the message initiator intended. The reality, however, is that seldom does message sent = message received. The reason is that in any message-sending/message-receiving situation, each party brings his or her own unique “maps” and “personal luggage”⁷—his or her unique needs, values, attitudes, goals, aspirations, styles, education, cultures, physical and emotional

abilities and disabilities, life history, present life circumstances, goals, and aspirations. These “belongings” travel with an individual and influence every aspect of the way messages are created, sensed (or not), made sense of, and reacted to (or not). Often the communication “luggage” of one individual does not align all that well with the attributes, outlooks, states, and orientations of others

with whom they are engaging. Generally speaking, the greater the extent of mismatch, the less the likelihood that message-sent will equal message-received (Ruben & Stewart, 2006).

All of these factors are at play in even the most basic situation, and the net result is that communication is an extremely complex phenomenon. Unfortunately, that complexity is not well captured by definitions that talk about the exchange, sharing, or transmission of information.

A poignant example of these dynamics is provided by the communication efforts undertaken in the United States to bring about smoking cessation. Beginning in 1965, packages of cigarettes prominently displayed a warning message cautioning consumers that smoking had been determined to be a serious health risk. The mechanistic view of communication would predict that as consumers noticed, read, and digested this message, they would understand the dangers of smoking, react logically to the message, and make an effort to quit immediately. In fact, initial exposure to these messages brought about only limited MS = MR impact.

More than 40 years later, as a consequence of purposeful, highly redundant message-sending from a multitude of sources through multiple channels, a striking decrease in smoking occurred—from 42.4% of the U.S. population in 1965 to 19.8% in 2007. While impressive in its longitudinal impact, even this massive, systemic, and highly organized communication campaign has been less than fully successful with some 20% of the smoking population—many of whom are new smokers and not subject to addictive influences in their initial decision to smoke or not.⁸ This case underscores the limitations of the linear, cause-and-effect view of communication, and similarly reminds us that single messages and single message-sending events seldom yield momentous message-reception outcomes. Rather, communication is an ongoing process through which messages wash over individuals—somewhat analogous to waves repeatedly washing upon the shore. Over time these messages shape the sensibilities and responses of receivers, much as waves shape a shoreline. The exceptions to this subtle process are those rare, life-changing messages—often health-related in nature—that can have a tsunami-like impact on message reception.

Provider-patient communication is the prototypical example of a problematic setting. One reason pertains to differences in needs, purposes, beliefs, predispositions, emotional states, and educational background the individuals bring to the health communication situation.

The challenge of communication in typical healthcare settings is exemplified in research by Wertz, Sorenson, and Heeren (1988) which demonstrated that, at the end of 40–60 minute genetic counseling sessions, just less than half (47.4%) of patients and counselors left the session knowing the primary issues the other had wanted to convey. These sorts of interactions become even more challenging with the explosion of data from all types of sources on predictive and prognostic genetics. How, for example, will the clinician, in a 30-minute consult, communicate what is essentially a complex probabilistic recommendation for a woman who may want to consider having her breasts or ovaries removed based on her genetic profile and her family history, but who also has a strong desire to have children. Other studies report the presence of communication problems in 84 – 94% of clinical encounters (Fallowfield, Lipkin, & Hall, 1998; Foot & Sanson-Fisher, 1995; Lerman, Daly, Walsh, et al., 1993).

As this research illustrates, provider-patient communication is the prototypical example of a problematic setting (Ong, DeHaes, Hoos, & Lammes, 1995). One reason pertains to differences in needs, purposes, beliefs, predispositions, emotional states, and educational background the individuals bring to the health communication situation (Kirmayer, 2012; Rosenstock, 1966). Providers come to medical encounters with a particular set of needs and goals, including the desire for full and accurate medical history, information pertinent to diagnosis of the presenting problem, efficient information exchange, and patient compliance and cooperation.

Other communication goals—not directly related to patient care—may include such things as the desire by the healthcare provider to expedite a patient conversation because he or she is nearly an hour behind in his or her schedule. Or, the provider may be preoccupied by a presentation he or she will be making to colleagues later in the day, frustrations with the clinical or patient skills of his office staff, or concerns about financing the renovation of the facility.

For their part, patients enter the situation with needs that only partially correspond with those of the physician. In addition to goals related directly to clinical care, they may also have concerns about how to best describe their health concern, a need to reduce uncertainty about their condition and its future implications, and anxieties about disclosing personal information on a sensitive topic. In cases of chronic or serious illness, such as a diagnosis of cancer, an initial patient visit is often the beginning of a long journey in which they want to be able to rely on their physician for informational and decision-making support, as well as for emotional and social support (Arora, 2003; Butow, Brown, Cogar, Tattersall, & Dunn, 2002).

There was a time when physicians enjoyed more complete control of the message-sending, message-receiving process related to health communication. In these circumstances, knowledge differentials, professional deference, and limited direct access by patients to alternative information sources greatly privileged physicians and other professional providers in their efforts to more directly shape and control patient communication.

Additionally, patients may be frustrated about having to wait an hour to be seen, annoyed with the lack of courtesy of the doctor's office staff, or dismayed at the condition of the examining rooms and the equipment, and so on.

Viewed from the perspective of human communication, the complexity that is present in healthcare provider-patient encounters is extraordinary. The luggage and maps that each interactant brings to the situation are extensive and multifaceted, and the challenges to effective and satisfying communication—from the perspective of either party—are formidable, to say the least.

The Diminishing Centrality of Face-to-Face Health Communication

There is another significant health communication challenge to consider. Given the changing healthcare landscape, only a limited—and likely a decreasing—amount of the communication that plays a role in shaping healthcare practices occurs directly between a professional provider and his or her patient. There was a time when physicians enjoyed more complete control of the message-sending, message-

receiving process related to health communication. In these circumstances, knowledge differentials, professional deference, and limited direct access by patients to alternative information sources greatly

Alternatives to face-to-face communication are proliferating, access is broadening, and the technological skills needed to take advantage of these options are becoming increasingly commonplace.

privileged physicians and other professional providers in their efforts to more directly shape and control patient communication. Diagnosis and the provision of healthcare typically were administered by doctors and nurses in professional clinical healthcare settings—the physician’s office, a clinic, or a hospital. But those times have been changing. Alternatives to face-to-face communication are proliferating, access is

broadening, and the technological skills needed to take advantage of these options are becoming increasingly commonplace.

To illustrate, consider the following actual transcription of a health communication event, with names and other minor details changed for anonymity and clarity. The vignette involves Ned (a nine-year-old boy), Rene (Ned’s mother), Mike (Ned’s father), their pediatrician, Jane (Rene’s Mother/Ned’s grandmother), and Bruce (Rene’s Father/Ned’s grandfather).

Mike and Rene took their nine-year-old son, Ned, to their physician in order to discuss their concerns that Ned snored loudly, had trouble sleeping, woke up and got up frequently in the night, and often remembered none of this in the morning. After examining Ned, the family physician expressed some concern about large adenoids and thought a sleep center assessment would be appropriate.

The results at the sleep center indicated he had an obstruction of some kind, which could be adenoids, and that his oxygen level was only 90 percent; therefore Ned would need to have an EKG and see an ENT specialist.

The EKG was scheduled, the test was conducted and read, and the physician’s office phoned Rene to advise her that she would need to call to schedule a follow-up appointment with a specialist. The following is the email exchange that transpired immediately after the phone call to Rene.

From: Rene@aol.com
Sent: Friday, January 8, 2013 1:17 PM
To: Mike; Jane; Bruce
Subject: first degree heart block

I just got a call from the doctor’s office. They found a first degree heart block.

From: Jane@comcast.net
To: Rene; Bruce
Sent: Friday, January 8, 2013 1:18 PM
Subject: RE: first degree heart block

What does that mean?! What has to be done?

From: Rene@aol.com
Sent: Friday, January 8, 2013 1:19 PM

To: Mike; Jane; Bruce

Subject: RE: first degree heart block

I don't know. They said the cardiologist could be seen on Jan 20th. But, I asked to call the hospital to see if I can get in sooner than the 20th and let me know. The degree of the block will determine if they need to do anything about it...he doesn't know now.

From: Bruce@comcast.net

Sent: Friday, January 8, 2013 1:22 PM

To: Rene; Mike; Jane

Subject: RE: first degree heart block

I'm checking the NIH website. This explanation seems quite good, and it explains that a "first degree heart block" is the least severe, and it sounds like typically, no intervention is required. So, it's good the problem was detected so it can be followed up, but hopefully, it will turn out to be nothing of major consequence. <http://www.nhlbi.nih.gov/health/health-topics/topics/hb/>

From: Rene@aol.com

Sent: Friday, January 8, 2013 1:28 PM

To: Jane; Bruce

Subject: RE: first degree heart block

Yes.... I am just starting to read some info and it really does sound like first degree isn't so bad, thank goodness. It sounds a lot worse than it is. When she said "first degree..." I was thinking of first degree... as in murder! But sounds like it's more like as in first degree burn!

From: Jane@comcast.net

To: Rene, Bruce

Sent: Friday, January 8, 2013 1:43 PM

Subject: RE: first degree heart block

Yes, the words "first degree" were startling to me too—but the reverse in this case—fortunately. You wonder if without the sleep study this would have ever been found. It sounds like possibly one of those things that people might have but never be aware of unless they have an EKG.

From: Bruce@comcast.net

Sent: Friday, January 8, 2013 1:44 PM

To: Rene; Mike; Jane

Subject: RE: first degree heart block

The words ARE alarming—and you think "first degree" might be the worst end of the spectrum, but it's just the opposite. Have tried to read through a more technical research piece, and again it says that "In general, no treatment is indicated for asymptomatic isolated first-degree atrioventricular (AV) heart block." So, this is a concern to follow up on, for sure, but nothing to cause panic.

From: Rene@aol.com

Sent: Friday, January 8, 2013 1:52 PM

To: Jane; Bruce

Subject: Re: first degree heart block

The cardio is in the hospital near our office.

From: Jane@AOL.com

To: Rene, Bruce

Sent: Friday, January 8, 2013 1:33 PM

Subject: Re: first degree heart block

That's great that the hospital facility is so close to you—is this affiliated with that new hospital at all, or a separate facility? The cardiologist is a man? Do you know anything more? From what I could find on the web, it appears that he's been affiliated with several hospitals around here—if I have the right person.

From: Rene@AOL.com

Sent: Friday, January 8, 2013 1:53 PM

To: Jane; Bruce,

Subject: Re: first degree heart block

Yes, it looks like he is in (another hospital), too. They are affiliated with the both hospitals, I think. No....The hospital in Your Town is only affiliated with the hospital in Another Town...

From: Mike@aol.net

Sent: Friday, January 8, 2013 1:57 PM

To: Bruce, Rene, Jane

Subject: RE: first degree heart block

I've just been catching up with these emails. Thanks for forwarding [these messages]. The name "heart block" sounds pretty scary, but after reading this I guess we can feel a little better. And knowing that he has so much energy all the time means that he can't be too bad.

All these exchanges transpired within a 45-minute period, with no direct contact with any healthcare professional, and before any formal efforts directed toward patient “information sharing and exchange” were initiated. Within this short time period, a phone had been used to notify the parents to follow up with a cardiologist. That triggered a number of email exchanges among members of the family, all trying to acquire information and clarification from one another and the Internet. There were also needs for emotional support and reassurance that were met through communication with other family members and by web-based information sources. Lay and professional sites on the Internet were utilized for self-

It is significant to note that, often, a primary professionally trained provider has no opportunity to mediate the information received from “other” caregiving sources, and as a result, is unable to control the quality, safety, accuracy, or applicability of the information in a given situation.

education, and the web was also used to identify and assess physician credentials and the hospital's reputation. All of this interaction occurred outside of the scope of awareness, control, and direction of physicians or other healthcare professionals.

The vignette demonstrates the complexity of communication, and illustrates the central role message selecting, interpretation, and response play in the process. Even in the absence of intentional message-sending by physicians or other healthcare professionals, some of the most critical functions of health communication occur.

Increasingly, a number of the health communication roles once primarily the province of professionally trained and licensed physicians and nurses interacting with patients in face-to-face contexts are being provided in a broadening array of settings and by an expanding cast of healthcare providers. Pharmacists, nutritionists, and personal trainers play an increasingly central role as “primary” information providers for many patients. Health communication occurs in health food shops, retail

stores, through television, billboards, and magazine ads, as well as via the Internet. Healthcare provider roles are being performed not only by trained and licensed professionals, but also by support groups, pharmaceutical advertisements, health food store personnel, TV celebrity product endorsers, and peer and group sourcing sites via the Internet (Pilzer, 2003).

Clearly, the growing number of health and wellness message-sending sources and settings may be accurate or inaccurate, helpful or harmful, directing or misdirecting. As the options have expanded, information has become less centralized, and those traditional professional providers with specialized expertise and training for their roles have increasingly less direct control over health communication processes. It is significant to note that, often, a primary professionally trained provider has no opportunity to mediate the information received from “other” caregiving sources, and as a result, is unable to control the quality, safety, accuracy, or applicability of the information in a given situation. In such circumstances, because providers are not a part of the communication process, their credibility and the perceived value of their professional expertise may not only be diminished in a particular instance, but over time will have a cumulative effect as well.

The professional health and wellness community is actively exploring new models and methods for encouraging integrated and inter/multidisciplinary professional training and patient care (Interprofessional Education Collaborative Expert Panel, 2011). Paradoxically, many consumers have found their own paths to “multidisciplinarity” in their thinking and their use of health and wellness services, settings, and sources. This multidisciplinarity manifests itself in the growing array of professional and alternative information providers and contexts, and the familiarity and comfort consumers have with these settings. Not all of these sources are equally accessible, and this factor alone may be critical in choices patients make as to whether to seek information and care. Does an individual make an appointment to see a nutritionist or simply stop at a health food store to get advice on supplements from the clerk there? Or, does a person schedule an appointment with a physician who may have no available times for two months, or elect to make his or her decisions based on product endorsement by a celebrity on a television infomercial?

The central point is that conceiving of health communication as an information exchange process, initiated and directed by the physician, is a limited and limiting conception. Communication is far more complex, far less linear, less predictable, less controllable, and less directed by physicians and other professional providers than traditional conceptions imply—particularly for a generation with a growing comfort with technology.

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Relationships and Impressions

As Lussier and Richard (2008) note:

The importance of interpersonal aspects of the practice of medicine has been universally recognized since ancient times. The doctor-patient relationship is at the heart of the practice of medicine, and it has been an object of rigorous scientific inquiry for the past 40 years. (p. 1089)

Relationships are a critical force in healthcare, and communication is the means through which interpersonal dynamics operate and relationships are formed and maintained. While conveying information is often the explicit goal for communication, in the process of pursuing this purpose, relationships and impressions emerge and evolve generally in a far more implicit way and with a significant and enduring impact (Ben-Sira, 1990; Ruben, 1990a). These processes, while generally not the primary focus of communication, create the backdrop and a context for future message-sending and receiving, and predispose the parties involved to particular expectations, patterns, and outcomes.

Generally speaking, the instrumental goals of communication pertain to *what* one consciously intends to convey through communicating—the explicit content of a message transmitted in an interpersonal or mediated modality. The *way* it is conveyed—the timing, tone, language choices, gestures, and facial expressions—represent the meta-communication that shapes and influences the manner in which the content is reacted to in the short run, and in the long run forms the fabric of relationships and impressions that influence future interactions (Fox, Heritage, Stockdale, Asch, Duan, & Reise, 2009; Street & Wiemann, 1987; Watzlawick, Beavin, & Jackson, 1967). Physicians' expressions of empathy, concern, friendliness, warmth, openness, interest, and reassurance, for example, are important to relationship formation and also contribute to patient satisfaction, as well as to patient information disclosure decisions (Lewis, Matheson, & Brimacombe, 2011; Thompson, Robinson, & Brashers, 2011). While communication serves two rather distinct purposes, the instrumental function and the relationship/impression function of communication are inseparable.

Unfortunately, provider-patient relationships are as problematic as they are important, embodying all the complexity and challenge—and even greater stress—than is present in other professional-lay encounters. As with the teacher and student, the attorney and client, or the librarian and the information seeker, the challenge of creating effective relationships between the provider and the patient is particularly difficult because these relationships are asymmetrical. In such relationships, expertise and power are unevenly distributed, and while both parties can be said—in a very general sense—to have a common purpose, they seldom share common perspectives, experiences, or expertise. Nor do they share a common perspective on the relative importance of the instrumental and relationship function of communication. But, unlike most other asymmetrical relationships, communication between providers and patients may involve extremely traumatic topics, and can have life-and-death consequences; depending upon the nature of the diagnosis and treatment modalities, the relationship between practitioners and patients may be an important component of care for weeks, months, or years, which greatly increases the importance of the relational functions of communication.

The relational dimensions of communication also may be of primary importance to patients and their families in their judgments of provider competencies and the quality of the care being provided.

Because, as mentioned previously, most patients and family members lack the knowledge necessary to assess the clinical quality of the care they receive, their evaluations emphasize *relationship* quality, the interpersonal communication skills and competencies of the provider, and the manner in which they are treated *personally* (Korsch & Gozzi, 1968; Korsch & Negrete, 1972; Ruben, 1990a; Ruben, Christensen, & Guttman, 1990). These priorities not only influence a particular encounter, but also provide impressions that shape future relations. Once formed, these relationships and impressions provide a backdrop that can be expected to have a significant impact on the perspectives of those involved, and on expectations that will guide subsequent patient-provider encounters.

Even when taking a more traditionally narrow perspective on the definition of healthcare provider, not only physicians, but also other members of a healthcare practice or organization play a significant role in the patient and family member impressions and health-related decision making. In some instances, as in the ENT example discussed earlier, the communication behaviors of nurses, physicians' assistants, and office and administrative staff can be even more central to patient impressions and follow-up than those of physicians (Ruben, 1992a). In cases such as this, the patient's assessment of the relationship can result in an unwillingness to continue seeing a particular doctor. As in this case, communication dynamics can also result in a decision to terminate a provider-patient relationship even when such decisions have no grounding in the medical quality of the treatment.

Provider-Patient Communication Is Cross-Cultural

When traveling to a foreign country where the language, monetary system, and geography are unfamiliar, there is no mistaking that one is engaged in an intercultural experience, one that requires careful observation, listening, and care in translation. Increasingly, cultural differences and disparities present these same challenges to clinicians, and a variety of education and training strategies are being developed and implemented to equip healthcare providers with appropriate cultural understanding and sensitivity (Juckett, 2005; Like, 2011, 2012).

All healthcare encounters have many of the defining characteristics of an intercultural experience.

Though far less obviously in most cases, all healthcare encounters have many of the defining characteristics of an intercultural experience. For their part, physicians, nurses, lab techs, receptionists, administrators, and other staff come to healthcare encounters as knowledgeable professionals, "at home" in the environment in which the interactions are occurring, and seeing patients on a schedule that they set. They

are familiar with terminology and protocols, comfortable with the tasks at hand (medical histories, physical exams, and diagnostic procedures), and equipped with substantial experience regarding the range of medical problems and circumstances that present themselves. Health providers also bring their own unique personal and professional "maps" and "baggage"—their attitudes, beliefs, values, assumptions, and conscious and unconscious biases that can impact on healthcare promotion and disease prevention, diagnosis, treatment, rehabilitative, palliative, and end of life care activities (Like, 2013).

Patients come to the relationship "looking for help" in some form. They do so in an environment that is unfamiliar—one that they often perceive as intimidating. Patients must schedule the encounter at the convenience of the providers, and often have to wait to be seen. Frequently they enter the interaction

anxious about their health, and lacking medical knowledge, familiarity with medical protocol and terminology, and without relevant professional expertise. For the patient, even "routine" history taking, physical exams, and diagnostic tests are often stressful, and they often call for levels of verbal disclosure and physical contact that may be uncomfortable (Greene, Derlega, Yep, & Petronio, 2003; Greene, Magsamen-Conrad, Venetis, Checton, Bagdasarov, & Banerjee, 2012; Ruben et al., 1984).

As noted earlier, from the patient or family perspective, health communication is about making sense of the messages related to the health or wellness circumstances they are confronting. This includes trying to grasp, interpret, and retain the names for procedures, medicines, diagnoses, medical specialties, and a vast array of opinions and advice—all of which an individual and his or her family are trying to sort out and process effectively at a stressful time and in a foreign environment. And, depending upon the outcome of these encounters, patients may be faced with the need to comply with recommendations for behavioral change, undergo additional testing, or accept continuing uncertainty about their health status. Moreover, all these "intercultural" impediments to communication are magnified by differences in age, language capability, cultural competence, and education, among many other factors (Betancourt, Alexander, Green, Carrillo, & Park, 2005; Kirmayer, 2012; Like, 2012).

Consider the following illustration:

A young pharmacist walks into the hospital room of a 96-year-old patient, and in a soft voice begins to explain that she is there to show him how to give himself insulin shots. She has a number of pieces of equipment and a large pile of materials with her. The patient is hard-of-hearing so asks her to repeat what she said, which she does. He is very confused because for 20 years he had only ever been given a very low oral dosage of diabetes medication. He has himself convinced that he doesn't have diabetes since it had always been so well controlled by one pill a day. Also, his assigned physician in the hospital has not yet shared anything with him about a need to make a switch from the oral medication to insulin injections.

His face reveals to family present in the room that he is startled and frightened, but the pharmacy student proceeds with her presentation on the glucose monitoring system that he will need to learn how to use. After nearly each sentence, the patient, or a family member, reminds the pharmacist that the patient is hard of hearing and asks her to please speak more loudly. After several minutes have passed, with the patient trying to hold one of the devices with trembling hands and limited dexterity, a family member asks the pharmacist whether she might check with her advisor about whether there is an easier monitor for elderly people to use, and she agrees to do so and come back to talk about the monitor once she has that information.

She then picks up the syringe and begins a demonstration of how to use it. She provides a rapid-fire list of five or six steps involved using quite technical language. From that, she proceeds directly to a discussion of the critical need to monitor insulin levels, and three alternative actions available to the patient if the insulin level, when tested, is too low or too high. During the presentation, the patient just stares blankly at her, and it is apparent from his nonverbal behavior that he is completely lost and very anxious. With no break in the presentation, she hands him the syringe and a simulated patch of stomach on which he is to practice giving an injection. She provides very detailed instructions in a soft voice, and once again he isn't able to hold the device, or to follow the instructions for its use.

The outcome is a very upset nervous patient and a perplexed pharmacist, neither knowing what to do next. A family member breaks the silence and asks if perhaps an oral medication alternative or

less complex pieces of equipment could be considered. The pharmacist eagerly adopts this line of discussion, and says she will check with her supervisor and the physician to see if that might be possible. After her departure, family members spend the next fifteen minutes trying to calm the patient and explaining what the visit had been about. His surmise had been that the pharmacist was a sales person from a drug company who had come in to try to sell him some medical devices, which he had no sense that he needed. Later discussions between family members and the hospitalist led to a decision to treat the diabetes with one of several newer oral medications that it was agreed should be quite adequate, all things considered.

While an observer who happened to pass by the room and look in on the interaction would hardly characterize this as an intercultural encounter, from the perspective of communication it was just that. Differences in hearing capability, vocabulary, rate of speaking, age, background, familiarity with medical technology, education, and experience created a huge cultural and communication chasm—a chasm that was obscured by the fact that all parties spoke English. This situation represents a rather striking example of the cross-cultural nature of provider-patient communication—one reflective of age and generational differences. To a greater or lesser extent, the differences in education and life experience, health literacy, socioeconomic status, environmental familiarity, understanding of protocols, and other factors conspire to make cross-culturality a useful metaphor for thinking more generally about the communication dynamics at play in all interactions between trained healthcare providers and patients and family members. Ridley (1995) underscores the significance of this point when he notes that one patient may well occupy eight cultural roles – as a Mexican American, male, father, husband, Catholic, mechanic, night-school student, and a resident of East Los Angeles, for example – each of which poses its own intercultural communication challenges, not to mention the additional challenges created by the intersections of these memberships (Tervalon & Murray-Garcia, 1998).

Practice, Team, and Organizational Leadership Competencies

Another set of communication competencies that have become increasingly important are those associated with functioning effectively as members of a practice group, in team-based care, and in other healthcare organizational, community, and leadership settings (Interprofessional Education Collaborative Expert Panel, 2011; Tallia, Lanham, McDaniel, & Crabtree, 2006). Core concepts of communication that are basic to physician-patient interaction are also applicable in team and organizational settings where collaboration, cooperation, and coordination are essential (Orzano, Tallia, Scott, Nutting, & Crabtree, 2006). This knowledge and skill set are also important in interprofessional and interdisciplinary interaction between and among healthcare professionals from varying specialties, in communication between health professionals and administrative staff, and for providing informal and formal leadership in these settings. In all of these contexts, leadership and organizational capabilities are necessary for effective patient transitions, team-based care, and integrated organizational delivery systems.

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organizational capabilities are necessary for effective patient transitions, team-based care, and integrated organizational delivery systems. These include competencies in planning, change management, knowledge management, organizational design, leadership development, process analysis

and improvement, and community development, among others (Orzano, Tallia, McInerney, McDaniel, & Crabtree, 2007; Tallia, Strange, McDaniel, Aita, Miller, & Crabtree, 2003).

As but one example of how organizational concepts may provide a perspective both on problems and on solutions, consider the following patient vignette published in the blog of the Malcolm Baldrige National Quality Program (Schaefer, 2013):

If My Doctor Used the Baldrige Criteria, I'd Have a Flu Shot by Now

I recently went to my primary-care doctor to get a flu shot. Before venturing out ... I called ahead to confirm that such shots are available on a walk-in basis. (I was put on hold twice to learn that simple fact, foreshadowing my experience at the office.) After arriving and completing the check-in process, I waited for nearly an hour without further communication from any staff member. By the way, the check-in process took at least 20 minutes, even though I'm not a new patient, and there was only one other patient in the room, already checked in, when I arrived.

My wait surely would've lasted longer, but ... I got up to ask the receptionist the reason for the long delay, especially considering that I didn't need an appointment. She appeared to have forgotten why I was there—and next, I learned that the office was actually out of flu vaccine!

This blog is not meant to be a rant about the poor customer focus of one medical practice, however. Instead, I want to share the epiphany I had during my wait for the elusive flu shot: the Baldrige Award is so much more meaningful and indicative of true excellence than some other accolades for organizations. And that's because the Criteria and award evaluation process are comprehensive and based on a systems perspective of organizational performance. You see, I noticed my doctor's office continues to be adorned with prestigious commendations the practice has received, in particular, being named among the region's "Best Doctors." My awareness of that reputation was part of what drew me to the practice several years ago; however, the recurring office management-related problems I've experienced there have prompted me to look elsewhere for a better-run practice....

Given my familiarity with the rigorous assessments of an organization's performance for the Baldrige Award, I am practically itching to introduce my doctor's practice to the Baldrige Health Care Criteria.... I am convinced patients of that practice could benefit significantly if the organization were to adopt the multidimensional Health Care Criteria for Performance Excellence rather than measure its performance more narrowly, for example, tracking only its doctors' care ratings....

This example, as well as the ENT practice vignette discussed earlier, illustrate the fact that effective organizational and leadership challenges are often quite significant to patient perceptions and preferences, and ultimately to their decision about healthcare providers and institutions. Even when the quality of clinical care is not in question, operational dimensions of a practice can be an important source of messages about the effectiveness and efficiency of the organization, and by implication, about the level of concern for patients and their family members. Feedback solicited from individual patients is a valuable source of information on operational and service aspects of care, and new and more systematic approaches to assessment that highlight patterns and trends in satisfaction of particular patient populations, medical specialty groups, practice groups or individual providers can also be extremely useful (Newhouse, 2009).

Implications: For Provider Practice

A review of the core concepts provided in the previous sections underscores the importance of communication to the goals of patient-centered healthcare. It also highlights the many challenges that arise as a consequence of the complexity of the communication process and the limited control providers are able to exercise over outcomes. Beyond informing provider expectations, a more nuanced understanding of the nature of communication generates a number of insights and implications that can be helpful in healthcare practice. The following list identifies some of these:

- Recognize the Complexity of Communication. Recognize that the communication process is complex, that message sent seldom equals message received, and that information is not “exchanged” in a linear, person A -> person B manner. This “commonsense” view can be limiting and misleading when it comes to understanding and shaping the dynamics of health communication situations. The linear perspective fails to take account of many factors that have an impact on the process, and most especially the “maps” and “luggage” that all parties bring to healthcare interactions. Professionals have the responsibility—and can acquire and apply the understanding and competencies necessary—for assessing and guiding interactions toward desired outcomes.
- Identify Communication Facilitators and Impediments. Determine what “maps” and “luggage” patients are bringing with them to the healthcare situation that can facilitate or impede communication. Develop methods to quickly and accurately assess patients’ communication and information needs, and use this knowledge as a guide in shaping provider communication strategies and approaches. How do patients understand and describe the health or wellness problem that brings them to you? What are their concerns relative to the problem? What do they think caused the problem? How is it affecting their life? What, if anything, have they been doing to deal with the problem? (Kleinman, Eisenberg, & Good, 1978). Obviously, time constraints are a factor, yet avoiding a rush to judgment, stereotyping, and overgeneralization are issues of concern. Clearly, each provider must develop methods that are best suited for accomplishing this assessment in his or her specialty. However it’s done, this may be one of the most critical elements for successful communication outcomes. Failing to take account of the mental model a patient uses in understanding and treating a particular health concern, or determining that a patient has a hearing impairment, for example, may well render an entire encounter useless and frustrating for a patient. It may also create false expectations of a successful outcome for a provider. Similarly, it can be very helpful to determine what level of information a patient may have about a health problem for which they have come for treatment—and from what sources—before launching into a standardized script. Accurate and rapid assessments permit adjustments in approach that can profoundly influence the effectiveness, value, and satisfaction of the encounter for the provider and the patient. While it falls to the professional to take account of this kind of knowledge in interactions with patients, much of this information could be gathered by support personnel or through a “health communication history” completed by patients prior to being seen by

their provider, as a part of their pre-visit documentation. Equally important is reflective attention to the “maps” and “luggage: that providers themselves bring to the clinical encounter, as noted earlier.

- Assess the Patient’s Health Communication Practices and Preferences. Analyze the full spectrum of communication and information sources that are in play in a particular health situation. Many of these elements will not involve professional providers directly, occur outside their scope of their awareness, and often are not initiated, directed, or controlled by trained professionals. “Nonprofessional” sources, sites, and settings—and the information and impressions a patient may have based on these—can have a substantial impact on the way in which patients receive, perceive, interpret, and ultimately, how they act related to health and wellness. Information on sources consulted by a patient, if any, prior to a visit to a provider could be routinely acquired in an opening discussion with a patient, or on documents patients complete while waiting to be seen.
- Adopt Patient-Specific Communication Strategies. Create “customized” patient-directed, patient-focused messages that take account of the particular needs, factors, and circumstances, and convey messages in a manner, at a time, and through channels that have the potential to effectively compete for maximum attention and impact. Utilizing the kind of assessment discussed above, informed decisions can be made as to whether presenting information orally will be appropriate and sufficient. Is this patient fluent in the language spoken by the healthcare provider? Will education level present special challenges? Is the diagnosis likely to be anxiety-producing, and if so how is this best handled? Along with documentation of clinical comments following patient interactions, notes relative to communication protocols and approaches can be recorded for future use.
- Follow-up to Assess and Reinforce Communication Goals. Implement follow-up methods to increase the likelihood of patient follow-up on recommendations. Even problems that seem routine to providers may well be anxiety-producing for patients and family members, and in these situations one’s normal information processing capabilities are often compromised. Minimally, this would include “playback” strategies such as asking the patient to replay what he or she heard to be sure it was clear. If multiple patient follow-up actions are being recommended, additional communication tactics may be appropriate. Assure sufficient redundancy in the communication process, realizing the limitations of a single message, particularly when conveying information that is stressful. Moreover, in situations where the information is complex or technical, multiple messages and channels are helpful. Consider using complementary and reinforcing verbal, written, and electronic messaging to maximize the probability of arriving at convergent understandings relative to key message points. Consider other follow-up techniques such as a phone call or email from support staff to remind patients of the recommended course of action, to create an opportunity for patients to ask questions, to provide a record for future reference, and to convey the sense of concern that contributes to an enhanced provider-patient relationship.

- Utilize Alternative Communication Channels. Recognize the importance of the growing array of information sources, settings, and media in which health and wellness communication takes place. Develop strategies that leverage this reality to create or utilize integrated, multichannel communication methods that are responsive to the needs of particular patients and populations. This may involve developing or using emails or blogs, recommending particular health or wellness websites, and/or encouraging the use of relevant support groups or services, in addition to the more familiar patient pamphlets and short videos (Robinson, Turner, Levine, & Tian, 2011).
- Value Relationships and Impressions. An inevitable but often unexamined by-product of information-related message sending is the formation of relationships and impressions that influence communication outcomes. These outcomes occur in encounters with professional providers as well as with administrative staff, and in all cases contribute substantially to the climate and context that shape current and subsequent interactions as discussed previously. As simple as it may sound, a friendly welcome, a display of concern by members of a healthcare team at points during a patient visit, and caring words upon departure can be of considerable value in creating and promoting the kind of partnering relationships and patient-focused that facilitate progress toward desired health and wellness goals.
- Choose the Most Appropriate Relationship Approach. Failing to consider the particular relationship approach that will be most appropriate to a particular patient and circumstance can misdirect communication, waste time and effort, and undermine intended providers' goals. As Lussier and Richard (2008) note, the healthcare professional has a range of relationship options available—including expert-in-charge, expert-guide, partner, and facilitator—and each has its unique assets and liabilities. Selection of an appropriate relationship and adopting communication approaches that are consistent with that prototype can be based on the nature of the health issue, the match between the relationship preferences of the provider or patient, and both. A visit to an emergency room for acute care is different in a number of ways from a series of appointments to deal with a chronic illness such as diabetes or cancer. For each, differing relationship strategies may be appropriate. There may be situations where a provider determines that the relationship styles with which he or she is most comfortable do not well match the preferences of a patient. This could become a useful topic for discussion, negotiation, or in some cases, the basis for referral to another provider with whom the relationship preferences and communication styles might better match.

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- View All Patient Encounters as Cross-Cultural Communication. Recognize that all successful provider-patient, interprofessional, and interdisciplinary health communication requires cultural sensitivity and cross-cultural literacy. Even when interactants appear to be speaking the same language, a full range of cultural differences complicates the communication process. These cultural complexities are present to some extent in all professional-layperson encounters. However, nowhere are these issues more critical than in health communication, where life-and-death consequences may be associated with ineffective communication (Juckett, 2005; Like, 2005, 2011, 2012). Applying the cross-cultural metaphor in conceptualizing and approaching provider-patient and interprofessional and interdisciplinary communication provides a very helpful frame of reference. This issue is an important consideration for physicians, and also for all members of a healthcare team or practice (Tervalon & Murray-Garcia, 1998).
- Assess and Improve the Messages Created by a Practice or Organization. Recognize that the operational dynamics of a practice communicates clear, albeit often unintended messages that often influence healthcare decision making by patients and their families. These messages can be as important to perception and actualities of quality healthcare as purely clinical dimensions of the treatment provided. Sometimes these messages emanate from interpersonal dynamics involving staff. In other instances, confusion, uncertainty, and anxiety result from confusing communication about forms and procedures, insurance regulations, or institutional policies. Regardless, many of the messages created by a practice or organization can be identified and controlled. Doing so requires the application of communication concepts integrated with organizational assessment and systematic feedback systems for patients and family members. Also essential is a commitment to reflective leadership and ongoing organizational improvement by leaders within a practice or healthcare organization (Ruben, 2006).

Implications: For Provider Education and Training

Ultimately, improving the quality of patient-focused communication will require refinement in the education and training of healthcare providers (Interprofessional Education Collaborative Expert Panel, 2011). Interestingly, a number of the challenges of patient-centered care have parallels to those associated with professional and interprofessional education. It is no surprise, then, that an understanding of core communication theory has implications for addressing the challenges of the education and training of providers, as it does for patient-centered practice.

The importance of provider-patient communication as a component in patient care is an idea with a considerable history (Ernstene, 1957; Ley & Spellman, 1967), and in recent years, efforts have been made to include communication competencies as central elements in provider training and assessment. A frequently vocalized challenge to increasing attention to communication and an emphasis on physician education goes something like this: “If you were selecting a physician to take care of your mother’s serious heart condition, would you want a bright and skilled clinician or a good communicator?” Of course, one reasonable answer might be: “Why should you have to choose?” There is certainly no necessary dichotomy between communication competence and clinical competence, and as noted previously, both are vital to patient satisfaction and other desired outcomes. Moreover,

patients and family members are often unable to differentiate one from the other (Ruben, 1990a, 1992a).

A review of research in the area of communication education and training in provider education suggests that there are many potentially valuable benefits, but also numerous challenges (Brown & Bylund, 2008; Duffy, Gordon, Whelan, Cole-Kelly, First, 2013; Frankel, et. al, 2004; Gilliland, La Rochelle, Hawkins, Dillon, Mechaber, Dyrbye, Papp, & Durning, 2008; Interprofessional Education Collaborative Expert Panel, 2011; Kissane, Bylund, Banerjee, Bialer, Levin, Maloney, & D’Agostino, 2012; Lehman & Guercio, 2013; Thompson, Robinson, & Brashers, 2011; Wouda & Harry, 2013).

Given the nature of communication and the concepts discussed previously, a number of these difficulties are quite predictable. This is particularly the case when approaches to teaching and training are built on the same assumptions that are associated with the more limiting views of provider-patient communication. In models of education and training that embody an exchange-of-information perspective, what may be quite easily underestimated is the controlling role of learners in shaping outcomes. Indeed, the role learners play in teacher-learner communication is quite analogous to that of patients in provider-patient communication. Messages-taught do not easily or naturally become messages-learned.

The profound implication of this perspective—and one worth underscoring once again—is that the outcomes of communication, whether in patient care or provider education and training, are not easily shaped by message senders or their messages, but rather are more fundamentally guided by the predispositions, susceptibilities, and take-into-accountabilities of receivers (Thayer, 1968). Intended instructional messages must compete with a plethora of other messages in the learner’s environment, and the instructor often has little direct influence over key components in

the information-processing associated with learning. It is not easy to predict, and even more daunting to try to exercise control over, the way in which intended teaching messages are received, interpreted, remembered, or integrated behaviorally. A number of implications flow from these insights that help to explain the substantial challenges associated with enhancing practitioner communication competencies. Among these are the following:

- Changing communication behaviors shaped over the course of a lifetime is an extremely difficult task, not one that can be easily or quickly accomplished, regardless of how clear or compelling messages—lectures, books, or training programs—advocating change may be.
- Articulating desirable communication behaviors is considerably easier than enacting them; neither conceptual knowledge nor good intentions are necessarily good predictors of successful practice.

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- Even self-reflective and highly motivated learners face significant challenges when it comes to consistently translating communication principles into effective practice.
- Exhibiting appropriate understanding and skills in a classroom or assessment situation does not assure consistency in displaying these behaviors in everyday practice.⁹
- Self-assessing one's behavior with any degree of accuracy, which is essential to reflective learning in this area, is an extremely difficult process. Parenthetically, it often seems that those who would most benefit from ongoing self-assessment are least equipped and motivated to engage in the process.
- Acquiring third-party, "objective" observation and reports on one's behavior is generally essential to accurate assessment, but systematic observation and feedback methodologies are complicated, difficult to implement, and frequently resisted.
- Focusing communication training too narrowly—on particular skills such as maintaining eye contact, shaking hands, or sitting while talking to the patient, for example—can result in the acquisition of skills that have too little transferability. Focusing education on broader domains such as information gathering, relationship building, and patient education can direct energies toward a more appropriate emphasis on generic communication concepts, competencies, and meta-skills that promote flexibility in adapting to varying situations, populations, cultures, and conditions.
- Emphasizing communication skill improvement for physicians may lead to overlooking the critical impact of the communication practices of other members of a healthcare team—professionals, paraprofessionals, and administrative staff—whose communication competencies are often as critical to the desired patient-centered outcomes as those of physicians.

Notwithstanding the obstacles involved, heightened emphasis on communication competence in provider assessment and education is vital from any of a number of perspectives. In addition to the reasons noted earlier, the prospect of performance-based reimbursements in which hospital compensation is based in part on patient satisfaction, and the patient experience more generally, is also likely to continue to focus attention on the importance of communication competencies.¹⁰

One very reasonable strategy to consider is devoting additional effort to articulating the necessity of communication competence, and ideally, to defining an understanding of and skill in these competencies as entry requirements for those aspiring to medical careers. This approach seems quite promising in that teaching communication competency to those who have limited skill is far less productive than directing those same energies to identifying and recruiting professionals who already understand and are competent in these areas (Eva, Rosenfeld, Reiter, & Norman, 2004; Kealey & Ruben, 1983; Ruben, 1976; 1977a, 1977b; Ruben & Kealey, 1979; Terregino, Kramer, & Dunleavy, in preparation). Clearly, developing effective entry-level assessment and screening methods to attract and recruit individuals with superior competence in communication is a goal deserving of increasing future attention among health educators. At the same time, continuing efforts are needed to create and

implement improved approaches to communication competency development among current providers, taking into account the obstacles noted previously.

All of the usual challenges of communication are magnified many times over in teaching or training situations where the goal is to enhance the communication practices in a team, group, or organization. Leadership communication—which is subject to many of the same challenges as those facing healthcare providers and educators—becomes increasingly important and challenging with progressively larger and more complex systems.

Implication: For Patient Education and Training

A recognition of the central role patients play in influencing health and wellness communication and clinical outcomes inevitably leads to a discussion of the value of patient education and training. Various authors have recognized the merits of educating patients to become more literate and to take a more active role in their communication with healthcare givers (Zarcadoolas, Pleasant, & Greer, 2006). In their “Top Ten Things a Patient or Family Member Can Do to Ensure Quality Care,” for instance, Jeppson and Thomas (1994) provide the foundation for a list of ten suggestions that are consonant with this approach.

1. Ask a nurse or doctor to answer questions that you have before, during, and after your care experience.
2. Become educated about your healthcare insurance policy covered benefits.
3. Learn about scientific evidence and the most current treatment options related to your condition by reading articles or information on the Internet.
4. Make a list of questions in advance of your medical appointment to ask about your condition and care options.
5. Practice telling doctors about your symptoms, and how you are feeling. Practice asking questions when you need more information.
6. Keep a notebook of current medications, specialists, and other relevant information to discuss with a doctor. If hospitalized, be sure to ask every time you are given a medicine what you are being given.
7. Bring an advocate/friend who can listen, take notes, and help ask questions. Remember that family members are there to support you; inform them when issues are too difficult for you to handle alone.
8. Be honest with yourself and your provider about your needs, expectations, and feelings about your care. Be specific about what treatments you want or do not want. If you are unsure, ask for time to think about your decision prior to signing consent forms, and speak to your physician about those uncertainties.

9. Keep communication open at all times. Find out the appropriate channels so that questions and concerns may be brought to your care team when your main contact is unavailable. Make sure you have designated "power of medical decision making" in writing in the unlikely event that you cannot communicate those wishes—and give a copy to your doctor.
10. Ask for and review written discharge instructions for medications, return appointments, and information for follow-up and ongoing care.
11. Ask caregivers for alternatives to the treatment options they are proposing, and ask for their perspective on the benefits and liabilities of each.¹¹

These are good suggestions, and they are illustrative of the communication strategies the public, patients, and family members can learn to utilize. Education and training addressing anticipated communication needs and concerns is provided regularly in a variety of settings to help patients and family members prepare for upcoming procedures or to offer advice on follow-up care.

Health and wellness promotion campaigns—such as the smoking cessation effort referenced earlier—also represent an important tradition in patient education efforts (Hornik, 2002; Maibach & Parrott, 1995; Rice & Atkin, 2001). There are also a number of formalized health promotion and illness prevention programs aimed at patient education and behavioral influence (U.S. Department of Health and Human Services, 2012; National Prevention Council (2011). Traditionally, these efforts have made use of mass media, and increasingly social media are employed to serve these purposes.

Internet-based patient education approaches, methods, and channels—along with eHealth and mHealth, given the increased use of smart phones—will undoubtedly continue to grow in number and popularity. While some of these are designed primarily for educational purposes, many have commercial success as the primary goal. That said, one can imagine a future with a growing number of websites created, maintained, and sponsored by providers, academic medical centers, and public service organizations. Some of these might be proprietary sites to which physicians subscribe, and in turn these sites can be made available as reference sources for their patients as a formal part of the caregiving experience.

Another promising communication strategy for patient education engages consumers in developing health promotional messages for themselves and other consumers (Greene, 2013; Lederman & Stewart,

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2004). Using what researchers Lederman and Stewart termed socially situated experiential learning, consumers in effect educate themselves and their peers as to appropriate wellness behaviors—in one case, behaviors related to alcohol consumption (Lederman & Stewart, 2004). Generically, this model fits the definition of a “prosumer” approach, which involves consumers as collaborators in the creation of the products or services they, themselves, consume. “Prosumers” become co-innovators and collaborate

with producers to develop better products and services (Tapscott & Williams, 2006). Formalizing and

giving greater structure to these prosumer networks can have great value in identifying and communicating about innovative treatment strategies and in sharing information on perceptions of physician expertise.¹²

Beyond patient and family-centered training, there are other strategies to consider for enhancing the public's knowledge of health and wellness. For instance, training programs and courses in health consumer literacy in high schools and at the university level could be developed with the goal of better preparing individuals to be competent health and wellness consumers. A forum on "Health and Wellness Services, Sites, and Sources: Becoming Literate Consumers"¹³ could include such topics as managing one's own health; evaluating healthcare claims; using the Internet appropriately for health information; locating and evaluating healthcare experts and expertise; learning from other patients; being an effective advocate for one's own and family members' healthcare; and becoming better prepared to interface with healthcare systems.

Patient and family advocates, facilitators, or advisors will also serve increasingly useful educator roles. Patients struggling to navigate the medical, regulatory, and financial dimensions of healthcare for themselves, and especially for family members who may be limited in their communication competencies due to age or disability, are likely to find this type of education service particularly useful.

Using these and other mechanisms to promote health literacy is precisely the kind of activity suggested earlier by the perspective on communication—a perspective that recognizes consumers as active, engaged, and critical consumers of healthcare products and services.

Concluding Comments

Variouly described in the professional and research literature as a symptom, partial cause, and potential cure, communication is certainly an apt focus for attention in efforts to enhance patient-centered care. Beyond developing strategies for improving healthcare message-sending and -receiving activities by providers in professional settings, it is also important to devote greater attention to fundamentals of communication theory, and the many conceptual and operational challenges associated with translating theory into practice. These same concepts have applicability for identifying the challenges and advancing the effectiveness of provider and patient education.

Communication, along with metabolism of matter-energy, is broadly conceived as one of two basic life processes for all living systems (Miller, 1965; Thayer, 1968; Ruben, 1972, 1975). In this systemic perspective, communication is the process by which individuals sense, make sense of, and act toward the messages and people in their environment. While this view affords attention to messages and media, it suggests the need for relatively greater focus on providers, patients, families, and the public and the way they make sense of and respond to the vast array of health and wellness-related messages that inundate them on a daily basis.

Communication is the process by which individuals sense, make sense of, and act toward the messages and people in their environment.

At a time when professionals engage in efforts to encourage interdisciplinary and interprofessional knowledge and collaboration for improved patient focus, the growing reality is that many consumers are able to access information from various disciplines and professional areas with little difficulty. However, in many if not most cases, consumers certainly lack the expertise needed to make appropriate use of these sources. The expanding array of health and wellness settings, the increasingly broadening list of sources serving as provider and/or medical information providers, and the growing need for healthcare literacy raise important questions about the future directions of health communication. These developments also point to significant issues as to the roles future healthcare professionals will play relative to the evolving healthcare environment, and how best to equip tomorrow's professionals with the blend of clinical and communication competencies that will be needed to meet these emerging challenges.

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Endnotes

¹ Among the other dimensions of organizational behavior to receive additional attention have been leadership strategy and development, clarity of purposes and plans, effective and efficient work processes, workforce well-being and satisfaction, outcomes measurement, benchmarking, tracking, and continuous improvement. These and other elements have been the focus of attention in organizational quality literature and practice, and are highlighted in the Malcolm Baldrige organizational assessment and recognition framework, developed in 1987, and arguably one of the most influential models of its kind. Customer focus is one of the seven categories identified in the Baldrige organizational systems framework. See <http://www.nist.gov/baldrige/>

² The Baldrige program was open to healthcare organizations beginning in 1999. The criteria are included in the framework, available at: http://www.nist.gov/baldrige/enter/health_care.cfm. Information on the applicability, value, and validity of the Baldrige in Healthcare is provided at: http://www.quality.nist.gov/PDF_files/Issue_Sheet_HC_Excellence.pdf and <http://nistbaldrige.blogs.govdelivery.com/2013/02/28/why-baldrige-ask-leaders-of-top-u-s-hospitals/>

³ This conceptualization of organizations—and particularly the implication that the quality of products and services, could—or should—be evaluated by consumers—was quite controversial in some quarters. Today, the generally accepted view is that the consumer perspective is essential in conceptualizing, evaluating, and improving quality and effectiveness in any organizational setting. But, this in no way obviates the importance of producer/provider/professional perspectives.

⁴ A comment made by a patient during hospitalization, January 20, 2013.

⁵ See Cleveland Clinic (2012). Patient experience is next measurement in value-based care. *American Medical News*. <http://www.amednews.com/article/20130304/business/130309987/4/>; and Cleveland Clinic (2013). For more on patient experience empathy and innovation summit, see <http://www.clevelandclinic.org/collective/default.htm>

⁶ The Pew-Fetzer Task Force Report (1994) also uses the phrase “exchange of information” to describe the nature of the interaction that takes place between practitioner and caregiver (p. 8).

⁷ The terms “maps,” “luggage,” and “belongings” are used to capture, in simple language, the complex system of physical, cognitive, emotional, experiential, and behavioral elements that interact to constitute unique individual identities at any moment in time. Thanks to Bob Like for suggesting the term “maps” for use in this context.

⁸ See Cigarette Smoking Among Adults—United States 2007, November 14, 2008 / 57(45); 1221–1226. www.cdc.gov/mmwr/preview/mmwrhtml/mm5745a2 and www.cdc.gov/tobacco/data_statistics/tables/adult/table_2.htm

⁹ Volunteer or formally required internship experiences in which medical students serve for extended time periods in communication support roles for physicians, spending time with patients, explaining diagnoses and treatments, and answering questions, could be one approach to enhancing communication training and the ability of future physicians to relate to, understand, and anticipate patient communication needs. This idea was suggested by Luming Li, medical student, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ. March 14, 2013.

¹⁰ Comments provided by Luming Li, medical student, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ. March 21, 2013. For perspectives on these developments, see Wall (2011) and Geiger (2012).

¹¹ Item number 11 was suggested by Dr. Alfred Tallia, Professor and Chairman of the Department of Family Medicine and Community Health, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ. February 24, 2013.

¹² The following websites, <http://www.everydayhealth.com/forums/heart-health/topic/hearing-heart-beat-in-my-ears.html> and Transparency Life Sciences (<http://transparencyls.com/node/9>), provide two examples of the “prosumer” concept applied to healthcare and health science.

¹³ A Rutgers–Robert Wood Johnson Medical School seminar will be offered in the Fall 2013 to address this topic. The seminar is entitled “Making Sense of the Health and Wellness Tsunami” and will be jointly taught by Brent Ruben, Professor of Communication and Executive Director of the Center for Organizational Development and Leadership at Rutgers University; and Alfred Tallia, Professor and Chairman, Department of Family Medicine and Community Health at Robert Wood Johnson, School of Medicine.