MEANING, MESSAGE, AND MEDICINE:
INTEGRATION OF COMMUNICATION STUDIES IN THE MEDICAL HUMANITIES CURRICULUM

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ABSTRACT

Meaning, Message, and Medicine:
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Doctorate of Medical Humanities

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Medical Humanities may be defined as “an interdisciplinary field that explores contexts, experiences, and critical and conceptual issues in medicine and health care, while supporting professional identity formation” (Cole, Carlin, Carson, 2015). There are only a handful of universities in the United States which offer degreed programs in Medical Humanities. Drew University, in New Jersey, has one of the most comprehensive programs in the country and thus, is very well-positioned to be at the forefront of a movement to elevate the field to even higher ground. Studying communication helps us to acknowledge that we do not always view the same picture through the same lens. More often than not, it seems, we each see the same thing very differently. Communication provides us with the vocabulary to seek a common ground, a shared meaning, that enables us to move forward together; or conversely, to recognize that we may choose not to move forward together. Communication Studies support the theoretical lessons of Medical Humanities. Incorporating theories and processes from Communication Studies into the discipline of Medical Humanities can support the field

and expand the discipline’s relevance through expanded application. The expectation, as presented in this dissertation, is that by using the tools of communication, we can better employ the lessons and tenets that Medical Humanities provides.

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Foreword

The dissertation is respectfully presented as the final requirement for the fulfillment of a doctoral degree in Medical Humanities from Drew University in Madison, New Jersey. The topic was suggested to me by my mentor and advisor, Dr. Philip Scibilia. Aware of my interest in the art of effective communication and my professional work training medical professionals in those skills, Dr. Scibilia saw a natural fit and encouraged me to use this opportunity to develop the link.

The work presented here is based on the research of hundreds of professionals in the fields of Medical Humanities, Communication, Sociology, and other humanities disciplines. It is also based on my own experiences and knowledge gleaned from years of working with medical professionals in the field and from coursework at Drew University. A portion of this has been previously published in an article I co-wrote in Academic Medicine (2015).

I have learned so much from my professors, colleagues, and classmates and I am very grateful to all with whom I have studied.

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Glossary of Abbreviations and Acronyms

The following acronyms have been used throughout this dissertation:

AAFP	American Academy of Family Physicians
ACA	Affordable Care Act
ACGME	Accreditation Council for Graduate Medical Education
AMA	American Medical Association
BATHE	Background, Affect, Trouble, Handling, Empathy
BLS	Bureau of Labor Statistics
CDC	Centers for Disease Control
CMS	Centers for Medicare and Medicaid Services
EBM	Evidence-Based Medicine
FSEE	Facilitated Simulation Education and Evaluation
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HIV/AIDS	Human Papilloma Virus/Acquired Immune Deficiency Syndrome
ICA	International Communication Association
IOM	Institute of Medicine
NCA	National Communication Association
NIH	National Institutes of Health
NPR	National Public Radio
NURSE	Name, Understanding, Respect, Support, Explore
OR	Operating Room
PCC	Patient-Centered Care
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
SPIKES	Setting, Perception, Invitation, Knowledge, Emotion/Empathy, Strategy/Summary
WHO	World Health Organization

Chapter 1

Purpose and Introduction

The thrust of this dissertation is to develop methods for bridging communication theories and practice with existing Medical Humanities studies. In so doing, the dissertation is primarily concerned with formalizing the role of communication studies in a Medical Humanities program. Accordingly, a curriculum for communication-based courses are presented. These may constitute the basis of a concentration or track which will also be shown to have applicability to students in other disciplines.

In order to accomplish this objective, context is essential. Thus, the dissertation explores the roots of Medical Humanities' focus on patient-centeredness, a concept emanating from humanistic doctrines in psychology. In order to create an environment conducive to patient-centeredness, practitioners must be proficient at employing communication skills which allow for the patient to fully participate in the care giving experience. Absent those skills, the forces which promote a practitioner-centered interaction, for example, paternalism, are more likely to dominate the transaction. Thus, it is argued that attention to relational aspects of that transaction, achieved through studies on communication theory and practice, is vital to a Medical Humanities curriculum.

When I was about five years old, I went to my first Broadway play, *My Fair Lady* (Lerner and Lowe, 1956). From the middle row in the center of the balcony, I hung onto every word, thrilled at every note, and still many decades later, I can recall the vivid colors and the full, rich tones of the orchestra, the clarity of the vocals, and the excitement and symmetry of the choreography. The musical, based on George Bernard

Shaw's *Pygmalion*, tells the tale of Eliza Doolittle, a cockney flower seller, and Henry Higgins, an esteemed professor of phonetics. Doolittle is a simple, yet street-smart woman and Higgins is a pompous, yet highly respected well-to-do gentleman. Higgins offers a colleague a wager that he can transform Doolittle from a common and unsophisticated cockney-speaking girl into a grand, elegant duchess. He painstakingly coaches her in phonetics, the sound of speech and how words are pronounced. The manner by which she communicated, he theorized, would ultimately define her in the eyes of society. Speaking correctly, choosing exactly the right words, was the primary focus of his lessons, although he sought to alter her demeanor by dressing her in fine clothing, teaching her manners and etiquette, which he believed would contribute to elevating her performance so as to be convincing in the role of duchess.

Even at five years old, the message was not lost on me. Somehow, early on I recognized and understood that how we communicate has a direct impact on how we define ourselves and how we are defined by others. Our word choices, our tone, the pacing, dialect or accent all contribute to the version of ourselves by which others judge us and how we make initial judgements about others.

Although I could not have known this then, the seeds for this dissertation were born during those moments. How we communicate, especially in health-related contexts, can have a profound impact on medical outcomes. Communication shapes how we understand, how we feel, and how we move forward with our lives. The field of Medical Humanities, at its core, is about sharing messages and their meanings, whether through philosophical discussions of ethics and law, retelling of histories, revealing hopes and dreams through narrative, and enlightening through literature and theatrical performance.

Characters in plays are more relatable when their words and cadences feel familiar or expressive of someone or something in our realm of experience and have the potential to be intriguing and provocative when they are not. Sparked by those moments in the balcony of the Mark Hellinger Theater in 1959, my interest in theater continued to grow. Theater, especially musical theater, became integral to my life experience. As a second grader, I convinced my teacher to allow me to direct my classmates in the plays I had written based on stories in our reader. In summer camp, I acted in the plays and felt drawn to this medium. Dance, music, and theater were fundamental in my life although I had little formal training until college, where I took a variety of courses in dance and theater while majoring in economics. The power of the theater, the concept of looking inside ones' self to portray another, was transformative and captivating. After college, I worked in a variety of jobs during the day, while choreographing musicals in community theater by night. Eventually, I transitioned to directing and producing on those levels and discovered an even deeper love and appreciation for the art form than I could have as a member of the audience.

After the birth of my second child, a friend who performed as a birthday party clown encouraged me to join her and to develop my own act and repertoire. Thus, Bonabini the Clown was born. My "clowning business" grew and at its height, I was performing at 40 functions every month. My clowning act consisted of educational, creative stand-up comedy for children, mixed with original music (I played guitar and sang), balloon art, and face-painting. I was still choreographing musicals, eventually directing and producing musical theater and serving as president of a local community theater company in New Jersey. At the time, our town offered performing arts education only at the high school level. My children, not yet in high school, were interested in the arts and the void for the younger students within the school system beckoned me. The principal at the middle school leaped at my offer to create an after-school drama club. The first meeting was set up and announced a few weeks before we were set to begin. That Thursday, over two hundred eager eleven and twelve-year-olds packed into the middle school's all-purpose room. It quickly became apparent to me and to the school principal that there was clearly a desire and a need for a theater arts program.

Over the next seven years the program grew and was so well-received that classes in theater arts were incorporated into the school's daily curriculum on a cyclical basis so that every student, regardless of expressed interest, had the opportunity to participate in a theater learning experience for one quarter of the school year. Teachers in other subject classes reported that the students who had taken theater classes were more confident in presentation skills and participating in class discussion. Moreover, the success of the theater program was one of the considerations when the planning began to improve the school's infrastructure, resulting in a one-thousand seat state of the art theater which was incorporated into the architectural design.

Years later, I am still in contact with former students who always remind me that their experiences in my program have benefitted them in ways they did not foresee. One student informed me that when he has to give presentations at work, he remembers to do the pre-performance breathing exercises to "calm his jitters" and help him to speak naturally. Another reported that as a librarian she reads aloud to children and is so comfortable acting out the characters.

The stories I heard made me realize that it might be useful to share what I had learned, creating a theater program from the bottom up with other educators. I co-founded and became the executive director of Arts Across America, a non-profit organization with the following mission: *To enlighten the community of educators and the public on the value of theater arts education in curricula and to provide strategies, tools, and support for the implementation of theater arts programs in schools*. I travelled the country, facilitating workshops which I had developed for educators tasked with the responsibility of teaching theater arts to students.

One of the most valuable lessons most of the educators gleaned was the need to impart the message to students that regardless of the size of their role or the number of lines they spoke on stage, each was a critical member of the cast and crew. While "art for arts' sake" may be a sufficient justification for such programs, and one which I whole-heartedly endorse, garnering support for their inclusion in curricula is made easier by demonstrating how theater arts programs also provide a multitude of important developmental and academic benefits.

Thus, a goal of these workshops was to illustrate how these programs can be structured to ensure that academic, as well as psycho-social, benefits may be attained. The response to the workshops was extraordinarily favorable and I believe I learned as much from the other educators as they did from me.

Several years ago, I was approached by Susan Rosenthal, M.D. In addition to being a physician, Rosenthal is also an accomplished flutist. Years before, at my invitation, Rosenthal had agreed to play the flute in the orchestra pit for some of the musicals I was directing. She and I became close friends as we admired the skills and talents of one another. Trained as a pediatric gastroenterologist and still maintaining a small clinical practice, Rosenthal had just become Director of Medical Education at a large community teaching hospital in New Jersey. After a few months in her new position, recognizing that her students, medical residents, were having difficulty forming and sustaining productive communication relationships with patients, she called upon me to explore the possibility of using theater techniques to train the residents in more effective communication skills.

Coincidentally, Rosenthal and I had two mutual acquaintances; she knew each as former medical students, I knew them as actors. Both were quite adept at practicing medicine as well as theatrical performance. Additionally, both were exceptionally competent in communicating empathically with patients. It occurred to Rosenthal that there could be a useful link between theater arts training and empathic communication in the medical context.

Additionally, many of the residents in Rosenthal’s charge were international medical graduates, which imposed additional barriers to effective communication. Aware of my background in theater arts and the mission of Arts Across America, Rosenthal reached out to me to explore possibilities of using theater arts as a training platform for medical residents. She hoped that I could bring my thirty plus years of expertise in theater arts education to effect a change in the way interpersonal interactions were managed, and ultimately increase patient satisfaction scores in the hospital with which she was affiliated. I was most encouraged at the prospect and leaped at the opportunity. The idea of working to improve physicians’ communication skills to help a vulnerable population was very appealing to me. (Perhaps, in the recesses of my mind, I longed to play Henry Higgins to others’ Eliza Doolittles.)

With some trial and error, a program we eventually called Facilitated Simulation Education and Evaluation, or FSEE, was developed. By providing strategies and techniques for practicing and honing communication skills, medical residents would be able to have more successful interactions with patients. Additionally, these residents would be more comfortable and confident in these interactions, ultimately leading to better medical outcomes.

Chapter 2

Medical Humanities – Bridging the Arts and Medicine

The more FSEE was used to train these young doctors, the more interested in health communication I became. New curtains parted and the world that opened for me at that Broadway show in 1959 had eventually found me standing at the proscenium of the next stage of my life. Realizing that I had much to learn, and a voracious appetite to learn it, I applied to Drew University's Medical Humanities program. I dipped my toes in the water taking a class in "Biomedical Ethics. I was hooked. I devoured every assigned reading and searched for more. I hung on every word uttered by professors and classmates alike. The program was multi-faceted and every course broadened my capacity to work with the residents in a more meaningful way. I could not wait to immerse myself in my studies. The more I learned, the hungrier I became to learn more.

My focus on and interest in how communication plays a role in health-related experiences guided my approach to my education. For a class in "Literature of Addiction," I used my knowledge of musical theater to examine how society viewed substance use and abuse from 1940 to the present day. For a class in "The Human Condition," using the story of Jean Val Jean, the protagonist in Les Miserables, I showed how present-day practices of prisoner reintegration have not significantly evolved in over 200 years. Employing the narratives and stories from theater in conversation with the teachings of the other humanities has proved a viable and valuable application to medical training.

We may think of communication in healthcare contexts fundamentally as a tool to overcome the powerful barriers that potentially stand between caregivers and their patients. Once we appreciate that communication transcends the parties in the interaction, we become open to improving, learning, and growing.

There is an increasing presence of humanities classes in medical school curricula. More and more, health care professionals are learning how to recognize the barriers to effective communication and how to dismantle them. This is a positive trend; however, skill development and reinforcement are contingent on discovering and using effective pedagogical methods. And it is in this area where efforts must be more fully concentrated. In a field in which “hands-on” learning is a vital component of acquiring expertise, it follows that communication skills should be “hands-on” as well. It is posited that the field of theater arts provides a valuable model. For example, improvisation and role-playing classes are gaining ground in medical education curricula aimed at guiding medical students, residents, and practicing physicians through the murky waters of effective communication techniques.

Learning and acquiring effective communication skills is a process. Having practitioners participate in improvisation and role-play workshops over a period of time may prove crucial in ensuring that these skills are incorporated comfortably and naturally into their daily interactions.

In keeping with the pedagogical model with which medical students are trained, FSEE training is comprised of three components, each of which relies on the other two for a successful training experience: Didactic, Simulation, and De-Brief.

The initial component is the interactive didactic session in which the importance of communication, the consequences of miscommunication, and the things which inhibit or interfere with communication effectiveness are presented and discussed. It is emphasized at the outset, that when it comes to communication descriptors such as “good or bad” and “right or wrong” have little place in training. The focus of FSEE is on how to be more effective communicators therefore, discussion centers on identifying strategies and techniques for eliminating *less effective* styles and bolstering *more effective* methods of communicating. Sharing anecdotes from the learners’ experience is an essential element in the process and, therefore, is encouraged. The honesty displayed during the workshops was frequently cathartic for the residents and revelatory for me.

When deciding on a topic for my Master’s thesis, I considered many options. The one which prevailed incorporated blogs that third and fourth year medical students wrote into the basis for a play. Hundreds of blog entries were catalogued and were amalgamated into six profiles, from which six distinct characters were drawn. The play which centered on these characters, *A Tear in the Universe*, showed the audience a glimpse of the journey medical students travel. Each character had a different reason for entering medical school to pursue a career in medicine, and each had a different approach and perspective on patient care. My goal was to create a piece of writing that would bridge a gap between how a patient might view his physician’s experience and how a physician views her patient’s experience. By understanding that each is a person outside of their specified role, I hypothesized, barriers to effective communication might just erode.

This dissertation is a natural outgrowth of my journey from an immersion in theater to studying Medical Humanities to applying those lessons to medical contexts. The field of Medical Humanities has at its core the philosophies and tenets of communication studies. However, communication theory and practice are not currently being offered as distinct and comprehensive academic pursuits in most Medical Humanities programs. When I discussed this missing piece with my advisor and mentor, Dr. Phil Scibilia, he suggested that I develop a communication concentration for Drew’s Medical Humanities degree program. We agreed that the concentration should include courses which were general enough to appeal to graduate students in other departments as well as in our own in addition to those which focus more directly on Medical Humanities. This seed of an idea has blossomed into this dissertation.

Dr. Scibilia has always been open to new ideas and encourages each student to follow their “arrows” wherever they point. This dissertation was, for me, the bulls-eye for the path of that arrow, as it examines the evolution of patient focused care in conversation with Medical Humanities and suggests how to incorporate communication education into that conversation. As presented throughout this dissertation, unifying the two, can significantly advance the field of Medical Humanities as Communication provides the theoretical and skill base for advancing principles of patient-centeredness.

Chapter 3

Background: The Growing Relevance of Medical Humanities

Dr. James Boudwin has a small family practice in a small suburban town in New Jersey. He considers himself to be somewhat “old-fashioned” in that he will spend as much time with a patient as both feel is necessary (Boudwin, 2015). Dr. Boudwin provides each patient with a highly-personalized experience. His devotion to his patients is well-known in the community. He professes to be a “dinosaur,” a throwback to a seemingly kinder, gentler time in patient care. This, much to the chagrin of those in the waiting room, is how he believes a family practitioner best helps his patients. He knows not only each patient but each family and how illness has an impact on their lives. The irony is that the patient in the treatment room is grateful for the time Dr. Boudwin is giving and not likely to be thinking of those in the waiting room. The patient feels like she is the only one who matters and for Dr. Boudwin in those moments, she is absolutely correct.

On the other hand, the doctor’s limited staff are frequently frustrated with his approach because they are responsible for calming the impatient patients in the waiting room, mollifying callers when the doctor cannot speak to them immediately or even that day, and explaining to callers why he has not yet phoned in prescriptions. They are also concerned because the volume of patients seen does not always cover costs. And there, in the details of that last frustration, lies the rub: how can practitioners establish bonds that contribute to their patients’ well-being while remaining sensitive to the complex nature of the demands of health care delivery?

Costs associated with medical care have increased at a rapid and unprecedented rate (Brill, 2013). Most consumers of healthcare are unaware of the costs of various treatments (Reed, Graetz, Fung, Newhouse, & Hsu, 2012). And for those fortunate to have healthcare insurance, the actual monetary value of treatments bears little resemblance to the associated charges which appear on their explanations of benefits. To illustrate, let us follow one person who we will call Pat. Pat is a confused consumer of healthcare. In fact, Pat does not see himself as a consumer. Rather, he sees himself as a patient – a sick person in need of care and worried that he may not be able to afford that care.

Those who study and/or practice Medical Humanities are trained to view Pat as a person first, a patient second, and lastly, as a consumer. However, given that all perspectives have merit, Pat is, at once, all those things. Some argue that it is a matter of semantics and that it really makes no difference to the patient what label is assigned to him or her. Others believe it matters a great deal. Deber et al (Deber, Kraetschmer, Urowitz, & Sharpe, 2005) conducted a survey of individuals in three different outpatient clinics to determine their preferences about terminology as it related to them as recipients of care. They limited their study to patients with one of the following four illnesses: Breast Cancer, Prostate Cancer, Bone Fracture, and HIV. Terms offered were: Patient, Consumer, Partner, Client, Customer, and Survivor.

The overall results indicated that the term “Patient” was preferred. The authors concluded that perhaps this was a reflection of the patients’ relationships with their physicians as one of a more personal and caring nature. The term defined an association with specific and clear roles. This is not to say that the patient is not a partner in his own care nor does this necessarily imply that the physician is practicing in a paternalistic manner. It speaks, perhaps, more to the patients' desire to be in capable, responsible hands when they are in vulnerable situations. The relationship, defined as such, alleviates some of the patient's burden. Our patient, Pat, is experiencing many concerns simultaneously, not the least of which is apprehension about his well-being, his healthcare options, and the associated affordability of those options.

Pat, and patients like him, would be well-served if the practitioners involved in his care had training in Medical Humanities. Putting the "human" back into the equation of medicine and care, forces Pat's needs and concerns into the center of the calculation. Medical Humanities scholars and those who practice with a grounding in the field understand the critical nature of this inclusion.

According to Cole et al, Medical Humanities is "an inter- and multidisciplinary field that explores contexts, experiences, and critical and conceptual issues in medicine and health care, while supporting professional identity formation" (Cole, Carlin, & Carson, 2015). This rather broad definition does not include a rationale for the exploration of those "contexts, experiences, in medicine and health care" which would point to the goal of maintaining a dignified place in all facets of health for all stakeholders, and most especially for people who find themselves in the role of the patient.

Although Medical Humanities emerged in the 1970s as an independent academic discipline, it did not gain a substantial foothold in the academic community until ten to twenty years later. For much of the twentieth century, treatment of illness focused primarily on a biological model, that is, that healing focuses solely on physical or clinical factors. Social and emotional considerations were, for the most part, given secondary status if addressed at all (Cole, Carlin, & Carson, 2014).

In the second half of the twentieth century, a physician, Edmund Pellegrino, emerged as a pioneer in biomedical ethics as he set out to reform the way medicine was practiced and considered. In addition to serving in a multitude of prominent posts, Pellegrino served as Chair of the President's Council of Bioethics from 2005-2009 (The Center for Bioethics and Human Dignity). His overarching goal was to restore the essence of what it means to be a human being into what he called the "sins" of medicine (Cole, 6). Pellegrino considered the then new trends in medicine, the "sins," to be dehumanizing. For example, increased specialization, greater reliance on technology, constriction of the role of the physician, disenfranchising of the poor and fringe social groups, and general insensitivity to the patient as a "whole person" contributed to the estrangement of the person from his illness. Medical Humanities, with Pellegrino playing a central leadership role, emerged as a holistic approach to healthcare with the well-being of the patient at the center.

Crawford, et al argue that while Medical Humanities has finally gained a strong foothold in the world of healthcare, a more inclusive and representative discipline would be called "Health Humanities" (Crawford, Brown, Tischler, Baker, 2010). This term, the authors contend, acknowledges the critical contributions and roles of those who work in health professions but are not necessarily bound by a medical model. For example, those who work in the mental health field may have an orientation toward care that does not include medicine. We are slowly but surely moving toward that way of thinking; we talk about "health" insurance and "healthcare" options and do not generally refer to those entities as “medical” insurance although we often mean the same thing.

Employing the term “medical” establishes the implication that health concerns will be addressed by looking for physiological causes of illness and the inclusion of pharmaceuticals as symptom alleviation or even cure. Employing the more general term “health” lends to discussions a more inclusive and integrative therapeutic approach. Allied health professionals, that is, those distinct from medicine, nursing, and pharmacy, have a place in a field called “Health Humanities” and would be excluded from, or at least peripheral to, the field of Medical Humanities. A more inclusive term opens the playing field and expands the role that medical or health humanists can play. Semantics was discussed above in terms of how a patient perceives him/herself in the context of illness and here, too, word choice can make a difference in how we think of the inclusion of humanities in the practice of health provision. Nevertheless, for the purposes of this dissertation, the term Medical Humanities will be used and will refer to a field which encompasses all health care professionals who offer services to those seeking to improve or maintain their overall physical, mental, and emotional health and well-being.

The humanities, by definition, are “those disciplines which contribute to understanding the human condition: philosophy, ethics, history, anthropology, sociology, literature, and the visual and performing arts” among others (Kidd and Connor, 2008). Medical Humanities, as a discipline, addresses the health and well-being of the human as more than a collection of body parts with functional and dysfunctional systems. For example, understanding the human being from an historical perspective gives a sense of place on the life continuum. Additionally, this perspective “encourages critical thinking about the notion of medical progress” (Kidd and Conner).

From the point of view of a medical humanist, the way that Pat can be best treated is by taking into consideration the fact that he is a whole and multidimensional being. Additionally, attention would be paid to the multiplicity of existing relationships his illness will affect - as well as be affected by - new relationships in the health care community he will necessarily form and develop. This does not appear to be a controversial statement yet there is much discourse on whether it is a truism or an idealized vision of what might be a “nice, but not necessary” practice. To many, this approach seems to be an easy concept to accept and actualize. It seems not only reasonable and logical, but an obvious positive force. Surely, respect for a patient as a person with a life beyond his illness appears to be an easy concept to accept and one on which we can all agree is sensible.

If this is the case, then why is there resistance? Why is there a struggle to find funding for these programs? Why, for example, are palliative care professionals not reimbursed by the vast majority of insurers? Why are some researchers bending over backwards to find evidence-based proof that studying and practicing medicine from a Medical Humanities vantage point is valid?

These questions give rise to the ongoing issue of the value and place in medicine of art, that is to say, the humanities, in conversation with the science of medical practice. In a now famous essay by C.P. Snow, first delivered by the author as a speech in 1959, a specific definition to this centuries-old debate was given a name (C.P. Snow, 2012). Snow’s phrase, the “two cultures” dichotomy has since endured.

However, as a discipline, Medical Humanities, has the capacity to transcend and unify this characterization of “science” versus “art.” Pedersen (2010) articulates this perspective effectively, arguing that inclusion of the humanities in medical education curricula should not be a "soft add-on" because it "may cloak medicine's hard edges instead of drawing attention to the systems and paradigms shaping these hard edges." A corollary to this argument is the assertion that not only should the humanities occupy a respected role in the conglomerate fields of healthcare, but rather, they should have a central and critical presence. However, the orientation of the scientific approach prevails. An overriding need to support efficacy with evidence wends its way into the conversation and holds the potential for shifting the direction of the discourse.

Ousager and Johannessen (Ousager, June 2010) reviewed 245 articles focusing on the role Medical Humanities plays in medical education. Of those, the vast majority extolled the virtues of such programs, but as Ousager and Johannessen report, offered no "evidence" of any lasting positive effect. Moreover, they point out that a mere nine articles discussed any attempt to determine lasting effect, and ten articles indicated unenthusiastic attitudes toward inclusion of such courses in medical school curricula. This review stirred up the ongoing polemic discourse about what Medical Humanities, as a discipline, actually encompasses. It raises questions about the unanimity in accord of the very definition Medical Humanities. Is it the inclusion of an understanding of narrative? Is it a dissection of film, art, theater, and literature to understand the human condition? Is it the discussion of ethics versus law? Or, perhaps, are Medical Humanities studies, something more esoteric, more akin to an "I'll know it when I see it" construct?

One of the overriding questions is does the inclusion of a Medical Humanities curriculum in medical schools produce better doctors? Can the answer to that question be proven empirically? Ought it be? Does the study of Medical Humanities help toward avoiding or alleviating burn-out in medical practitioners? Or, rather, are the Medical Humanities specific areas of study which can shape and change the context in which healthcare is understood? Questions of evidence build roadblocks which obstruct the more critical discussion establishing the potential value to humankind, and yet they must be addressed.

Crawford et al elaborate on the discussion of seeking evidence to legitimize the inclusion of the humanities in healthcare practices (Crawford, Brown, Baker, Tischler, & Abrams 2015). They advance the argument that measuring efficacy of incorporating humanities into treatment plans is not the same as measuring the value of a pharmaceutical intervention. For example, if it is learned that dance therapy has the effect of reducing stress levels in some patients with throat cancer does this mean that all patients with throat cancer ought to be engaging in dance therapies? On some level, it does seem like a pleasant idea but as a policy it clearly does not make sense. However, for those patients with throat cancer who do have decreased levels of stress after a dance class it can be viewed as a successful and useful endeavor.

The reasons for factoring the humanities into how we conceive of treatment plans are as wide-reaching and diverse as the populations they address. Culture, age, gender, and social class to mention a few variables all contribute to the likelihood of receptivity and result. So, while there may be clear evidence that dance can be a stress reducing activity for some patients can we make the leap that this can qualify as an evidence-based practice? While there are quantifiable methods to make such a determination, they are not without a multitude of limitations, not the least of which is the necessity for longitudinal study. Thus, evidence-based approaches are certainly important. But practitioners must be mindful to employ them correctly, that they isolate and control for the proper variables, and that they consider the proper timeframes in which to examine results. If not, and this is particularly true with phenomena in the realm of Medical Humanities, promising developments may not be pursued.

Warner and Spandler (2012) suggest that the research to determine efficacy of inclusion of the arts, for example, in treatment plans ought to combine aspects of behavioral, cognitive, and emotional experience in assessments. Oliver Sacks wrote that “Music can lift us out of depression or move us to tears — it is a remedy, a tonic, orange juice for the ear. But for many of my neurological patients, music is even more — it can provide access, when no medication can, to movement, to speech, to life. For them, music is not a luxury, but a necessity” (Sacks, 2008).

Looking at the nuances of response, as suggested by Sacks, might provide a more accurate window into what helps individual patients. Crowe, et al, suggest that smaller studies might yield more useful information because the case study approach often allows for a more in-depth evaluation of behavioral nuance than do examinations of broad behavioral patterns that are amassed on large-scale aggregate bases (Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A., 2011). This is not to suggest one is more methodologically correct than the other. However, it is important not to overlook the vital nature of methodological tools that allow us to penetrate and understand the behavioral principles captured by Sacks.

The point of employing practices that have evidence of effectiveness is that there is some unifying truth inherent in the practice. The hope and expectation is that the practice is generalizable and can work for many. However, if the practice functions in a generic manner, we run the risk of losing nuance in the mire. And when treating and analyzing results when employing tools generated within the humanities, the main benefit may just lie in the nuance.

There is also the question of whether the application of evidence-based practices inhibits innovation. Are healthcare professionals likely to shy away from experimenting with new techniques because there is not yet substantiating evidence that the technique might have a positive effect? Again, it is important to consider that wrong assumptions about the phenomena under study, or the misapplication of methodological tools could derail progress.

How are theory and proof permitted to find their natural intersection if that is to be the case or their natural departure should that be the result? For example, using marijuana in medical circumstances has taken a very long time to demonstrate widespread evidence of its efficacy. Winnie Hu reported on the increased use of marijuana for elderly patients in New York City’s Hebrew Home for the Aged. The staff, she reports, are not permitted to “store or administer pot” however residents are allowed to purchase it from a dispensary and self-administer provided it is kept under lock and key.

The use is still illegal in 21 states despite the evidence that it does have a clear positive impact on a variety of ailments including Alzheimer’s disease and Parkinson’s disease (Hu, 2017). The unwillingness to legalize the use of medical marijuana in the majority of the states in this country results in a reluctance to use it in innovative ways. Even more problematic, in states where it is legal, there is still an aversion on the part of the medical community toward using it in cases where there is reasonably clear evidence that it is an effective treatment for many medical conditions.

The effectiveness of humanities-based treatment protocols may be more ambiguous to cite as evidentiary. While results obtained from qualitative studies clearly play a key role in developing treatment plans do we need to have research studies with randomized as well as controlled trials to evaluate all methods of treatment? Of course, but this should not be at the expense of establishing studies that allow us to search for nuance through the acquisition of qualitative data. The search for the truth is not merely for altruistic motives, although the knowledge that offering beneficial aid is far better than doing nothing. The search for evidence and truth also provides a rationale and support for justifying financial backing to advance these practices and allow them to gain wide-spread acceptance.

There is even disagreement as to whether Medical Humanities is a “field” or a “discipline,” a field defined as an encompassing approach and a discipline as a more specific course of study (education.stateuniversity.com/pages/1723/Academic-Disciplines.html). Bleakley offers to settle the debate by characterizing Medical Humanities as a field which is both “multidisciplinary” that is, draws from a variety of disciplines independently and at the same time is “interdisciplinary,” using a variety of disciplines in a unified manner (Bleakley, 2015). This is perhaps, an acceptable compromise of terms, however, it is the context in which Medical Humanities are employed that may better fit the studies into one or the other category for the purposes of clarity.

Polianski and Fangrau (Polianski & Fangerau, 2012) respond by offering an analysis of why this debate gets at the heart of the answers to those questions. These two distinguished Professors of Ethics recognize that discussions of the “humanities” are often reductive, referring solely to conversations about morality. By not “distinguishing among the concepts of ‘human,’ ‘humanistic,’ and ‘humanizing,’” critics focus on humanities programs as having goals which are ill-defined and difficult to measure. Thus, it follows that a general and somewhat intangible goal of improving the quality of doctoring is not substantial and therefore, humanities programs fall into the realm of “soft” as opposed to “hard” sciences rendering them nice at best and useless at worst. They also offer an alternative way to think about this, specifically in the ‘Medical Humanities in medical school curricula’ conversation. They suggest that we stop thinking of the two fields as polar opposites and trying to justify fusing them, we take a look at how “concepts” from science and art be used as “instruments” in teaching medicine to students.

The theme under which all of these arguments gather is the question of the role Medical Humanities should play, that is, is it merely one of benign significance or is it an essential component to medical care. This dissertation asserts the premise that it should gain momentum toward the latter, and the terms field and discipline will be used interchangeably,

Chapter 4

Medical Humanities – A Vital Component in Our Understanding of Caregiving Contexts

This chapter will demonstrate that Medical Humanities can and ought to be integrated into everyday medical care and messages relating to healthcare and the debates over semantics are reductive and dismissive of their inherent value and potential for impact.

The humanities can weigh heavily in the practice of medicine and health care in general. The health care industry is gigantic, with annual costs exceeding $3.2 trillion and occupying almost one-fifth of the national economy (Sahadi, 2016). It is complex, comprised of an enormous spectrum of stakeholders with potentially conflicting and competing agendas that relate to policy, ethics, law, economics, cultural disparities, technology, and others. All these factors have an influence, either directly or indirectly, on the care giving process and contribute to how we think about care and access to care.

The mission of the Medical Humanities discipline includes providing insight into how potentially differing agendas of stakeholders may be reframed such that all perspectives, with particular emphasis on those which promote the welfare of the consumer, may be honored and dignified. There is much in the literature about the *who, what, where, and why* of Medical Humanities: *who* includes, but is not limited to a broad array of institutional providers and individual practitioners, consumers, suppliers, payers, communities, legislators, and other publics; *what* is an amorphous collection of ethical, social, spiritual, philosophical, cultural, and historical issues; *where* is at the intersection of key stakeholders from the boardroom to the bedside; and *why* relates to a multifaceted rationale underlying all elements of conduct.

What is absent from this list of terms from a journalist's lexicon is *how*. And the *how* is critical. At the nucleus of medical care and practice is how ethical considerations are discussed; the conversation that all members of society have between and among themselves; the relating of the historical record; the dissemination of critical public health information; and the interaction between physician and patient. The *how* is what is missing from what must be a guiding force in the overarching theme of Medical Humanities. The *how* involves the creation, exchange, and accuracy of meaning between and among interactants. How we best execute the *how* to guide our understanding of the complex ways the stakeholders create and sustain meaning, and why it is integral to every Medical Humanities program, is at the heart of this dissertation.

The *how* is what determines the quality and nature of the links; it binds the *who, what, where, and why.* And, the *when* must be now since our population is older and sicker than ever before and since access to healthcare has become a divisive and controversial subject. The *how* can best be captured by the phrase, "Health Communication," a field that emerged as such during the same time period that Medical Humanities began to debut.

And, by bringing the tools provided by communication studies into the realm of Medical Humanities, overall care practices can be strengthened. Effective communication is becoming increasingly acknowledged as critical to patient care at the same time it is becoming increasingly complex. In 1999, the Accreditation Council of Graduate Medical Education (ACGME) recognized the importance of interpersonal and communication skills as one of their six core competencies, however treating interpersonal skills and communication skills as distinct entities. Benson (2014), defines the six domains within this core competency.

First, on an interpersonal level, a medical graduate must be able to

1. create and sustain a therapeutic relationship with patients, families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds
2. demonstrate the insight and understanding into emotion and human response to emotion that allow one to appropriately develop and manage human interactions

The communication portion is comprised of the following competencies:

3. Communicate effectively with physicians, other health professionals, and health-related agencies
4. Work effectively as a member or leader of a health care team or other professional group
5. Act in a consultative role to other physicians and health professionals
6. Maintain comprehensive, timely, and legible medical records, if applicable

These domains highlight the understanding that communicating effectively requires give-and-take from all parties. There is recognition that not only should a medical resident be able to demonstrate clear and active listening skills, she must be able to speak in an articulate manner. This is essentially about relationship-building: doctors with patients and their families and doctors with their peers and team members.

Another important step in the recognition of the critical relevance of communication in health care is in the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient survey that Medicare and Medicaid has instituted. While many hospitals have used patient satisfaction surveys such as Press-Ganey for their own internal use, HCAHPS (pronounced “H-caps”) is the first survey of its kind to be used on a widescale basis. It is the “first national, standardized, publicly reported survey of patients' perspectives of hospital care” (CMS.gov, 9/25/2014). Until the implementation of the HCAHPS “there was no national standard for collecting and publicly reporting information about patient experience of care that allowed valid comparisons to be made across hospitals locally, regionally and nationally” (CMS.gov).

This innovation in reporting has caused hospitals to stand up and take notice. For the first time, patient satisfaction provides a real (i.e. economic) incentive to ensure that quality of care is up to their stated and desired standards. The results also allow for consumers of healthcare to compare and contrast the care practices of various hospitals using objective measures. As a result of HCAHPS, hospitals are taking a much closer look at the communication practices in their systems and taking steps to improve them.

Before delving into a discussion of *how* best to integrate health communication into Medical Humanities curricula, some attention will be devoted to the *why*. *Why* should the humanities be incorporated into healthcare situations? And *why* does communication matter? Earlier, this dissertation raised the discussion of how debates of efficacy obscure the more critical discussion establishing the potential value to humankind. Certainly, one dissertation cannot quell a centuries-old debate, but an examination of the work of experts who have attempted to prove the value of *why*, and then adding my own voice as a practicing professional in this area, might help move our understanding a step forward in that direction.

Much of the literature addresses the inclusion of Medical Humanities in medical education. That is, how can we help physicians, for example, to become better practitioners through the teachings of ethics, philosophy, narrative, and history? This is a valuable conversation as well as a necessary one. After all, physicians are the ones we seek for medical attention when we feel ill. Thus, it is difficult, more accurately, impossible, to think about medicine without thinking about physicians. But, Medical Humanities can reach beyond the medical school context. For example, it is generally not within the purview of the medical school curriculum to teach how to assess a variety of insurance options or how to choose an appropriate long-term care facility for an aging loved one.

We may safely assume that the preponderance of medical school education does not focus, for example, on how to evaluate public health campaigns about alcohol and pregnancy, for example. Most medical textbooks do not comprehensively address or provide information about how patients can navigate through the complex maze of a healthcare system or seek advocacy when they believe their rights have been compromised. These, and more, are areas that Medical Humanities can address both in the medical school and for the general population.

Medicine and the humanities are not at odds; they are inextricably linked. Recall our fictitious patient, Pat. He is not “stomach pain.” He is not “constant nausea.” He is a father of two teenaged boys who miss him on the sidelines of the soccer field when he is not there. He is the husband of the woman who would like to share popcorn at the movies. He is the history teacher at the local high school who is also the school's coach of the Model United Nations Program. Pat is a lot of things to a lot of people, but when he sits in the examination room behind a flimsy, barely closed curtain, with a young resident, he is viewed as a collection of gastrointestinal discomforts: stomach pain and constant nausea.

Consider the following two scenarios:

SCENARIO A

Dr. B: Hi Pat! What brings you in today?
Pat: Hi Doc. My stomach has been killing me and I feel nauseous 24/7.
Dr. B: Vomiting?
Pat: No, just queasy all the time.
Dr. B: How long has this been going on?
Pat: I'd say about 3 weeks. Maybe a month.
Dr. B: Have you lost weight?
Pat: Yeah – maybe that's the silver lining (laughs).
Dr. B: Well, I'll set you up with a GI series and we can see what's going on. In the meantime, eat light and non-fatty foods. My receptionist will call you to set up a follow-up when we get the results. See you then.
Pat: Thanks, Doc.

SCENARIO B

Dr. B: Hi Pat! What brings you in today?
Pat: Hi Doc. My stomach has been killing me and I feel nauseous 24/7.
Dr. B: Vomiting?
Pat: No, just queasy all the time.
Dr. B: How long has this been going on?
Pat: I'd say about 3 weeks. Maybe a month.
Dr. B: Have you lost weight?
Pat: Yeah – maybe that's the silver lining (laughs).
Dr. B: Smiles. How is Betty? The boys?
Pat: Eh. Things have been rough.
Dr. B: What's going on?
Pat: Well, we have to find a nursing home for Betty's mom. She had a pretty serious stroke so we need to get her up north from Florida.
Dr. B: That is stressful – we went through a similar thing last year with my dad. Julia, at the front desk, can give you the names of ones we researched and liked. How are the boys?
Pat: Well, that's another thing. Ryan got into some trouble and has been put on academic

probation. Betty is a mess about it all.
Dr. B: And you?
Pat: Yeah….I guess I want to fix it all but I don't know what to do.
Dr. B: Sounds like you have a lot on your plate. Pat, I think your stomach discomfort may be related to stress. I have another two patients to see but if you can hang around, I'd be happy to talk it out with you.
Pat: Actually, Doc, I would love that if you're sure.
Dr. B: Sure thing. Have a seat in the waiting room and Julia will let you know when you can come on back.

Both physicians are demonstrating appropriate levels of medical care. Both have ascertained "chief complaint" and asked relevant questions. The physician in Scenario A responded to the complaint by ordering tests to determine the physical status of Pat's gastrointestinal tract. This would certainly be the responsible approach and presumably no one could find fault with this, and, assuming that Pat has the means or insurance to cover the costs of these tests, all could turn out well.

The physician in Scenario B demonstrated a familiarity with the patient; he knew and asked about Pat's wife and two sons. There is clear indication of an established relationship between the two. Pat felt comfortable responding with honesty and shared some details of his life. The astute physician recognized that Pat's family situation could very well be a contributing factor to Pat's physical ailment. By offering to talk for a while, the physician could save both of them a lot of time and money. In addition, there is the possibility that the insurance company would be saving money and the imaging facility might use that time for another patient. Of course, it is possible that Pat may ultimately require those tests, but a pre-emptive conversation might negate that necessity. A few extra minutes, or the use of the limited number of minutes in a more communicatively sensitive manner, has the potential to save several hours and several hundred dollars. Indeed, as Fogarty, et al point out that an extra "forty seconds of compassion" can have a significant impact on decreasing patient anxiety (Fogarty, Curbow, Wingard, McDonnelland, & Somerfield, 1999).

The physician who treats patients based on the recognition of and acknowledgement that a patient is more than his collection of symptoms but, rather is, a collection of relationships, dreams, fears, and joys, is a physician who is practicing "patient and family centered care" the *art* and heart of medical humanism. As a term, "patient-centered care" runs the risk of being overused, that is, the literature is deluged with articles either denouncing it or proclaiming its virtues. The term itself has been around for decades, its origin generally attributed to Enid Balint in her paper, *The Possibilities of Patient-Centered Medicine,* published in 1969. She coined the term as part of her analysis of psychosomatic illness. Balint describes the conceptual difference between an *illness* model and a *patient* model as the difference between looking at a broken leg versus a predisposition to accidents.

Others since have used the model to describe medical practices which are focused on how illness affects the patient as a whole person and not on just the nature of the ailment. For example, Engel called for a treatment model which considered the social environment in which the patient's illness exists (Engel, 1977), that is to consider, among other things, the patient's family, culture, and living conditions. Kleinman examined the subjective experience of the patient who feels ill creating a distinction between "illness" and "disease" (Kleinman, 1989). More recently, the term "sickness" was added to the dyad. The triad, disease, illness, and sickness reflect three conceptual views of ill-health; "disease" is the medical community's view, "illness" descries the patient's perspective, and "sickness" refers to the societal view (Twaddle, A. 2004;

Wikman A, Marklund S, Alexanderson K, 2005). Hofmann writes that this triad, which has become a convention in the fields of medical sociology, medical anthropology, and in philosophical studies of medicine, is under increasing scrutiny (Hofmann, 2002). Nordenfelt argues that Twaddle's three perspectives on ill-health are only valid in "the context of a general theory of health" (Nordenfelt 1987, 1994). (It should be noted here that mental illnesses are not part of this specific discussion, rather only somatic illnesses are addressed in this conversation.)

The usefulness of this conceptual framework is manifold. How a person experiencing a deviation from a baseline of what is generally considered to be good health is viewed by the person, the medical community, and society has a direct impact on the course that deviation will take. The distinctions among the three concepts give rise to questions of patient autonomy, paternalism, ethics, and whether a condition ought to be medicalized. The discussion of overlap poses further challenges; for example, is the case considered a disease and a sickness, an illness and a disease, an illness and a sickness, or only one of the three. In the latter case, it becomes incumbent upon the individual entities (patient, doctor, social relationships) to advance that point of view. If there is overlap, as in one of the three dyadic examples, it is easier to negotiate a position. An understanding of the trichotomies and the interplay among the concepts is critical to ensure that the patient is at the center of the discussion.

This is not to say that it is only the patient's view or perception that matters. Certainly, few would argue that a physician's assessment of a condition is crucial even if it is in conflict with the patient's own interpretation. This is not an uncommon occurrence. But can a patient expect treatment when a medical assessment yields no explanation? The flip side of that question is should a patient receive treatment for a disease they do not acknowledge exists? The same is true for a societal view – where does the responsibility begin and end with respect to treatment when there is not congruence in assessment from all three entities?

In all cases, the problem is not just one of a semantic nature. We seek multiple things simultaneously. We strive to ensure that the individuality of the patient is central to healthcare decision-making while at the same time we think about how we can provide access to more and more citizens. It is not that these are necessarily in conflict, but it does raise questions about how and to whom we distribute healthcare resources. Of course, there are economic concerns which often drive the trajectory of care.

Accordingly, it also raises questions about whether our philosophical leaning is more toward utilitarianism or deontology. Utilitarianism dictates that "all actions must seek to produce the greatest good for the greatest number of people" and deontology "focuses on the moral aspects of any action, not its consequences" (What is the difference…utilitarianism, n.d.). If utilitarianism is to prevail, we can make an easier ethical case to reach an objective that we believe has overriding importance. If the medical community deems the *illness* a *disease*, and society agrees that it is a *sickness*, there is greater likelihood that there will be economic support (Hofmann, 2002). However, if there is inconsistency in assessments, however, patients who believe they are ill may find they cannot receive support from medical and social service agencies.

Placing the burden of discovery on the importance of the patient's central role in determining a treatment plan is critical. Acknowledging the perception of a patient's illness to the patient for whom that perception is fact is key, whether or not the medical community or societal views agree. This is not to say that patients should receive treatment when there is no apparent diagnosis. This is to say, however, that the patient needs to be taken seriously in all cases. Ultimately, it is a question of dignifying the experience of the individual.

However, some hospitals who claim to be advocates of patient-centered care view patient-centeredness in a manner indicative of their intention to practice sensitivity to and awareness of patient rights and patient information (Groene, et al, 2014). While these practices are positive and useful, they derive largely from legal and regulatory mandates; as such, the view may be a necessary component of patient-centeredness, but may fall short of the more comprehensive approach as captured in principles of Medical Humanities.

Additionally, the concept is called into question as the perceived barriers and challenges to implementation are put forth as roadblocks instead of opportunities. One study revealed that the time needed to implement patient-focused care (as opposed to provider-focused visions) was perceived as a barrier. Instead of a definitive time-frame, say six months, for implementation, the transition was long-term, therefore appropriate and necessary resources may not be available for allocation (Luxford, Safran, Delbanco, 2011). Changing the culture of an institution takes time; it is a continuous process, one which is on-going. Viewing that change as a “project” with a beginning, middle, and an end constitutes a disservice to all stakeholders. Viewing that change as a “process” acknowledges that there will be advances and set-backs and that change involves learning, adaptation, practice, feedback, and building on accomplishments, all with the ultimate goal of improvement in care.

Differing perspectives on health and illness have a direct influence on how messages can be constructed and shared. The medical model offers two general categories of how health and illness are viewed. One is the biomedical model, which is the model which has been operational for the past few centuries. This model looks at illness as something which can be explained and addressed with physical measures and processes. This is a scientific, cause and effect, symptom and cure approach. Certainly, this method has proven effective in a wide set of circumstances. A patient presents with a set of symptoms which have been identified, treated, and perhaps cured with a specific protocol.

This model is very much still the norm in a majority of illness situations and will continue to be prevalent. Given the nature of the model, with inherent status hierarchy assignments, the model, invariably, has a strong paternalistic lean. The "experts" have principal responsibility for defining what the care-seekers experience. Thus, relationship development and communication occur in a context inherently challenged to be patient-centered. This physician-centered model has its limitations as we are recognizing the importance of the patient's role.

Moreover, on a more universal scale, the world is 'shrinking" and populations have broader access to health information and health care in other lands and cultures as never before. In addition to potential exposure to plants, animals, climates which have previously been alien and therefore lacking in natural immunities and resistance, travelers are exposed to a variety of methods for dealing with changes in health status.

What the physician-centered model also does not take into account very effectively are individual attributes, cultural influences, religious beliefs, or social attitudes or norms which can all play a part in illness and in health. It also does not often give substantial weight to individual personalities, or the hopes and fears that individuals bring to healthcare situations. Different individuals as well as different cultures have multifarious views and attitudes about health and illness which can have a direct impact on how symptoms are addressed and treatment is applied. This model has been, traditionally, a curative approach.

The biomedical model faces new challenges as symptom relief and disease cures are not as readily accessible nor appropriate. This model, whether applied to the largescale or the smaller, interpersonal, level of health communication, has limitations and presents barriers which are almost impossible to overcome given the global nature of the human health and wellness experience. Another model might more aptly be used to address health concerns on both levels.

This second model, the biopsychosocial model, is based on the acknowledgement that poor health is more than just a physiological event, but rather is influenced and is affected by a person's feelings, attitudes, and beliefs. For example, George Engel's holistic model asserts that ill health can and ought to be viewed in a context of culture and socio-economic status. Borrell-Carrio et al assert that the biopsychosocial model is both a philosophy and a clinical map for care. (Borrell-Carrio, 2004).

Essentially a systems theory based model, it begins with the patient's narrative. Understanding the patient's concerns by hearing their version of their illness puts a unique spin on the trajectory of next steps in care. Often the narrative includes significant others and the illness is seen in conversation with the relationships specific to the patient. Significant others may be those in family relationships, work or school cohorts, or friends from other areas of the patient's life, religious groups, hobbies and clubs, etc. The narrative will often give insight into what will likely not show up in blood tests. A clinical model which includes an appreciation of the patient as a person will be more apt to yield a correct clinical diagnosis and plan for treatment.

Arthur Frank wrote that illness calls for stories in at least two senses (Frank, 1995). First, stories need to "repair the damage" which illness has wrought upon the ill person's sense of his future and how he fits into a newly prescribed life. He writes that "stories are a way of re-drawing maps and finding new destinations."

The second sense offered by Frank is more literal, specific, and pressing. The ill person recounts, often repeatedly, his or her symptoms, reactions to medications, and response to treatment. Moreover, he or she shares the litany not only with family and friends who are concerned but also relates the details to medical personnel, admissions counselors, insurance workers, employers and colleagues.

A practitioner employing the biopsychosocial model will use the narrative to more fully and accurately understand the patient's illness as a part of the patient's life experience. Treatment of the whole person is likely to reveal more than an examination of test results alone and outcomes may be better. Arthur Frank uses the apt metaphor of a "shipwreck" to describe the reparations story telling can provide. He writes, "The repair begins by taking stock of what survives the storm. The old map may now be less than useful, but it has hardly been carbonized. The illness story is wrecked because its present is not what the past was supposed to lead up to and the future is scarcely thinkable." Patients who feel that their future is in the hands of someone who cares about their past are more likely to feel trust and therefore, more likely to disclose honestly.

The Picker Institute, an independent, non-profit organization with the mission of "advancing the principles of patient-centered care," conducted a research study along with Harvard Medical School (Davis, et al, 2005). Stemming from a seminal work, *Through the Patient's Eyes* (Gerteis, et al 1993/2015), the study identified eight domains which they assert are central to positive patient experiences. The Eight Picker Principles of Patient-Centered Care are:

- Respect for patients' values, preferences, and expressed needs
- Coordination and integration of care
- Information, communication, and education
- Physical comfort
- Emotional support and alleviation of fear and anxiety
- Involvement of family and friends
- Continuity and transition
- Access to care

These principles reflect the core concept that improving the patient experience requires a systemic and cohesive approach, beginning with a universally accepted definition. And although the term, "patient-centered care," endures, that overarching coordinated definition still does not exist.

However, the Institute of Medicine comes close, defining patient centered care as "care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions" (National Academies of Science, 2001). This definition identifies the significance of an "all-players" approach, that is, there are many people who need to work together to best coordinate each patient's care.

The necessity for a unified definition, one which encompasses the roles of the various stakeholders in patient care from hospital administrators to private practice physicians, is long overdue. An approach from a Medical Humanities perspective can provide that clarification and definition.

Chapter 5

Person-Centered Care Vs. *Patient*-Centered Care

The implication in the term "person-centered care" is that medical care takes into account the entirety of the experience of the one receiving care. It acknowledges that there is a life outside of the illness, a life despite the illness, a life affected by the illness, and a life interrupted due to the illness. It acknowledges that there are families and friends who are involved and engaged. It acknowledges that cultural factors are bound up in the attitudes and emotions surrounding the illness. It acknowledges that the person is the whole and the person is the patient only in one specific context of that whole.

The origin of the term has its roots in the twentieth century. Generally acknowledged as the founder of nursing as a profession, Florence Nightingale, in the mid-1850s, differentiated nursing care from medical care, the former focusing on the patient as a person and not as a receptacle of disease. In her book, *Notes on Nursing: What it is and What it is Not*, she writes "…For the above reasons, whatever a patient *can* do for himself, it is better, *i. e.* less anxiety, for him to do for himself…" (Nightingale, 1860). This awareness that the patient's need for autonomy, even in the face of illness, should factor in and prevail was a startling new idea. Through persistence and evidence, Nightingale's theories eventually prevailed and changed the face of nursing moving forward.

A century later, Carl Rogers, an eminent American psychologist, originated the concept of person-centeredness. In the 1960s, the humanistic movement was taking shape and, at its core, Rogers was espousing new ideas in response to the prevailing and well-regarded Freudian theories on psychotherapy (Rogers, 1967). At the time, most existing psychotherapies operated on the belief that people had mental health conditions which needed fixing. The central tenets were similar to the medical model which was based on the thinking that the disease or disorder should be the focus of attention more so than the person seeking help.

Rogers' focus indicated a significant change from other approaches which sought to modify behavior and/or analyze the unconscious or subconscious mind. His focus was on the relationship between client and therapist, and his client-centered approach changed the way therapists initiated and managed relationships with their clients. Moreover, he believed that the term "patient" had a dehumanizing effect because of the implication of illness and thereby had the effect of reducing the person to a set of symptoms.

Rogers theorized that by acknowledging and listening to the way people think about themselves and the choices they face, a more effective method for helping them address their challenges emerges. Rogers described the "fully functioning person" as one who is open to experience, lives in the moment, trusts in themselves, feels free to make choices and assume responsibility for those choices, and contributes to the world in a creative fashion. One of his principal beliefs was that each of us has the potential to create meaning in our lives and to create a life which is meaningful.

He wrote that in order for a therapist to be effective, it is essential that he is "congruent, empathetic, and respectful" (Rogers). He further contended that if a person was in therapeutic treatment with such a therapist, he or she would be treated with "unconditional positive regard" leading the person becoming a "fully functioning human being." This is to say that a client is to be viewed as having positive intentions and motivated by good. In order to be "congruent" or balanced, Rogers believed that self-actualization occurred in three areas: self-worth, self-image, and ideal self.

Rogers believed that people know what is best for themselves and, given the opportunity, they will choose actions which lead to them becoming fully functioning. He also believed that people can learn and grow from their experiences and mistakes. This thinking was foundational and transformative.

Stephen, discussed the concept of self with me. It is the subject of his forthcoming book. He explained, in our interview:

> One's idea of self is at the center of one's life and its function, the function of the self that is, is to provide an understanding of one's position in the highly challenging, fast changing and contradictory condition of modern western society. When one has organized a sense of who one is, one knows what one believes and what one can ignore. One is comfortable and settled, and the world is filtered. So, in this sense self is a vital filter. Self is an active filter that tells you what to ignore and what to value. Therefore, among the top ten situations in everyday life where we encounter discourse that is potentially threatening of ideas of self, surely way up the list would be the doctor's office. The doctor/patient interaction can in many ways be consequential for one's ideas of self. A doctor who delivers self-threatening information—“the scan showed a distortion on your right kidney. we'll need to get that checked out”—is going to be reacted to in predictable ways (ignore, rationalize, distort perhaps, or freak out with anxiety, or become depressed). A threatened self leads to narcissistic focus, turning inward, stopping listening, empathic shutdown. It is the self that is suddenly in crisis. All this goes home with the patient. (Stephen, n.d.)

Medical training is based on science and knowledge acquired empirically. Students of medicine are taught how to diagnose illness, formulate a prognosis, and devise and recommend a prescription for care or cure. Their education is clinical and based largely on the study of biomedical pathology. However, as Michael E. Whitcomb writes, since the early 1980s the expectations society confers on medicine have evolved. He explains:

> …important changes have occurred in medical practice that have

> critical implications for the content of students' clinical education. For example, concerns about the cost of medical care have led to major changes in the organization, financing, and delivery of medical care services. As a result, physicians now entering practice are expected to be able to provide high quality care in an efficient and cost-effective manner; to be skilled at accessing, managing, and using electronically stored information in clinical decision-making; and to understand the population-health dimensions of providing care to individual patients.
>
> During the same period, society's expectations of medicine have changed. The public has come to recognize that the promises of curative medicine that dominated thinking about medical practice and medical education in the 1960s and 1970s were somewhat overstated. Americans recognize that that the emphasis placed on "biomedicine" during that period resulted in a devaluing of the humanistic dimensions of medical care, and they are dissatisfied with the impact this has had on doctors' professional behavior. People now want doctors who are able and willing to communicate more clearly with them and their families, who will respect them as persons and honor their wishes about their care, and who will continue to care for them when medical treatment is no longer indicated or desirable (Whitcomb, 2000).

The Institute of Medicine has defined patient-centered care (PCC) as “care that is respectful of and responsive to individual patient preferences, needs and values” (IOM, 2001). Greene, et al, have modified the definition to include “honors, and responds to individual patient preferences, needs, values, and goals” (Greene, et al. 2012). Greene argues that this modification leads to a call to all health care providers, whether a large institution or a solo practitioner and all in between, to care for patients in a manner which puts the patient’s needs in sharp focus. Greene explains:

> Several important arguments for making care more patient centered have been offered. Patient-centered care results in improved care processes and health outcomes, including survival. Two systematic reviews identified promising patient-centered interventions directed at patients, clinicians, or both, which resulted in improved communication and health outcomes. Patient-centered care is the right thing to do. In fact, it is hard to imagine how care that has not been patient centered could ever have been

> justified. There is a business case for patient-centered care, on the basis of evidence that patients who report stronger relationships with their clinicians undergo fewer tests and are less inclined to pursue legal action if a medical error is handled in a sensitive, patient-centered fashion.12 Finally, it has been argued that clinicians and their teams may benefit from a patient-centered orientation by knowing that they have more effectively addressed the needs of their patients. Collectively, these studies demonstrate that patient-centered approaches can lead to improved healing relationships (Greene, 2012).

This is, perhaps, easier said than done. There are a wide array of forces and factors which interfere with the actualization of a patient-centered approach to care in a healthcare system—whether it is a solo-physician practice or a large healthcare system. Additionally, as Fredericks, et al, posit, a patient-centered approach may not be effective or indicated in every situation. They conducted a systematic review of a variety of studies to ascertain when, why, and how patient-centered interventions were or were not deemed to be effective. The authors focused their review on studies which included hospital in-patients and self-care of those patients during the period following discharge. They employed the PRISMA framework (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) which, they explain, “ensures accurate and complete conduct and reporting throughout this review” (Fredericks, et al 2015).

They concluded that while patients can be active participants in their own care and be considered a member of the healthcare team (rather than just a recipient) there are situations in which patient-centered care interventions were not effective. For example, they cite studies demonstrating that patients living with chronic illnesses like asthma or diabetes do not benefit from a patient-centered approach since they have likely formed their own patterns of self-care and have more bonded relationships with their care-givers. Patients with acute illnesses, however, were more apt to be receptive to a patient-centered approach and be open to change of habit and life-style.

Adjusting the words “patient-centered” to “person-centered” may ultimately, over time, have the effect of fine-tuning attitudes and practices. Simply using the word “person” can have the desired effect of encouraging providers and care-givers to think first of the person and second as the person with an illness, which is what a patient is. Words matter and when the term “person-centered” is used, there is an implicit understanding that the care provided gets closer to Institutes of Medicine’s definition of what a “person-centered” orientation looks like. That definition, “care that is respectful and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions” (IOM, 2001).

Others have revised the definition. McCormack broadened it, offering that person-centered care is “the formation of a therapeutic narrative between professional and patient that is built on mutual trust, understanding and a sharing of collective knowledge” (McCormack, 2003). Starfield writes that the terms “patient-centered” and “person-centered” differ in some fundamental ways and that it is not simply a matter of a semantic differential. She cites as a basic point of departure the length of time one is working with a person who is a patient. Patient-centered, she explains, is the term for the individual interactions during visits whereas person-centered refers to the relationship over an extended period of time (Starfield, 2015). Other differentiations speak to an overarching view of the spectrum of health-related experiences, the states of illness and wellness and the gamut in-between. For example, she writes that patient-centered coding systems “reflect professionally defined conditions” while person-centered coding systems “allow for specification of people’s health concerns.”

Interestingly, moving closer to understanding and respecting the patients as individuals, as person-centered approaches dictate, gives momentum to the idea that healthcare for the broader population would benefit from a similar philosophical mandate. Changing the culture of healthcare institutions from one that puts the organizational needs before the needs of the clients, patients, consumers to one which recognizes that putting the needs of the latter group first optimizes results overall. This concept has been largely studied with respect to the elderly.

Nursing home culture has been examined from this perspective as well as dementia care. Generally, it has been assumed that chronic illnesses benefit from person-centered care since there is an ongoing and continuous relationship. If the principles work in practice, they do so when the staff is supported by the organizational culture since providers never feel conflicted that they are putting organizational values (such as cost and time efficiency) before patients' values and needs. McCormack calls this "rule orientation" which is "the ability to determine when and how to deviate from the established norms and standards when the situation dictates (McCormack, 2003).

There are a host of barriers which can potentially confound the efforts of even the most enthusiastic supporters – and these will be discussed below. First, however, a rationale for such an approach: Why is a person-centered care orientation important? First, it seems somewhat intuitive from a human and ethical standpoint that it is "the right thing to do." Treating people with respect and being responsive to their concerns, especially when they are in a vulnerable state, i.e., ill, is inherent in the tenets of the golden rule.

However, there are other, measurable reasons to practice PCC. There is a positive correlation between medical compliance and the trust one feels for his/her physician. Primary care consultations with higher levels of patient-reported physician-patient concordance were associated with one-third greater medication compliance (Kerse, Buetow, Mainous, Yung, Coster, Arroll, 2004). Compliance with care directives can have a direct impact on outcomes as well as the need for repeat visits. Survival rates have been demonstrated to be higher in patients who experienced a high degree of patient-centered care. Mererko, et al, reported on their findings of a "significant relationship between the degree of PCC experienced by patients during their hospitalization for acute myocardial infarction (AMI) and their post-discharge cardiac symptoms (Meterko, Wright, Lin, Lowy, Cleary, 2010).

There is also a case to be made from a business perspective; that is, the incidence of malpractice suits levied against physicians is lower for those who report strong and positive relationships with their patients. Levinson, et al, conducted a study which looked at how communication between physicians and their patients affected claims of malpractice. They found a difference between primary care physicians and surgeons but reported that "the study identifies specific and teachable communication behaviors associated with fewer malpractice claims for primary care physicians. Physicians can use these findings as they seek to improve communication and decrease malpractice risk. Malpractice insurers can use this information to guide malpractice risk prevention and education for primary care physicians" (Levinson, Roter, Mullooly, Dull, Frankel, 1997).

There is also some preliminary evidence suggesting that preventable readmissions are associated with caregiving models that conform to PCC principles. For example, Mount Sinai Medical Center in New York City implemented a program in which patient-centered communication approaches were undertaken with patients long considered among the strongest candidates for health relapses; results indicate considerable progress has occurred with respect to holding down the rate of needless readmissions (Lipani, 2013).

There is also discussion as to the difference between compliance and adherence. Here again, words matter. The term “compliance” has overtones of paternalism while “adherence” implies a more balanced relationship between physician and patient. Tilson (2004) explains that historically, the tacit agreement between physician and patient was one in which the physician, as the professional in that dyad, held a dominant role. The physician prescribed a course of action, whether it is pharmaceutical or another form of therapy, and the patient followed the directive according to the physician’s specifications. In this scenario, the patient is not in any way a partner in his own care. He owns no part of the decision-making process, that is, he “complies” with a physician’s care directives.

Although the term adherence implies that the patient bears some of the responsibility for taking prescribed medications correctly, nonadherence is a widespread epidemic in America which, according to Jane Brody, costs more and affects more people than any disease (Brody, J. 2017). The American Academy of Family Physicians (AAFP) Director Rebecca Jaffe, M.D., M.P.H., called poor medication adherence a "leading driver of hospital admissions and readmissions" and the cause of at least 100,000 deaths a year (Crawford, C., 2014).

There are a variety of reasons that people do not follow through on taking prescribed medications. Some reasons are economic, as Bruce Bender, co-director of the Center for Health Promotion at National Jewish Health in Denver explains. “When the co-pay for a drug hits $50 of more, adherence rally drops" (Brody, J.). Patients either take fewer than the prescribed dose or, worse, do not take the medication at all. Brody reports that "Dr. William Shrank, chief medical officer at the University of Pittsburgh Health Plan, said that when Aetna offered free medications to survivors of heart attacks, adherence improve by 6% and there were 11% fewer heart attacks and strokes compared with patients who had to pay for their medications. The adherence rate among the latter group was greater than 50% (Brody, J.)

Doris Eisenberg, (this author's aunt) born two months before the sinking of the Titanic, has been in excellent health until recently. Her blood pressure had been well within the normal range but her decreased mobility and advanced age has caused a change. Her doctor prescribed medication to keep it within healthy parameters. Unused to taking medication, Doris balked and refused, claiming that she never needed "pills – and I don't need them now!" Her physician encouraged her in-home caregivers to do what they could to convince her to take the medication. A discussion of the ethics of lying for a good cause ensued as some were uncomfortable telling Doris that the pills were her vitamins (which, she believed were intended to maintain her health). The upshot was agreement and Doris now takes her "vitamins" daily with no resistance.

There are a host of other reasons that patients do not take medicine or follow other care directives as prescribed. Some do not understand what it means to "take as needed;" some become confused about whether they have already taken their medication that day; some believe if they are symptom-free there is no need to take their medications, and on and on. This phenomenon of nonadherence causes serious illness and deaths which are entirely preventable with an improved physician-patient dynamic.

The relatively recent trend, however, is the acknowledgement of the importance and acceptance by both parties of the patient’s role in their own care. Patients generally are more knowledgeable about their conditions and understand the relationship between following or changing “doctor’s orders.” This understanding on the part of patients has led to a change in terminology from using the word “compliance” to the term “adherence” which indicates greater balance in the relationship. This change reflects not only the patient’s increased awareness of her own role in the care process, but also awareness on the part of the physician that engaging the patient in the process can have a positive effect. Changing terminology is a step in the right direction, changing the communication dynamic is a giant leap. The greater the “synchronicity” the more likely the success of the treatment (Tilson).

Chapter 6

Barriers to The Humanization of the Healthcare Experience

Assuming that it is a desirable practice to locate the person receiving care in the driver's seat, the question arises as to why it is not universally applied. The concept of hospital and medical care-giving, by definition, implies bettering the human condition. It is grounded in a humanistic ethic. However, the evolution of this organized and structured discipline has blurred the humanistic intention. Some of the reasons for this clouding, that is, the barriers to effective patient care are (see Du Pré, 2005):

- Medical training emphasizes a mechanistic view of patient care
- Culture establishes different roles and rules for patient and provider contact
- Providers insulate themselves emotionally
- Geography – patient care generally occurs on provider's territory
- Managed care imposes constraints on providers and patients
- Physician-centered communication
- Feelings are overlooked in favor of evidence
- "Time" is different for patients and providers
- Lack of privacy
- Patient's desire to be "good"
- Providers practice defensive medicine
- Technology mediates relationship between patients and providers

This dissertation offers a brief examination of each of these barriers and how they inhibit effective patient-centered care in the context of hospital provided healthcare.

Medical Training Emphasizes a Mechanistic View of Patient Care

Today's medical education programs are primarily science based. Although students engage in activities designed to foster communication skills, with little to no time is spent on understanding how and why people communicate as they do (Du Pré). Patients become their "disease" and are treated accordingly. "The academic emphasis on physical matters often persuades [medical] students to think of patients as adversaries or as mere bodies to be fixed" (Du Pré).

Culture establishes different roles and rules for patient and provider conduct

"People have various beliefs about the transitions that accompany health, illness, birth and death" according to Lipson and Dibble (2005). The term "culture" is defined by the authors as "integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and /or institutions of racial, ethnic, religious, and/or social groups." They continue: "Providing appropriate, cross-cultural health care is impossible without partnerships based on trusting, respectful, and responsible relationships between health care providers and patients, their families, and their communities."

Providers insulate themselves emotionally

Doctors often feel unsure about how to cope with their feelings of grief when a patient dies. Their training is aimed at maintaining life and they may view the patient's death as a failure on their part. Adopting a detached demeanor could help to conceal their feelings of self-doubt and separate their emotions from their professional duties.

Geography – patient care generally occurs on provider's territory

The vast majority of care giving in medical contexts occurs in the environment of the provider. This could surely create an imbalance in the control of the relationship with the patient occupying the lower status position. In turn, it is common for the patient to treat the physician with deference, and in so doing, fail to assert his/her presence and communicate feelings. Moreover, a hospital may seem, to the patient, a maze of hallways and limited-access entryways. Signage is not always user friendly which also compounds the confusion and anxiety patients and their families already feel upon entering a hospital environment. On the other hand, identification-tagged personnel—doctors, nurses, transporters, technicians, administrators, and others—whiz by confidently, comfortable in their surroundings often not even noticing lost or confused "others."

Managed care imposes constraints on providers and patients

Among other things, the managed care systems tend to influence the amount of time a physician may spend with each patient, which medications they are permitted to dispense, and even which services are accessible to each patient. This limits the doctor-patient relationship to prescribed treatment options which sometimes preclude what the patient actually requires in order to achieve improved health. If a patient is reluctant to disclose information and requires a bit more time to be comfortable sharing information, the prescribed time allotment may prevent such disclosure resulting in incomplete or incorrect diagnosis.

Physician-centered communication

Traditionally the medical transactions in the U.S. have been physician-centered. That is, doctors do most of the talking, choose conversational topics, and begin and end each interaction (Du Pré). Patients tend to regard the doctors as experts and defer to them, and may feel inadequate to participate as an equal in the relationship. Patients often feel that "doctor knows best" and the doctor often communicates more assertively and avoid "confusing" the patient with "medicalese."

Feelings are overlooked in favor of evidence

Medical research has led to the development of evidence-based medicine –

making treatment decisions based on scientific studies (Levin, 1998). As any person who has ever been ill can understand that physical evidence does not always explain everything. Patients make sense of their discomfort in different ways from the empirical methods physicians employ to diagnose and treat. Often there are other factors which contribute to a person not feeling “themselves.” Eliot Freidson, describes various sociological types of illness, with symptoms having nothing, or little, to do with scientific evidence (Freidson, 1988).

“Time” is different for patients and providers

A physician generally looks at a patient’s chart before knocking on the door and entering the treatment room. For that physician, the relationship “clock” starts at the moment s/he looks at the chart to acquaint her/himself with the patient about to be seen. For the patient, however, the clock started days, weeks, even months before that moment. There is the onset of the first symptom, a day or two go by to “see if it goes away,” a call to make an appointment, a few days to a week or two until the appointment, a wait to sign in, a wait to be called, and then the wait in the room (often in a paper gown) for that knock on the door. This time-clock is clearly different for physician and patient and therefore, each come to that moment with a different sense of that time.

Lack of privacy

Many doctor-patient interactions are conducted behind a curtain which limits and precludes a private space for conversation as well as physical seclusion. Additionally, the “rules” and expectations are different for patients and physicians. For example, it is expected that patients will forego privacy exhibited by such things as being asked to don a skimpy paper gown; the physician can touch the patient and, while this may be necessary, it contributes to the imbalance in the relationship and fuels the notion that the patient is the sum total of his or her symptoms and chief complaint. It is worth noting that this can be as uncomfortable for the physician as it is for the patient, especially, new and unseasoned medical practitioners.

Patient's desire to be "good"

Frequently patients believe that it is in their best interest to maintain the physician's "positive regard" (Du Pré). Therefore, they may communicate in ways which, although counterintuitively, present barriers to their care. For example, patients may believe it is more appropriate to be passive and let the doctor "figure out" what is wrong, they may withhold critical information such as whether and how much they smoke or drink alcohol, they may not give accurate accounts of their symptoms so as not to be viewed as complaining.

Providers practice defensive medicine

A survey by Mount Sinai School of Medicine researchers found that 91 percent of physicians believe concerns over malpractice lawsuits contribute to practicing "defensive medicine," including ordering more tests and procedures than necessary as a protective measure. "About $60 billion is spent annually on defensive medicine and many physicians feel they are vulnerable to malpractice lawsuits even when they practice competently within the standard of care," said Tara Bishop, MD, Associate, General Internal Medicine at Mount Sinai School of Medicine, and co-author of the study. "The study shows that an overwhelming majority of physicians support tort reform to decrease malpractice lawsuits and that unnecessary testing, a contributor to rising health care costs, will not decrease without it" (Mt. Sinai, 2010).

Technology mediates relationship between patients and providers

We live in the digital age; much of our communication and source of information comes via the computer. While it has made the world considerably “smaller” it also has many drawbacks. According to J. Quittner, “Online communication typically occurs without touching or watching other human beings, which limits nonverbal feedback and may add to people’s sense of isolation” (Quittner, 1995). Additionally, access is limited for people who do not have computers and are not tech-savvy. Another drawback is the potential for interference with the physician-patient interaction. A physician’s cell phone or pager goes off during an exam and the physician feels compelled to at least acknowledge, if not respond, immediately. This interrupts the flow of the communication and often the patient feels that he/she does not have the complete attention of the physician. On the other hand, newer technology is providing access to those who live in remote locations, via telemedicine for example, so they can get more immediate medical response.

Chapter 7

Patient-Centered Roots in Client-Centered Therapy

It seems then, that the tenets espoused by Rogers over a half-century ago are relevant, applicable, and desirable in the training of physicians in the twenty-first century. To demonstrate the applicability of Rogers' concept of client-centered therapy to patient-centered care, this dissertation offers the following parallels (Table 1). Rogers' philosophy and method of client-centered therapy were based on four premises:

First, the therapy is non-directive, that is clients take the reins and the discussion is free flowing. Second, there must be a genuine environment which goes both ways. That is, the therapist must share openly and honestly thereby modeling the behavior. Third, the therapist must have unconditional positive regard. The therapist ought not to make judgements and must be supportive and accepting of the client regardless of behavior or expressed negativity. And lastly, the therapist must mirror the client's feelings, reflecting empathetic understanding. The corresponding behaviors demonstrate means of overcoming the barriers to effective care. Patient-centered care can follow those four tenets as well, although the behavior may look different, they are conceptually congruent.

Patient-centered non-directive interactions would encourage patients to disclose concerns about how their ill-health has an impact on their life and loved ones. Genuineness in a patient-centered approach would have the physician minimizing barriers to create an environment conducive to honest expressions of concerns and emotions. A physician having unconditional positive regard for their patients would use verbal and non-verbal communication behaviors to demonstrate respect for their patients' values. And finally, a physician who is an active listener, who asks open-ended questions allowing time for hearing patients' feelings and worries, is practicing empathetic understanding.

Martin Buber, an author, scholar, and political activist, is perhaps best remembered for his essay, *I and Thou* (1923), in which he espouses his philosophy that our existence is defined by our interactions with one another, with the inanimate, and with God (however that is personally defined). While that characterization is a gross over-simplification of his tenets, it offers a basis for a fuller grounding in interpersonal communication which is not complete without an understanding of his philosophy.

Buber says that "the *I-Thou* relation is a direct interpersonal relation which is not mediated by any intervening system of ideas. No objects of thought intervene between *I* and *Thou*.[1] *I-Thou* is a direct relation of subject-to-subject, which is not mediated by any other relation. Thus, *I-Thou* is not a means to some object or goal, but is an ultimate relation involving the whole being of each subject (Buber, 1958).

He believed that "genuine dialogue" is the path to true understanding. He wrote:

> That peoples can no longer carry on authentic dialogue with one another is not only the most acute symptom of the pathology of our time, it is also that which most ungently makes a demand of us. I believe, despite all, that the peoples in this hour can enter in dialogue, into a genuine dialogue with one another. In a genuine dialogue each of the partners, even when he stands in opposition to the other, heeds, affirms, and confirms his opponent as an existing other. Only so can conflict certainly not be eliminated from the world, but be humanly arbitrated and led towards its overcoming (Kramer, 2003).

Buber's philosophy, at its core, recognizes the intrinsic value of honoring one another, regardless of position or station through interpersonal discourse. Physicians would benefit from training in interpersonal communication skills. Although some are intuitively and naturally empathic communicators, many are not. In fact, the barriers cited above thwart the efforts of even the best among them. Through training physicians can improve upon their techniques to provide patient-centered care. By being aware of, recognizing, acknowledging, and working to overcome these barriers medical practitioners can move toward more effective patient interactions and achieve better medical outcomes as well as healthier interpersonal relationships.

Chapter 8

Evidence-Based Practices

Miles and Mezzich worry that “now that we can cure we have no more responsibility to care” (Miles and Mezzich, 2011). They cite this as the “modern myth in medicine” and express concerns that evidence-based medicine and patient-centered care movements are developing side by side without a cohesive and “rational form of integration.” Their contention is that it is person-centered medicine, as opposed to patient-centered medicine, that forms that cohesion. And although the evidence-based medicine movement is often paralleled to the patient-centered medicine movement, they are actually different and, some contend, in conflict.

Evidence based medicine, or EBM, is a concept which dates back about 25 years to 1990, and the term is attributed to Gordon Guyatt. He coined the phrase, not realizing at the time the impact it would have, and the change it would precipitate, on the way medicine would be discussed and illness and treatment plans evaluated and established. If the medical literature give any indication of the prominence of a paradigm, the precipitous rise in the sheer number of academic articles speak to the status of EBM. According to an article in the AMA Journal of Ethics and based on a PubMed bibliometric search, there were a mere two articles in which EBM was included in the title. By 1997, that number increased to 1000, and by 2004 the number of academic publications (which included 24 dedicated textbooks) is well over 3000 (Zimmerman, 2013).

This new paradigm was a divergence from the then-existing assumptions about how to guide clinical practice and was devised by a group of physicians who called themselves the Evidence-Based Medicine Working Group (Guyatt et al, 1992). The former paradigm emphasized adherence to scientific conviction and expert testimony. The following four conventions were the guiding tenets:

1. Unsystematic observations from clinical experience are a valid way of building and maintaining one's knowledge about patient prognosis, the value of diagnostic tests, and the efficacy of treatment.
2. The study and understanding of basic mechanisms of disease and pathophysiologic principles are a sufficient guide for clinical practice.
3. A combination of thorough traditional medical training and common sense is sufficient to allow one to evaluate new tests and treatments.
4. Content expertise and clinical experience are a sufficient base from which to generate valid guidelines for clinical practice. (Guyatt, et al).

The proposed (and now widely accepted paradigm) places far less emphasis on scientific authority, while in no way discrediting the benefits of what can be gleaned from colleagues. Rather, the "underlying belief is that physicians can gain the skills to make independent assessments of evidence and thus evaluate the credibility of opinions being offered by experts" (Guyatt). The guiding principles of this paradigm assume the following:

1. Clinical experience and the development of clinical instincts (particularly with respect to diagnosis) are a crucial and necessary part of becoming a competent physician. Many aspects of clinical practice cannot, or will not, ever be adequately tested Clinical experience and its lessons are particularly important in these situations. At the same time, systematic attempts to record observations in a reproducible and unbiased fashion markedly increate the confidence one can have in knowledge about patient prognosis, the value of

> diagnostic tests, and the efficacy of treatment. In the absence of systematic observation one must be cautious in the interpretation of information derived from clinical experience and intuition, for it may at times be misleading.
>
> 2. The study and understanding of basic mechanisms of disease are necessary but insufficient guides for clinical practice. The rationales for diagnosis and treatment, which follow from basic pathophysiologic principles, may in fact be incorrect, leading to inaccurate predictions about the performance of diagnostic tests and the efficacy of treatments.
> 3. Understanding certain rules of evidence is necessary to correctly interpret literature on causation, prognosis, diagnostic tests, and treatment strategy.

The assumptions do not negate the value of original literature, but do ask physicians to consider and weigh the information therein and not to blindly accept it as gospel. There are some misconceptions concerning the practice of EBM. The Evidence Based Medicine Working Group cite three:

> 1. EBM does not recognize clinical experience and intuition.
> 2. There is no role for an understanding of rudimentary enquiry as well as pathophysiology (defined by Merriam-Webster as “the physiology of abnormal states, specifically the functional changes that accompany a particular syndrome or disease” Merriam-Webster.com, 2016)
> 3. There is a disregard for what can be gleaned from elementary clinical training, such as the physical examination.

Indeed, they counter that the opposite is actually the truth. The heart of EBM beats as a result of scrupulous and judicious attention to objective recording of observations so they may be compared between and among a variety of institutions. Further, they argue that a clear comprehension of pathophysiology is key to valid interpretations of presented evidence. And finally, they contend, it is through the physical exam and the record of findings that evidence for diagnosis and recommending treatment plans can be developed and established. This is the crux of the discourse citing the different postures of EBM and patient-centered care.

Evidence-based approaches have advanced medicine and patient care immeasurably. When we look at EBM through a Medical Humanities prism, it is essential that the patient's perception, perspective, and feelings need to be factored into the matrix of evidence.

In an interpersonal physician-patient relationship, the central focus of EBM can be viewed as potentially physician focused. If the emphasis then, is not on the patient's view of the experience, but rather, the physician's interpretation of the patient's view of the experience, and if it is only the doctors' perceptions and records that define the "evidence" although the patient is the subject of the perception and the record, the evidence may be false or incomplete as the two interpretations may offer a very different view of each reality.

By extension, it may be argued that one person's "evidence" is another person's conjecture. In early 2017, the world witnessed a remarkable debate on the truth of evidence. As Donald Trump became the President of the United States, the world tuned in. The media reported on this historic event with multiple videos recording and sharing the events of the day. The next day, the news focused on President Trump's dispute with the reported crowd size. He argued, via Twitter, that this was a much larger turnout than the media reported.

The visual "evidence" of comparisons to the 2013 inauguration of President Barack Obama was not enough to quell his argument. The visual evidence was called into question by Trump who, speaking at CIA Headquarters, said that "one of the networks" had shown "an empty field," while he saw a crowd that "looked like a million-and-a-half people" and "went all the way back to the Washington Monument" (USA Today, 2017). The term "alternative facts" was offered as an explanation by White House counselor Kellyanne Conway, as she defended Press Secretary Sean Spicer's claim "this was the largest audience to ever witness an inauguration, period, both in person and around the globe" (Robertson & Farley, 2017).

President Trump and his team became embroiled in a tug-of-war over the "evidence" and the semantic possibility that there is truth in the concept of alternative facts, which are essentially, non-truths or lies. Neuroscientists Martinez-Conde and Macknik study perception and reality. More accurately, they study "misperception and illusion" and offer an explanation of the discrepant reporting from President Trump and the media from a scientific perspective.

> We have seen in the lab, over and over, that our senses are not to be trusted: no matter how assured we may feel in our perception of the events around us, we still may be dead wrong. A main part of the problem is that nobody experiences reality directly. Every sight, every sound, every feeling any of us has ever had has been filtered through the biological hardware and software of our brains—information processing machines made from tiny sacks of salt-water and protein. You have never experienced the world directly—only your brain's *simulation* of it. This simulation may or may not match reality (Martinez-Conde and Macknik, 2017).

It is not always easy to separate fact from fiction, the quest for fact being defined by these scientists as "obtaining unbiased knowledge" and they suggest three rules to help make that determination. The rules are based on the scientific method as well as the science of illusion:

> Rule #1 – We cannot ascertain what's true, but we can establish what is false
> Rule #2 – High confidence does not equal objective proof
> Rule #3 - Perception depends on perspective, but

> subjectivity is not a measure of reality
> (Martinez-Conde and Macknik).

Whether Trump and his team were basing their “facts” on their perceptions and sincere desire to see what they wanted to see and believe what they wanted to believe or whether they were out and out intending to deceive and therefore lying can certainly be subject to debate. But the result that remains is that the “evidence” is in direct conflict with the perceptions. By diligently peeling back each layer of the individual pieces of information and misinformation we can hope to get closer to an objective unbiased view of the reality, i.e. the real facts.

When determining what specific information the evidence is providing, it is critical to step back to understand the origin of the evidence and the motivations for seeking it in the first place. Is it unbiased knowledge or perception? Were conclusions developed first with support sought after? How reliable are the sources and how is that reliability established? Asking the right questions and paying close attention to the answers are an essential step in peeling back those layers and stripping away the wheat from the chaff.

Bensing contends that evidence-based medicine and patient-centered medicine are two very different paradigms (Bensing, 2000). Although the goal of each is to improve clinical outcomes, they may be approached from different directions. While both paradigms reflect the understanding that patients are each unique in their preferences and medical needs, EBM has a “positivistic, biomedical perspective” and patient-centered medicine has a “humanistic, biopsychosocial perspective” (Bensing, 2000). Bensing explains that the processes of arriving at clinical treatment decisions are very different.

That is to say, the EBM paradigm centers on the disease, while the patient-centered paradigm focuses on how the patient is affected by the disease. Therefore, EBM is may be seen as decidedly doctor-centric in its essence.

But this perspective, which emphasizes a mutually exclusive relationship between EBM and patient-centered medicine, may constitute short-sightedness. Bringing the best of each together, Bensing suggests that "bridging the gap" can integrate these two seemingly discrepant paradigms. The key to this bridge lies in researching and understanding the dynamic in the t exchanges and then examining the analysis therein. This requires ensuring that data provided by the patient – whether qualitative and quantitative – is appropriately factored into EBM methodological endeavors.

Smith identifies and defines the concept of basing treatment plans of "false facts" as "Psuedoevidence-based medicine" (Smith, 2007). He writes that it "is the practice of medicine based on falsehoods that are disseminated as truth. Falsehoods result from corrupted evidence — evidence that has been suppressed, contrived from purposely biased science, or that has been manipulated and/or falsified, then published. Or falsehoods may result from corrupted dissemination of otherwise valid evidence. These falsehoods, when consumed as truth by unwitting and well-intentioned practitioners of evidence-based medicine, then disseminated and adopted as routine practice, may well result not only in inappropriate quality standards and processes of care, but also in harms to patients" (Smith, 2007).

To bring home that point, Anna Lembke, author of Drug Dealer, MD, studied the effect of long term pain medication. She examines the notion pervasive in the 1980s that pain medications were not addictive and therefore, if a low dose did not alleviate pain, increasing the dosage would be the indicated recommendation. According to Lembke, the pharmaceutical companies' research was "evidence-based" and the findings were accepted and not questioned. Over the course of several decades, she saw hundreds of patients in her practice who were clearly addicted to pain medications.

A century ago, it was believed that pain served a positive function physiologically as well as spiritually. Enduring pain was viewed as a sign of strength and fortitude. With the increasing availability of prescription painkillers, people became less willing to suffer. Over time, reduction and/or elimination of pain became an important goal regardless of consequences. So, when patients presented with chronic pain the potential of addiction was ignored and important conversations were avoided. "Starting in the 1980s, doctors started to be told that opioids were effective treatment for chronic pain, and that treating patients long-term with opioids was evidence-based medicine," Lembke says. "That was patently false and that was propagated by what I call 'big medicine,' in cahoots with Big Pharma." In a radio interview on NPR (National Public Radio) with Terry Gross, Lembke explains what she means by that claim:

> The pharmaceutical industry realized that they can no longer directly go to doctors to get them to prescribe their pills. Various regulations were put in place to prevent them giving gifts and pens and hats and things that we do know can influence doctor prescribing. So instead they took a kind of Trojan horse approach and infiltrated regulatory agencies and academic medicine in order to convince doctors that prescribing more opioids was evidence-based medicine, and evidence-based medicine means medicine based on science, and that's something that all doctors are supposed to practice.
>
> ...So for example, what they did was Purdue Pharma joined forces with the Joint Commission, and the Joint Commission is an organization that accredits hospitals, and Purdue Pharma gave all kinds of teaching material to the Joint Commission and said, "You really need to make doctors treat pain more aggressively and that

> needs to be a quality measure." So the Joint Commission said, "You know what? You're absolutely right, and we're going to do that and we're going to take your videos that you made that tell doctors that opioids aren't addictive as long as they're treating them for pain." ...
>
> So it became a kind of groupthink where it looked like treating pain aggressively with opioids was something that was based on science, when in fact it was based on Big Pharma's influence of these major regulatory bodies (‘Drug Dealer, M.D.,’ 2016).

According to the CDC, overdose deaths involving prescription opioids have quadrupled since 1999 and from 1999 to 2015, more than 183,000 people have died in the U.S. from overdoses related to prescription opioids (CDC, 2016; Rudd, al. 2016). It is far from unrealistic to consider the possibility that had important conversations between doctor and patient as well as between doctor and pharmaceutical providers that this problem might not have reached epidemic proportions. Doctors became reluctant to ask patients if they believed they might be addicted to their pain medications because of the worry that doctors feel about alienating patients with questions and suggestions about possible abuses of the medications. Additionally, Lembke explains that asking runs the risk of opening a can of worms thus inviting potentially long and complicated discussions and new problems. Discussions for which there was little time and problems for which there were few solutions.

These conversations require a specific skill set which are not typically taught in medical school training and which may or may not develop over time with experience. It is far easier for the need for that conversation to be ignored. Ultimately, what really gets ignored are the patients’ escalating needs. Additionally, using the evidence as a starting point for conversations runs the risk of leaving the patient’s psyche and state of mind out of the equation. Having the “numbers,” that is to say, statistics and/or evidence-based facts, on one’s side ought not to be the exclusive characteristic of the discussion; delivery of the evidence needs to be tempered with language to which a patient and his or her family can be receptive. Physicians need to be aware of and sensitive to their patients’ desire to know, as well as their ability to comprehend and factor that information in life decisions.

There are roadblocks, however, to accessing and applying the information available to physicians. These roadblocks are not insurmountable, and best practices would support the need to overcome them. Haynes and Haines (1998) describe these barriers and offer possible solutions so that evidence-based medical practices can more effectively be implemented. For example, often the research is complicated and difficult to parse. Haynes and Haines suggest using services which can effectively deconstruct and consolidate relevant information to make it more manageable. Another barrier lies in the ability to generate policy based on the research. The authors note that broad-based organizations devise healthcare practices based on “historical, cultural, and ideological influences” more so than on factors based on evidence (Haynes and Haines, 1998).

There are also cultural factors which contribute to how a patient is likely to receive information. These skills are teachable and should not be left to be acquired “on the job.” Not every physician will develop effective means of having these difficult conversations over time, especially if there is a conscious effort to avoid them.

Chapter 9

Democratization of The Field

Now, perhaps more than ever before, there is a need to integrate the humanities into medical education and practice in order to democratize the field and pave the way for achieving a balance between the physician-centered and patient-centered care models. Ultimately, this balance will lead to the goal of increased patient safety, better patient care, and improved medical outcomes.

At the center of each of the Picker principles, and what may be the driving force, is the need for patient-centered communication and an understanding of how the patient narrative fits into that context. There is some discussion about the value of using narrative in patient care settings. The first principle, “Respect for patients’ values, preferences, and expressed needs” is directly indicative of the need for communicating effectively and the importance of narrative in patient care. Every patient has a “story” and that story can be the key which unlocks the door to a better medical outcome. For example, a patient may have values stemming from religious beliefs which may preclude certain medical procedures, e.g. a patient may need a blood transfusion immediately for survival, but if she is a Jehovah’s Witness, she may choose to refuse this intervention even though she may die without it (Why Don’t Jehovah’s…Transfusions?).

A physician who is not familiar with the patient or not familiar with the beliefs may not understand the refusal and the dire situation could be exacerbated and the outcome devastating. On the other hand, a physician who is aware of her patient’s stand may be able to offer alternatives or even arrange for a religious elder to consult. Without clear and open communication and hearing the patient’s narrative, the patient’s “values and expressed needs" as prescribed by a Picker principle may be overlooked or ignored.

Essentially, the narrative is the patient's subjective expression of her experience. Famed neurologist and author, Oliver Sacks, uses

> his medical knowledge to illuminate the complexities of the human brain and the mysteries of the human mind.At the same time, his compassion for his patients and his own philosophical outlook turn what might have been clinical case studies into humanely written short stories, written with humane themes, and animated as much by an intuitive appreciation of the human condition as by scientific understanding (Kakutani, 2012).

Sacks' account of patients' illnesses is well-known, even to the lay public, through works like the Academy Award-nominated film, *Awakenings* (Awakenings, imdb.com), which was based on his book of the same name. Not only do his accounts explain the subjective experience of patients, his works have also illuminated how the physicians' experiences have been affected by patients' illness narratives. In his frequently cited book, *The Man Who Mistook His Wife for a Hat*, Sacks writes that "narrative *is* us, our identities" (Sacks, 1985). That is, we are all defined by our own personal stories.

However, scholars like Galen Strawson have a different view of the impact narratives have on patient care. Strawson rejects Sacks' contention that we are the story that we construct for ourselves. He observes that our stories, our autobiographies have, "a chief fictional character" and that character is "one's self" (Strawson, 2004). He disputes the prevalent thinking that all "normal non-pathological human beings are naturally Narrative [sic] and also that Narrativity [sic] is crucial to a good life" (Strawson). He offers the notion that a person may have one version of himself as an ill person and an entirely different version of himself as a human being apart from the illness, thus compromising the inherent value of the subjective narrative.

Scholars in multiple fields from psychology to sociology to anthropology still debate whether the quality of the narrative influences its contribution to an understanding of the patient experience (Woods, 2011). Written narrative can be articulated in several different ways. Some narratives are autobiographies which are self- written retellings of the events in one's own life. There is usually a thematic focus, sometimes religious, intellectual, and possibly even fictionalized (DeJesse, 2012).

A biography is another form of narrative. Biographies are non-fiction accounts which focus on an individual whose story is told by the author. Typically, the purpose of biographies is to expose an audience of readers to the life of someone whose experiences are deemed worth sharing. Notable figures in history are frequently subjects of biographies. A third form of written narrative is the memoir. Memoirs are often, but not exclusively, written by an individual to relate specific incidents and events which played a role in that person's life.

Arthur Frank is one of the more well-known advocates of narrative in patient care. His seminal work, *The Wounded Storyteller*, is a collection of illness narratives of individuals, whom he defines as "anyone who has suffered and lived to tell the tale (Frank, 2013). Frank describes what he terms the "Voices of Illness." He suggests that there are three general types of narrative: Restitution, Chaos, and the Quest narrative. Every person's story, or narrative, will be told in one or more of these voices.

The restitution narrative is one which distances the patient from their illness and one in which the patient can rise above it. This is the voice that tends to dominate most people's stories. It is culturally driven and, particularly in Western cultures, it is what society wants to hear. Additionally, it almost always relates to a recent illness as opposed to a chronic one since there is perceived to be a happy ending. It is founded on the belief that good health can be restored after illness.

Within the narrative of restitution, Frank also discusses the prospective narrative voice in which, for example, prior to surgery the patient will say, “I’ll be fine. See you when I wake!” and the retrospective narrative voice, that is, after the fact, “I had breast cancer, but that is in the past, and I am fine, now.” This restitution narrative voice can be described in terms of luck. For example, “It is fortuitous that I had a heart attack since I can now change my diet and life-style. What a wake-up call!” The *Restitution Narrative* is one in which the ill person sees herself as experiencing a temporary set-back and is certain there will be a positive outcome.

The second narrative voice he refers to as the Chaos narrative; here, the patient feels as though he or she is being sucked into the undertow. This voice is the opposite of the voice of restitution. The patient’s story is a mess; he or she is so devastated by the illness that communication is near impossible. This patient is afraid to speak and the silence can be deafening. The patient is so overwhelmed with the illness that coherent language is stifled. This is the patient who needs to be drawn out rather than ignored. Frank calls it "the anti-narrative of time without sequence, telling without mediation and speaking about oneself without being fully able to reflect on oneself." The *Chaos Narrative* is one in which the patient is so distraught that she cannot see a light at the end of the very dark tunnel. These narratives frequently are untold, as the patient is not comfortable to even understand and articulate the experience.

The Quest narrative is one in which the patient takes a positive, pro-active stance and meets the illness head on. There is an acceptance and willingness to move forward and past either living with improved health or living with the illness. Many cancer patients have been heard to say "I'm living with cancer" rather than "I'm dying from cancer." Patients who use this voice often join or even found organizations to advocate for others with the illness or to speak about their experiences with it. Those who become advocates and work for social change often create a manifesto for others to follow. Those who speak publicly engage in auto-mythology relating to others with similar illnesses how they were able to re-invent themselves, surviving the illness and moving on with their lives. Frequently, the quest narrative is the voice that a memoir adopts. The *Quest Narrative* is described as a patient feeling the need to share his story with the belief that some good will come of the illness. It is a "silver lining" mentality, and projects the concept that there is more than one way to be a healthy person.

Even if we are all in agreement about the inherent and vital role of narrative in the health care arena, because time is such a limited commodity, doctors don't have the "luxury" of hearing patients' stories. "Real life is all about the narrative," explains Dr. Rajeev Alexander. He continues, "It's sitting down and talking about bowel movements with a 79-year-old woman for 45 minutes. It's not that interesting, but that's where it happens" (Scheiber, 2016).

Dr. Alexander and Dr. Boudwin have methods which are controversial and are at the heart of the debate about high levels of efficiency and cost containment vs. doctors' desire to get the information they need to properly diagnose and treat their patients. One of the movements to create greater efficiency and reduce costs is at the center of a recent issue in Oregon, but which will have far-reaching repercussions. Dr. Alexander is a hospitalist at PeaceHealth Sacred Heart Medical Center in Springfield, Oregon. He made headlines in early 2016 for being at the center of a controversial move to unionize hospitalists (Scheiber).

According to an article in the New England Journal of Medicine, over the last couple of decades, “The percentage of physicians in general internal medicine who were identified as hospitalists increased from 5.9% in 1995 to 19.0% in 2006, and the percentage of all claims for inpatient evaluation-and-management services by general internists that were attributed to hospitalists increased from 9.1% to 37.1% during this same period.” Additionally, “the odds of receiving care from a hospitalist increased by 29.2% per year from 1997 through 2006” (Kuo, Sharma, Freeman, Goodwin, 2009). The trend of late is that hospitalists are not employees of the hospital, rather they are part of a group which the hospital accesses by outsourcing. The goal is greater efficiency and reduced costs.

Within the last decade, the outsourcing of doctors has become a relatively common practice. In the mid-1990s there were few hospitalists, but this specialty materialized to address these issues, which were essentially economic concerns. Indeed, in the beginning, hospitalists were able to increase profits as they discharged patients in a more expedient fashion, thereby freeing beds for new admissions (Scheiber). At the same time, hospitalists could spend more time with patients, hearing their stories in greater detail which frequently led to more accurate diagnosis, better treatment, and reduced admission rates.

However, hospitalists were subject to similar economic pressures as well; much of their time was devoted to documentation which was in competition with time for patient interactions. This balancing act of competing values often leads to the detriment of patient care. Medical humanists, who are trained in communication skills, can provide a valuable resource in helping to ensure the scales are tipping in patients' interests. Understanding how to overcome the barrier of time can be a critical step forward.

For a patient who are nearing the end of life, time certainly takes on a new meaning, and in this context, narrative can be an extraordinarily beneficial tool in ensuring that the quality of that time is of manifest importance. There is a newly identified and acknowledged type of narrative which, although there is little scientific study at this time, is emerging as a critical and beneficial means of expression. Jan Hoffman ((Hoffman, 2016) describes how patients' dreams can inform their dying processes. In the *New York Times* article, "Dreams of the Dying," Hoffman quotes Dr. Timothy Quill, an expert in the field of palliative care at the University of Rochester Medical Center. Quill explains that there is so much that is unknown in this somewhat mystical phenomenon that dreams and visions of dying patients are underreported "for fear of ridicule" (Hoffman). But that is changing. More doctors are listening as are psychologists and social workers.

There is the germination of the idea that dreams, stories, and visions can play an important role in the quality of a patient's final days. Not only can recalling and talking about dreams reduce anxiety in patients near the end of their lives, but hearing about these dreams can be comforting to the mourning family members as well. The research is young but Dr. Quill believes the results may also prove beneficial to skeptics as the findings may give weight to the theory that the dreams do correlate to patients' positive attitudes and feelings of emotional comfort at their most vulnerable moments.

There is a preferred vernacular associated with the dreams and stories related by dying patients, which, again, speaks to the value of carefully choosing words, especially in a health care context. These are not “near death experiences” which is an entirely different phenomenon. Pei C. Grant makes the point that those who are in the dying process are “on a journey towards death, not people who missed it” (Hoffman). Anne Banas, a neurologist and palliative care physician prefers the term “vision” to “hallucination” indicating the trajectory of follow-up (Nosek, Kerr, Woodworth, Wright, Grant, Kuszczek, Banas, Luckiewicz, Depner, 2014). According to the National Institutes of Health medical encyclopedia, “Hallucinations involve sensing things while awake that appear to be real, but instead have been created by the mind.” For example, they cite the following considerations for common hallucinations:

- Feeling bodily sensations, such as a crawling feeling on the skin or the movement of internal organs.
- Hearing sounds, such as music, footsteps, windows or doors banging.
- Hearing voices when no one has spoken (the most common type of hallucination). These voices may be critical, complimentary, neutral, or may command someone to do something that may cause harm to themselves or to others.
- Seeing patterns, lights, beings, or objects that are not there.
- Smelling a foul or pleasant odor.

The NIH also states that “In some cases, hallucinations are normal. For example, hearing the voice of, or briefly seeing, a loved one who recently died can be a part of the grieving process” (Hallucinations: MedlinePlus Medical Encyclopedia). This last consideration is in contention by Dr. Banas, who recognizes a difference between a delirium-related hallucination and what she prefers to call a “vision.” Delirium is brought on by one or more of a variety of symptoms, such as fever, brain metastases, and end-stage changes in body chemistry. During bouts of delirium there is an altered state of cognition. Banas asks pertinent questions to assess the nature of the vision to determine whether it is a random experience or a significant one. For example, she wants to discern if the vision is “disorganized” or if there is meaning to it, and if there is meaning, “Does that need to be explored?” Perhaps even more important is the question of how the vision makes the patient feel – does it bring comfort or angst? And, ultimately, Dr. Banas offers this most critical of points: “If we don’t ask, look what we may miss” (Hoffman; Nosek, et al).

That last point is the part that so often gets lost in the shuffle. If those healthcare providers fail to ask, to delve, and to explore consider what may be missed. If the ultimate goal is to provide quality care, overlooking critical cues and clues can thwart that goal. Dr. Kerr, the research team leader at Hospice Buffalo where Dr. Banas also practices, advocates asking patients open-ended questions about their dreams or visions. He warns against unnecessary sedation since it may “sterilize them from their own dying process.” Kerr cites a patient who chastised him for robbing him of the time he was spending with his wife who predeceased him by administering palliative sedation. The patient was dreaming, or envisioning his wife, and was comforted by the experience. Dying can be a lonely process and acknowledging patients’ dreams and visions as part of the end of life experience can be a gift.

Engaging patients and encouraging them to share their dreams seems an innocuous enough practice, that is to say, what harm could there be? Why should care providers not take the time to sit and listen? The key word in that last question is often the trigger for a host of reasons that practices which could be so useful are not employed. Skeptics worry that they may be subject to ridicule if they engage patients, but that is perhaps not the foremost objection to spending the extra time. Time, or lack thereof, is often cited as a confounding factor, but as mentioned above, forty seconds of compassion can reduce anxiety.

Chapter 10

Communication Is Critical to Patient-Centeredness

Among the benefits of a communication perspective is its capacity to help us understand how self and identity are influenced by health and influence health. Modern society has become enormously complex, and institutions that helped us gain a sense of our place in the world—for example, religious institutions, schools, relationship configurations such as marriage, a simpler media system—are increasingly challenged to provide shape and definition to identity. Healthcare is an especially important societal entity with respect to identity in the modern world. We all engage it at some point. This is inevitable. But its enormity and complexity make it challenging to grasp. The more it feels anonymous, unwieldy, and incomprehensible, the more separated it can feel from us. We may have an intimate relationship with it by virtue of continuous engagement, but the nature of that relationship could easily have a disconfirming impact if we are unable to comprehend it and feel as through the relationship supports our psychological, emotional, and general life goals.

How do we move our impression of that relationship from one in which the "Other" (the healthcare system) feels nameless and intimidating to one in which it is personalized and nourishes and confirms a positive sense of self for people as consumers of healthcare? The study of Communication can be most helpful in this regard. In addition to providing analytical frameworks for the definition of self in the context of relationships in society, the field provides tools for practitioners to dignify the experience of patients in ways that validate self-concept.

Putting the patient and the patient’s narrative at the center of the care model can mean the difference between a positive outcome and a negative one. This is not to say that patient-centered care saves lives in every situation but operating from that vantage point can certainly be a move in a positive direction. Communication is key and even when outcomes are not what was hoped for, the manner in which messages were shared and conveyed make a difference.

It is not only in life or death situations that communication must be clear. Consider the senior citizens living on fixed incomes who choose to halve their medication doses so that they last twice as long; or the post-surgery patient whose pain is so great she chooses to double up on her pain killers. According to the World Health Organization (WHO, 2003), “Medicines will not be effective if patients do not follow prescribed treatment, yet in developed countries only 50% of patients who suffer from chronic diseases adhere to treatment recommendations.”

In developing countries, when taken together with poor access to health care, lack of appropriate diagnosis and limited access to medicines, poor adherence is threatening to render futile any effort to tackle chronic conditions, such as diabetes, depression and HIV/AIDS” (WHO). There are a multitude of explanations for low adherence to medical directives including social and economic factors. (As discussed, the term “adherence” is distinguished from “compliance” in that the former term implies that the patient has overtly agreed to the medical recommendations volitionally.)

Physicians who have developed trusting relationships with their patients in which patients feel comfortable sharing their concerns (affordability of medications, for example) are better positioned to intervene to ensure that those patients will more closely follow care directives. Patients who do not fully understand why medications need to be taken as prescribed or even how to properly take them are at risk for exacerbation of illness, hospitalization, negative drug interactions, and other complications.

According to a Washington University St. Louis study, “Medical errors such as delays in diagnosis, preventable surgical complications and medication overdoses are a leading cause of death and injury in the United States. An estimated 80 percent of the most serious medical errors can be linked to poor communication between clinicians, particularly during shift changes. For example, a medical error can occur if information about a critical diagnostic test is not relayed correctly from one medical provider to the next at shift change” (Washington University, 2014).

It is not only at shift changes that medical errors occur. Woolf et al (2004) studied medical errors by looking at the chain of events which contributed to such errors. Looking at a variety of cases and breaking down the overall narrative of care into individual “incidents” or mistakes, they were able to analyze the error as a “cascading” series of these events. Their conclusion revealed that “miscommunication appears to play an important role in propagating diagnostic and treatment mistakes.”

Schiavo offers that one of the foremost goals of health communication is to “engage, empower, and influence individuals and communities” (Schiavo, 2014). Among the key terms in that stated goal is “influence.” Health communication is vital in successfully reaching underserved, and therefore, vulnerable populations, in an effort to address and alleviate health disparities. Creating and disseminating effective communication campaigns requires an understanding and appreciation of specific cultural norms and taboos, economic constraints, access to health care, environmental factors, and the needs and wants of a given population. In order for a campaign to be effective, the message construction and delivery techniques must be sensitive to how they will be received. Macro-level health communication necessitates the involvement of relevant groups and other stakeholders to ensure a consensus on message and meaning. The goal, in general, is to achieve results for the long term even as short term issues are addressed.

In certain ways, communication on the macro-level is not fundamentally much different from communication on the micro, or interpersonal, level. In both cases, messages or comments that are appropriate in one setting may be inappropriate in another. For example, a parent of a sassy teen was overheard as she asked him if he would speak that way to his teacher; chances are (hopefully) he would not. An off-color joke might render the teller the life of the party in a bar and the same joke by the same teller might be considered rude and offensive at the office. So, clearly, context matters. And in the context of health communication, the matter can be one of life or death, and the quality of each.

Effective communication is vital in the health care setting and the recognition of its imperative is the growing field of health communication. Misinformation, misunderstanding, miscommunication, and mistakes all can lead to missed opportunities for better patient outcomes. Health Communication, a distinct field within the larger Communication discipline, is at the heart of medical care and as such, ought to be included in a well-rounded Medical Humanities curriculum.

Specific social and psychological areas which will be addressed, and hopefully improved, are the management of relationships in a healthcare context, the ability for practitioners to develop effective relationships with patients and other consumers of healthcare, and the ability to teach others in the healthcare community how to improve their relationships. Health Communication courses will enhance learners’ ability to understand, interpret, and explain the focus areas, ethics, for example, by learning how messages reflect and inform us as a society on how to think about health care issues.

Chapter 11

History and Evolution of Communication as a Discipline

As mentioned, Health Communication was an outgrowth of Communication Studies. The field has evolved over the centuries into what it is today. It is useful to consider the trajectory of its history to understand that evolution and the reasons behind the changes.

Though it emerged as a modern, distinct, and bona fide discipline in the nineteenth century, the academic study of human communication can be traced back through many centuries to Cicero, Socrates, and Plato. The ancient Greeks believed that an understanding of rhetoric, defined as "the art of persuading others through public speaking" was essential to every citizen's well-rounded education (National Communication Association, accessed 4/11/2017). Another orator, Isocrates, was a famous Athenian who wrote the speeches for others to deliver to influence public opinion.

> [Isocrates] sought to develop an educational middle ground between the theoretical study of abstract ideas and purely crass training in rhetorical techniques for influencing others to one's own personal advantage. In this way, he stood between the ideals of Plato and the promises of unscrupulous sophists.
>
> Rhetoric was the skill that Isocrates sought to develop, but that development, he insisted, could come only with natural talent and the practical experience of worldly affairs that trained orators to understand public issues and the psychology of the people whom they had to persuade for the common good. Isocrates saw rhetoric therefore not as a device for cynical self-aggrandizement but as a powerful tool of persuasion for human betterment, if it was wielded by properly gifted and trained men with developed consciences. The Isocratean emphasis on rhetoric and its

> application in the real world of politics won many more adherents among men in Greek and, later, Roman culture than did the Platonic vision of the philosophical life, and it would have great influence when revived in Renaissance Europe, two thousand years later (Martin, 1996).

Isocrates saw the power of rhetoric as a distinguishing characteristic (separating humans from beasts: “we have come together and founded cities and made laws and invented arts; and, generally speaking, there is no institution devised by man which the power of speech has not helped us to establish” (NATCOM). These words have served to characterize and distinguish the communication discipline as it has evolved throughout the centuries.

The evolution of communication as a discipline had its roots in oration, speech and rhetoric, and continued on that path until the emergence of technology. In 1810, John Quincy Adams, Harvard University’s Boylston Professor of Rhetoric and Oratory, authored a two-volume publication of lectures on rhetoric to be delivered to upper classmen at Harvard. Though largely neglected for a century and a half, these volumes, *Lectures on Rhetoric and Oratory*, (Triber, B., n.d.) were first reprinted in 1962 and are now generally regarded as having made a significant contribution to the discipline and “a high point in the history of rhetorical theory” (Hochmuth and Murphy, 1954).

In 1914, a small group of speech teachers formally broke away from their parent organization, the National Council of Teachers of English, to form their own separate and distinct association. The National Association of Academic Teachers of Public Speaking was thus born. The group sought “institutional and intellectual legitimacy” within higher education in America (NATCOM). The organization, through a few iterations, eventually became what is known today as the National Association of Communication, or the

NCA.

The period between World War I and II had a decided impact upon the discipline. For one thing, the use of radio technology to share and disseminate information to large numbers of people in diverse geographical locations stimulated interest in communication. Scholars began looking deeper into the power of communication to understand more fully how messages, specifically propaganda at the time, moved large masses of people to behave in ways they might otherwise never consider. These studies have continued to evolve and gaining compliance through the use of communication strategies continues to be an important area of focus and scholarship.

One of the most central communication theories, Systems Theory, had early seeds of development during this period. Systems Theory, which had its roots in thermodynamics, posits that all entities (people, organizations, etc.) do not exist separate from those with which they interact. Such interactions reinforce patterns of behavior. This was a departure from psychoanalytical theory, the popular human behavior paradigm and focus of therapeutic intervention in the first half of the twentieth century.

Psychoanalysis gained a strong foothold in the United States in the period between the two world wars. Sigmund Freud’s “ego psychology” was the predominant therapeutic perspective of this era. “Psychoanalytic treatment is based on the idea that people are frequently motivated by unrecognized wishes and desires that originate in one’s unconscious…patients’ stories, fantasies, and dreams (About Psychoanalysis, n.d.).

Ludwig von Bertalanffy, is generally credited to be at the helm of the group who brought the concept of Systems Theory from a largely mechanical and physics perspective into the domain of human behavior (Bertalanffy, L., n.d.).

Since Systems Theory is essential to an understanding of and appreciation for communication interactions in health contexts, exposition and elaboration is provided here. Family therapy was one of the earliest fields to be adopt systems theory as a central model of practice. Family systems therapy was first developed by Alfred Adler in Vienna in the 1920s but took root in America in the twenty years after World War II (Alfred Adler, n.d.). Adlerian therapy recognized that the system was integral to behavior well before systems theory was a generally applied method. This paradigm suggested that the traditional model of psychotherapy, which sought to explain root causes as accounting for neurotic or psychotic behavior, was incomplete and that such explanations were relatively arbitrary.

Family systems therapy suggests that individuals are best understood within the context of relationships and through an examination of the various interactions within a family (Family Solutions Institute, n.d). Family systems provoke and reinforce particular behaviors and discourage others. In such systems where excessive tension or conflict exists, or which have some level of dysfunctional behavior, one person may be subliminally or unwittingly “anointed” as the chief embodiment of the family’s ills, essentially serving as the family scapegoat (Matthews, A., 2011).

The orientation of systems theory is to examine the behavior of the social unit, in this example, the family, to understand the behavior of the individual. This does not contradict the notion of mental illness in which focus is on the psychological disposition of the individual. Systems Theory helps us to understand that things do not exist in a vacuum, but rather are shaped and influenced by their environments and the components of those environments. Systems Theory was one of the leading factors contributing to the growth of Communication studies as a field unto itself. This was due to the recognition that potential relevance and application to disciplines beyond family therapy were wide-reaching.

Although Harvard University was among the first institutions of higher education to bring communication studies into their program, east coast schools of higher education were slow to incorporate the discipline, not yet fully recognizing and acknowledging the importance of human communication research. However, the field was growing in the Midwest, as Michigan State University founded the first college of communication in 1958, where the focus was on the scientific study of communication. Following Michigan State's lead, Purdue University, University of Texas at Austin, Stanford University, University of Iowa, and University of Illinois created significant departments of communication. Three other schools of communication, University of Pennsylvania, University of Southern California, and Northwestern University were all subsequently endowed by Walter Annenberg (Rogers, 2001).

The late 1950s saw greater emergence of technology and Rensselaer Polytechnic Institute included a master of science degree in technical writing which later, under the leadership of Jay Gould, became called Technical Communication, thus expanding the field in another direction. Gould was an important and formative figure in the field of business communication. As the founding editor of the *Journal of Technical Writing and Communication,* Gould was instrumental in blending science and the humanities and had influence over bridging the gap "between technical subject matter and the human concern of communicating this subject matter" (Ramsey, 1990).

With the addition of technical communication as a specific entity to the field in general, there was some concern that the field was becoming too fragmented and the lack of cohesion could lead to its demise if innovation and change were not implemented. The increasing evolution of access to television was that new development that helped reunify the field. George Gerbner conceptualized and formulated “cultivation theory,” which articulated the notion that it was important to examine the long-term effects of media messages. Until that time, the general approach had been one on the emphasis of short-term consequences (Morgan and Shanahan, 2010).

Gerbner changed the face of “mass” communication. Before his influence held sway, the general goal of communication research was strategy-based, that is, trying to achieve institutional objectives by “selling” policies rather than examining the nature, values, and effects of those objectives (Gerbner, 1958). Reframing the focus to examine the “object” of the research as the objectives and defining “mass communication” as the mass production of messages, Gerbner suggested that there are three entities which lead to three distinct areas for analysis: “institutions,” “messages,” and “publics” (Morgan and Shanahan).

The first, institutions, examines organizations in terms of power relationships, how decisions are made, and the processes by which mass messages are produced. The second, messages, looks at patterns of messages in the broader sense and not individually. And the third, publics, investigates the previous two in conversation with the “public assumptions, images, and policies that they cultivate” (Gerbner, 1970). Gerbner wrote:

> The cultural transformation of our time stems from the extension of the industrial-technological revolution into the sphere of message production. The mass production and rapid distribution of messages create new symbolic environments that reflect the structure and functions of the institutions that transmit them. These institutional

> processes of the mass-production of messages short-circuit other networks of social communication and superimpose their own forms of collective consciousness—their own publics—upon other social relationships. The consequences for the quality of life, for the cultivation of human tendencies and outlooks, and for the governing of societies, are far-reaching (Gerbner, 1970).

This view was a departure from the prevalent view of the time that effects of messages were rooted in change, most often short-term. Instead, his view expanded the notion to examine broader and long-term consequences as dynamic expressions of social patterns and culture. In this way, these dynamics may be cultivated and tracked over time (Morgan and Shanahan). This divergence precipitated momentum of a growing trend in the discipline to move away from communication studies from sociology, psychology, English, and political science departments in universities and as its own independent field.

Events following World War II, leading to the Civil Rights movement, and then the Vietnam War hastened the response to cultural shifts and influences. The propaganda America used in World War II was an organized attempt to influence the public, soldiers, and even the enemy. “The United States was about six months into World War II when it founded the Office of War Information (OWI). Its mission: to disseminate political propaganda” (National Geographic, 2016).

The Civil Rights movement was the first ongoing American story covered by the then relatively new medium. Before a crowd of protesters and news media, Martin Luther King declared, “We are here to say to the white men that we no longer will let them use clubs on us in the dark corners. We’re going to make them do it in the glaring light of television” (Bodroghkozy, 2012).

Television became the primary medium for news coverage, shedding its “glaring light” on previously unattainable firsthand look on the events in and surrounding the war in Vietnam. The time devoted to news programs increased from fifteen minutes to a half hour; this was an economic decision as American households had television on for most of the day even if they were not necessarily paying close attention (Mandelbaum, 1982). This was also the first time that there was actual footage and real-time images of the atrocities of war.

Researching and understanding the effects that media had on society had a decided impact on the field engendering a stronger foothold. Thus, in the 1980s, communication studies expanded quite considerably.

> Separate communication departments began to form. At first often referred to as departments of speech communication to reflect both the rhetorical and social scientific roots, most departments today are simply called departments of communication or communication studies. In contrast to scholars in related disciplines who tend to consider communication as secondary process for transmitting information about the world, communication scholars see communication as the organizing principle of human social life: Communication constructs the social world rather than simply providing the means for describing that world (Littlejohn and Foss, 2009).

The number of field journals increased as well. As of June 2016, there are twenty prominent publications represented in the discipline (see Table 2). The surge in the field is an indication of the increased awareness of the contribution communication studies have made, and continue to make. Additionally, the number of journals reflects the diversity of communication areas of focus. Communication studies have a direct impact on our ability to analyze, interpret, and predict how messages and meaning affect behavior. Table 3 provides a listing and a brief description of the other field journals which are specific to health communication.

Communication holds the potential to be significantly paradoxical for we may convey different meanings through different channels of communication. Anyone who has ever had a disagreement with someone else has encountered this contradiction; that is, every one of us has experienced the frustration of not feeling understood or of not appreciating another’s point of view. The more complex our relationships, the more there is a need for a deeper comprehension of communication theory and applied practices.

Chapter 12

A Brief Background and History of the Field of Health Communication

When we think about communicating about health-related matters, while a very broad field, we generally think of two distinct areas of inquiry. One area addresses the delivery of care and the other addresses the promotion of care. Historically, the scholars in each area of the field in competition for what was perceived to be a limited number of resources, for example, research grants and space in journals (Kreps, et al, 1989).

Over time, however, each faction recognized the value of employing a more unified vision. Increasingly, the line between the two has become and continues to become blurred and the reach of the scholars' in each branch has broadened. Promoting positive health messages has evolved to be viewed as relevant across all channels of health-related endeavors.

The body of literature a field generates is a strong indicator of the strength and definition of a field and in the 1980s, the field of health communication began to see a proliferation of scholarly texts and articles. Kreps and Thornton are credited with publishing the first seminal text, *Health Communication: Theory and Practice,* which was an "introductory survey text written for an interdisciplinary audience of health care providers and consumers" (Graduate Programs in Health Communication). Two other texts soon followed, Sharf and Flaherty's concise text for medical students and practicing physicians, *The Physician's Guide to Better Communication* (1984), and another survey text directed primarily for nursing students, *Health Communication: A Handbook for Health Professionals,* by Northouse and Northouse, the following year. These were followed by a multitude of other books, edited volumes of essays, and contributions to journals, thus elevating the field and securing its place in academe.

The CDC and the National Cancer Institute have defined health communication as: "The study and use of communication strategies to inform and influence individual decisions that enhance health" (cdc.gov/healthcommunication/healthbasics/whatishc.html). Health communication was originally recognized as a subset in the general field of communication forty years ago, in 1975, when the Health Communication Division of the International Communication Association was founded (Duffy & Jackson, 1998). This division was an outgrowth of the field of Therapeutic Communication which primarily focused on the interpersonal dynamic in health care counseling and research.

The new, overarching term, Health Communication was a milestone for scholars who recognized the critical role communication played not only in patient care, but in the delivery of messages about health to the public. Additionally, this new moniker represented a wider range of communication scholars. “The therapeutic communication title was most attractive to interpersonally-oriented communication scholars, while the name health communication appealed broadly to scholars interested in persuasion, mass communication, communication campaigns, and the organization of health care services, as well as those interested in interpersonal communication (Kreps and Bonaguro).

Fourteen years after the International Communication Association (ICA) convention, in 1989, a significant and historic occasion for this field, marked the debut of the first peer-reviewed scientific quarterly journal, Health Communication, “dedicated exclusively to health communication inquiry, was introduced by its Founding Editor, Teresa Thompson. The publication of this journal marked the coming of age of this young field of study and encouraged scholars from around the globe to take this field of study seriously" (Duffy & Jackson). Thompson continued to make significant contributions to the field, including having served as the editor of the journal for twenty-five years (Theresa Thompson, n.d.).

The current and growing field of health communication can be thought of as the integration of two branches of the field: the macro and the micro levels of sharing health-related information. The macro level refers to broad-based communications which focus on health, such as public health campaigns and health information bulletins that are disseminated during a health care crisis (Ebola, for example). Macro level also refers to one sender communicating with many receivers, such as a university's public safety officer alerts students to an imminent danger on campus. The micro level refers to interactions on a one-to-one or one-to-a-very-few basis, such as that which occurs in the physician/patient dynamic.

The relationship between the micro and macro levels is undergoing significant change as the various functions of each are beginning to overlap as never before. "Micro-level communication patterns yield health care relationship models (e.g. paternalism, mutual participation, and consumerism). At the same time, macro-level systems appear increasingly likely to influence the nature of micro-level interaction" (Cline, 2003). Cline cites three examples of macro-level communication having a direct impact upon communication at a micro-level: direct to consumer prescription drug sales, information disseminated through the internet, and complementary and alternative therapies. Of these, the internet has wide-reaching effects especially because it is essentially a one-way path and how information is received, interpreted, and acted upon is not tracked or monitored.

Communication studies unite all the fields within the Medical Humanities discipline and as such, would provide a well-rounded grounding and greater credibility to the program as a whole. All students, regardless of professional orientation would have an enhanced comprehension of their unique fields of study. By understanding the *how*, we can better perform the *who, what, where, and why* of our experience.

Crawford et al cite an “additive vs integrative” structure to describe an alternative model for a Medical Humanities discipline (Crawford et al, 2010). An “additive” approach attempts to humanize “an existing biomedical knowledge base” while an integrative approach redefines and refocuses medical practice to more thoroughly examine “what makes us fully human” (Evans and Greaves, 1999). This approach takes into account the experiences of professionals such as physical and occupational therapists, radiology technicians, medical assistants, even dental hygienists, as well as a wide variety of others. An integrative approach synthesizes and seeks to understand the experiences of all types of health care professionals with the goal of bettering the human condition.

The additive vs. integrative construct can be suitable to the discussion of the inclusion of a communication concentration in a Medical Humanities degreed program. The additive approach may be taken with respect to overall programming. Adding a communication component to an existing Medical Humanities program may serve to broaden the opportunities for those concentrating on other areas within the discipline, for example, ethics or law. Students focusing on those areas would benefit by an overall understanding of how messages are constructed and meaning construed. An integrative approach at the course-level would give those students whose career goals include the necessity for a more comprehensive understanding of communication in health care contexts would benefit from specific courses in health communication. Those courses would range from the micro to the macro levels of health communication enabling students to have a broad understanding of how health communication principles and practices factor into all other Medical Humanities' studies.

Both constructs certainly have merit and each would fill a void in a Medical Humanities program which does not already include a communication concentration. An additive approach could likely be implemented in a relatively short time without the need to restructure existing program curricula. The addition of say, a course in social influence (persuasion) would stand on its own and attract students from other departments. Other courses in the health communication field would easily slide into the program as well. To introduce a health communication concentration into an existing Medical Humanities program, the additive construct would probably be the most appealing given the feasibility, especially as a first step.

However, an integrative approach offers another perspective, which, in the long term, might prove to be more effective in terms of achieving the goal of ensuring that messages and their meanings are best actualized in health care contexts. The tendency to separate communication from other disciplines is, perhaps, a counter-productive endeavor. The parallel example of art vs. science seems an apt metaphor: should these two critical entities be viewed as competitive or as complementary? Can a society be fully realized having one without the inclusion of the other? This debate occurs in a variety of fields, most notably, education, where allocation of funds for the arts repeatedly faces the need for defensive action and proof of its value to students. So too, with communication and health care, one cannot really exist without the other and the effective practices of each.

The science and art of health behavior are evolving and in a state of rapid change. Now, more than ever before, the influences on health and wellness are global and invite a fusion of a multitude of fields in the social sciences. Psychology, anthropology, and sociology to name a few, all play a part in how health behavior is viewed, analyzed, and motivated to change. Research tools and theoretical analyses from a variety of disciplines are used to enhance our understanding of healthcare practices and expand the literature.

Chapter 13

Occupational Outlook for Graduates of Medical Humanities Programs Supported by Communication Studies

As a major component of the national economy, "Healthcare occupations and industries are expected to have the fastest employment growth and to add the most jobs between 2014 and 2024," according to a report by the *U.S. Bureau of Labor Statistics* summarizing projections for 2014-2024 (BLS, 2015). Growth is anticipated to be so robust that, according to the report, "The healthcare and social assistance major sector is expected to become the largest employing major sector during the projections decade, overtaking the state and local government major sector and the professional and business services major sector. Healthcare and social assistance is projected to increase its employment share from 12.0 percent in 2014 to 13.6 percent in 2024."

Growth is expected to occur across the full range of healthcare occupations. It is worth noting that several key direct care-giving roles are projected to experience substantial growth during the 2014-2024 period; for example (BLS Occupational Outlook, n.d.):

- Audiologists: 29%
- Dieticians and Nutritionists: 16%
- Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners: 31%
- Occupational Therapists: 27%
- Physical Therapist: 34%
- Physicians and Surgeons: 14%
- Recreational Therapists: 12%

- Registered Nurses: 17%

It is important to note that those positions responsible for supervising, managing, and leading, and playing a support or staff role are projected to experience considerable growth as well. In fact, these occupations are projected to grow, collectively, at a rate of 17% during the period of 2014-2024. This is not surprising given the rapid rate by which the industry is growing. It will be essential for expanded work activity to be coordinated and managed effectively.

While the plentiful nature of career opportunities is indeed welcome news for those considering a career in healthcare, the challenges confronting healthcare workers are quite considerable. Consider just a few important trends:

1. The population is becoming older; in 2017, approximately 16% of the U.S. population is over 65; by 2030, it will be 20% (Reinhardt, 2008).
2. Technological and clinical advancement is occurring at a rapid rate. According to Gottlieb (2015): "…the pace of progress between the revelation of some basic scientific datum about disease, and its translation into a practical therapy that impacts medical practice has been considerably compressed as a result of better science and a base of understanding that enables progress to build on itself. The period of time between the uncovering of some fundamental scientific finding that underpinned a medical advance, and the realization of the corresponding advance in the form of a new drug or medical technique that improves the health of patients, is being continually hastened. Moreover, the platforms and approaches that we're using today to discover new treatments are so integral to biological systems that the resulting therapeutics often has profound impacts on progression of disease" (Gottlieb, 2015).
3. New models of care, particularly those which emphasize collaboration and inter-professionalism, are replacing silo-oriented approaches to all facets of caregiving.
4. Shifts and uncertainty in the direction of national health policy can prove unsettling to those administering care and receiving care.

5. The population, in general, is becoming increasingly diverse. According to Wazwaz (2016), “The minority population is expected to rise to 56 percent of the total population in 2060, compared with 38 percent last year” (Wazwaz, 2015).

These factors are significantly influencing the composition of the healthcare workforce. Moreover, for positions in many areas of healthcare, critical skills necessary for the successful management of those challenges lie at the intersection of Medical Humanities and Communication. That is, Medical Humanities provides the framework of principles essential to promote the humanization of the experience for the patient and others involved in the care giving experience, while Communication provides the skills necessary for sensitive and effective relationship development, interpersonal transactions, and message exchanges.

Below is a discussion about the relevance of a curricular concentration in Medical Humanities and Communication can support healthcare workers’ occupational development in the context of the five challenge areas noted above.

Aging Population.

With aging comes diminishment of cognition, retention, comprehension, and verbal aptitude. Accordingly, strengthening caregivers’ competencies in vital areas of communication will become increasingly important. Job realignment is taking place in a manner that reflects resource deployment associated with an aging population. For example, a dramatic rise in the number of workers assigned to hospice and related care is reported by Green (2015) and depicted in Table 4. It is posited that exposure to Medical Humanities and Communication by some workers in the various occupations noted below would heighten the efficacy of care environment:

Technological Advancement.

The rapid rate of technological advancement – whether for the implementation of electronic medical records, bio-medical advances, diagnostic and clinical activity – also calls for strengthened communication skills. Technological change imposes the need for training, skill adaptation, and facilitating patients' understanding of the benefits and use. Technological change affects the tools and processes that all healthcare workers use. Failure to provide proper training and to ensure that workers are up-to-date and possess the proper skills necessary for rapidly evolving technological environments creates risks associated with safety, patient outcomes, and organizational efficiency. As such, communication is vital to ensuring proper and effective implementation and use.

Trend Toward Inter-professionalism.

Inter-professional, and collaborative models of healthcare are gaining considerable ground in a relatively brief period. According to the Institute for Medicine (2011), "inter-professional collaboration among health care providers as an essential part of improving the accessibility, quality, and value of health care in the United States" (IOM, 2011). Moreover, as observed by Sullivan, et al (2015), "the World Health Organization (WHO) released a blueprint for implementing inter-professional education and collaborative practice to meet demand in the face of a global health care workforce shortage" (Sullivan, M, Kiovsky, R., Mason, D, Hill, C., Dukes, C., 2015). Thus, based on best practice understandings of suitable ways of delivering care as well as to respond to shortages of critical workers, the shift to collaborative models are well under way. Sullivan, et al identify four skills essential for the practice of inter-professional care that were endorsed by the Health Resources and Services Administration. It is evident from the titles of the four that if some members of the inter-professional team possessed grounding in Medical Humanities and Communication curricula, they would be well-positioned to contribute significantly to an institution's adoption of inter-professional basics: (1) values and ethics for inter-professional practice, (2) roles and responsibilities of the care team, (3) inter-professional communication, and (4) teams and teamwork. Accordingly, it is posited that healthcare workers with knowledge and skills in key areas of teamwork would be viewed as more positively advantaged in the emerging occupational environment.

National Health Policy.

It is anticipated as of this writing that national health policy will remain uncertain for the coming period. An effort to dismantle and replace the Affordable Care Act (ACA) in March, 2017 failed, and may usher in an extended period during which no clear direction on health policy is legislated. Moreover, while the ACA may remain the law of the land, at least for the time being, some of its key provisions, including that of the mandate, may not be enforced. Thus, we may be in the beginning of a time when there is a lack of certainty around who is eligible for coverage, by which organizations, and under what circumstances.

Healthcare workers across all professions are affected. The communication burden for advising and counseling patients, current and prospective, requires an understanding of the complexities of insurance and reimbursement as well as the skills for keeping patients properly informed about coverage, rights, and recourses. According to Uncertainty Reduction Theory, first advanced by Berger and Calabrese (1975), uncertainty is a particularly "aversive" state. When the environment is characterized by heightened levels of uncertainty, individuals strive to define and select alternatives in order to achieve stasis. Healthcare contexts can be significantly complex, and navigating through the healthcare maze is far from easy under comfortable circumstances. But given that the broader policy environment may lack coherence, contextual uncertainty is magnified.

The more that workers are schooled in principles that help them remain focused on the needs of patients, and the more they are skilled in communication practices that enable them to decipher those needs and offer sound and patient-centered responses, the greater the patient’s uncertainty will be reduced. Colleges and universities with Medical Humanities and Communication curricula are advised to identify relevant target audiences.

Growing Diversity of Population.

The population in the United States is becoming increasingly diverse. On the labor side, in 1994, the median age of all workers was 37.7; by 2024, the median age is projected to be 42.4, according to Bureau of Labor Statistics (2015). At the same time, according to the same Bureau of Labor Statistics report, cultural and racial diversity are projected to increase dramatically: “Labor force diversity is projected to increase, with white non-Hispanics making up 59.6 percent of the civilian labor force in 2024, compared with 64.6 percent in 2014.” The patient population will experience similar changes.

Thus, healthcare organizations will essentially constitute communication environments in which barriers of custom, language, demographic, and sociological mix will become more formidable. As this occurs, efficiency and quality of communication could suffer. The exchange of meaning though verbal and nonverbal means can become complicated because of the varied interpretations that actors bring to the transaction.

Resolute focus on the patient's needs requires an understanding of those needs. Dislodging and dismantling the barriers that interfere with vital communication processes between practitioner and patient – not to mention between co-workers – is not likely to occur by accident, as research shows. For example, while the number of healthcare organizations that provide training or orientation on diversity and cultural competence has increased in a relatively brief period – from 81% in 2011 to 86% in 2013, according to the Institute for Diversity (2013) – such interventions tend to have a more limited impact than desired. As a result, the National Call to Action, a "national initiative to end health care disparities and promote diversity," identifies three objectives critical to the achievement of the goal: "increase collection and use of race, ethnicity and language preference data; increase cultural competency training; and increase diversity in leadership and governance" (Institute for Diversity, 2013). Hospitals across the country have strengthened their commitment to achieving these goals. Again, according to the Institute for Diversity (2013), in most categories of diversity – race, ethnicity, gender, disability status, language, and religion – the "percent of hospitals having established a goal to reduce disparities according to patient characteristics" has increased in a relatively short time (an increase did not occur with respect to veteran status and sexual orientation).

Thus, it is posited that the employment outlook of direct caregivers, support and administrative staff, and healthcare educators will be strengthened to the extent they demonstrate a capacity for supporting an organization's commitment to achieve cultural competency goals. The fields of Medical Humanities and Communication can play a particularly helpful role in supporting the healthcare field’s achievement of these goals, particularly the second. Healthcare workers who receive such educational grounding will be equipped with the knowledge and skills to contribute to their organization’s development of activities – training and otherwise – that will enable principles and practices of patient-centeredness to prevail in the presence of cultural disparity.

Chapter 14

Integrating Communication into the Medical Humanities Program: A Curriculum Proposal

A Medical Humanities program is well-positioned to introduce and integrate a health communication curriculum. The perspective of Medical Humanities, which examines health and wellness from a patient's perspective, is a particularly hospitable academic environment for such a concentration. A survey of the top thirty health communication programs in the nation reveals an overall lack of attention to patient-centeredness which the Medical Humanities program can provide.

One of the most comprehensive health communication programs is at Indiana University at Purdue Indianapolis. According to their website, the objectives of their Ph.D. program in health communication center on obtaining competency in "health interpersonal relationships, intercultural health, and mediated communication in healthcare including health campaign development (Indiana University Purdue). This program, as well as many of the others, are designed to advance the research in these areas. The majority of the programs surveyed offer courses which focus on risk assessment and media campaigns from a research perspective (See table 5).

The inherent difference between a Doctorate-driven program and a Ph.D.-driven program is the application vs. research orientation, respectively. Given that, the purpose and trajectory of a health communication concentration in a Medical Humanities degree program would best serve those students if the approach focused on application. The objectives would emphasize the pragmatic nature of the discipline. This is not to suggest that theory is not important to an understanding of the practice. Certainly, having a foundation in theory will be necessary and relevant, but the thrust of the courses would be focused on practical daily application using those theories to solve specific case-based problems as well as an ability to forecast and stem issues before they manifest.

Therefore, a health communication program designed for inclusion in a Medical Humanities graduate degree program would design the courses in health communication from this vantage point. Inclusion of the fields specific to Medical Humanities would be the spring board for the conversation. Use of film, literature, fine art, theater, and even dance would provide the framework for communication-based studies. By way of example, consider the 2011 blockbuster film, *Contagion.* This film, which centers on a non-specific, never overtly identified epidemic which causes social panic, provides an excellent example of how a work of fiction effectively represents “the modern challenge of social panic during infectious disease outbreaks” (Lea, 2011).

A Medical Humanities program which lacks a concentration in health communication may prove inadequate in the increasingly complex and complicated world of healthcare. The challenge is in choosing the courses that would provide the greatest benefit to the students of Medical Humanities and determining the most effective manner in which to incorporate these courses, additive, integrative, or a combination of both as part of the larger process.

A recommended roster of courses which would serve a Medical Humanities program effectively is discussed below. The presentation includes courses which would also be beneficial to students in other disciplines in who are seeking to expand their skills as communicators or consumers of communication. Descriptions of each proposed course will follow and will include a rationale, learning objectives, suggested reading material, and sample learning activities.

Proposed course titles

- The Art and Science of Persuasion and Social Influence
- Multi-Cultural Communication and Public Health
- Health Communication Campaigns
- The Art and Science of Interpersonal Communication in Healthcare Contexts
- Interprofessional Communication
- Health Communication in the Arts

- **The Art and Science of Persuasion and Social Influence**

Course Description

The term “persuasion” is used so frequently and casually in everyday life that we can easily lose sight of the concept’s complex nature as a critical component of communication experience. The primary goal of this course is to provide students with a foundation in theories, principles, and strategies of social influence as it relates to interpersonal, public relations, and campaign contexts. Of equal importance, students will be afforded opportunities to gain practical experience in applying principles and strategies for gaining compliance to strengthen their communication skills and enhance their awareness as consumers of persuasive messages. A variety of pedagogical methods to develop students’ skills in persuasion will be employed, including discussions, narrative case studies, videos, interactive simulations, and daily classroom exercises. Activities will be humanities based. Viewing scenes from a variety of art forms, movies, television, and theater for example will provide a spring board for discussions of the methods, practices, and ethical direction of persuasive techniques.

Learning objectives

- Understanding of the theory, principles, and application of persuasion in a variety of contexts
- Understanding philosophies of ethics as applied to persuasion and the limitations and effectiveness associated with various strategies
- Understanding and gaining practical skills with regard to the roles and inter-relationships of participants in persuasive situations
- Understanding the theory of motivational appeals and gaining skill in analyzing their persuasive value and application of effectiveness
- Evaluate the impact of persuasive messages on individuals, groups, and society

Rationale

One of the most frequently employed communication techniques to motivate change is the art of persuasion. Persuasion is defined as "the use of messages to influence an audience" (Communication Institute for Online Scholarship). We are all exposed to persuasive messages every day and not only are we the recipients of those messages, we are also the propagators of them. In the realm of what seems like a trite encounter, convincing your spouse that he should be the one to change the litter box can necessitate a persuasive message. On a broader scale, convincing large numbers of people to quit smoking also necessitates a persuasive message. The ubiquitous nature of persuasion and the notion that we all engage in persuasive practice does not automatically make us all experts. Understanding how persuasive messages "work" is central to understanding how to use them ethically and effectively, and the potentially inherent conflict between those objectives..

Many campaigns, including Public Service Announcements, employ a particular kind of communication strategy that the social science literature calls “motivational appeals.” There is some debate about the ethics of motivational appeals. Some argue that these types of messages can be manipulative and even a form of brainwashing while others cite the positive effects of using persuasion to gain compliance (Gass & Seiter, 2016). Haynes argues that some agencies responsible for engineering persuasive messages support “the use of messages that attempt to avoid eliciting reactance in recipients, or the elicitation of attitudes and behaviors that counter an advocated message” (Haynes, 2015).

In healthcare contexts, persuasive messages can be life altering, for example, convincing someone to stop smoking in time for her body to reverse the negative effects or prevent exacerbations of an existing condition. The same message, constructed in a different way, can be used for a mass appeal and reach hundreds of thousands of people toward a desired end. This dissertation will incorporate the study of persuasion into the communication courses generally and will also recommend that a core course devoted entirely to the subject be integrated into the Medical Humanities program.

In healthcare, as well as other areas of our daily lives, the solutions for many problems may require change. Perhaps, what has been done in the past is no longer working, never really worked, or the attempts at solving were not implemented correctly or completely. Situations may arise which may necessitate an innovative approach. In many cases, if not most, there is a necessity to implement change. Sometimes the change is in behavior, for example, if there is an adverse health-related issue, dietary changes, increases in exercise, cessation of smoking, or changes in alcohol consumption may need to be instituted.

However, bringing about change in behavior is not often an easy thing to accomplish. If it hurts to bang your head against a tree, common sense would dictate that you should just stop banging your head against the tree. But what if you are banging as part of a cultural tradition or a religious belief that banging one's head against trees produces some ultimate reward? What if you enjoy the action but not the aftermath? That is, it might be kind of fun to be banging your head but later you suffer a severe headache and painful bump on your head. Changing behavior is often preceded by shaping or changing, or in some cases, reinforcing beliefs and/or attitudes. How does attitude change take place? What kind of messages can shape a belief system? Which methods of communication can reinforce positive behaviors?

There is an art and a science to inducing behavior change. Considering the role of intention, Fishbein and Ajzen (2010) scholars in attitude and behavior change theory, have built upon their seminal work which originated in the 1960s and 1970s and have updated their model of a "reasoned action approach." Their revised model, termed "the integrative model," has evolved over three decades and has developed in a notable order. Originally, in the 1960s, Fishbein, in response to critics of the utility of the attitude construct for predicting human behavior, examined the "conceptual differences between beliefs, attitude, and intention constructs." The discussion of intention is predicated on the assumption that if one intends to change a behavior and has reason to do so, change will occur. This seems to be rational, logical, and predictable. However, human beings do not operate in a vacuum and history has demonstrated that those who travel roads paved with good intentions do not always reach their desired destinations. That is to say, intent alone does not bring about change.

Politicians employ it, as do marketing experts, lawyers, teachers, parents, and anyone else who has a desire for their view to prevail. The popular television show, *Survivor*, demonstrates how effective, as well as ineffective, methods of persuasion are utilized in an effort to be the winner of a one million dollar prize. Contestants form alliances and strategize with and against one another toward that end. Politicians engage in endless persuasion campaigns, some in an effort to be elected to office, some in an attempt to pass or change a bill. Parents persuade their children to do their homework, eat their vegetables, and go to bed. Lawyers persuade juries to acquit or find guilt. This is to say that virtually every person at one time or another engages in the art or science of persuasion. And some are far more effective than others.

How these persuasive messages are constructed and delivered is at the heart of the art and science of persuasion. What kind of messages are needed to effect change? What types of messages and message delivery systems might be successful in changing smoking behavior? More persuasive techniques needed to be developed to stem that tide. Persuasion scholars, Gass and Seiter, are quick to point out that there are negative connotations of the word citing the example of the construction worker who refers to his sledgehammer as his “persuader.” Images of Puzo’s Godfather readily come to mind, suggesting “offers they can’t refuse” (Puzo, Godfather, 197_). Other terms for persuasion include “coercion, convincing, indoctrination, and propaganda” but also “influence and education.” Additionally, “compliance gaining” is a frequently employed expression. It is most important to distinguish among these terms for each has particular meaning and consequence for all parties involved in the communication encounter. Many of these terms stir up feelings that perhaps ethical considerations might need to be in play. And, indeed, that is often true. The study of persuasive techniques should not occur without an understanding of the ethical and moral considerations and impact.

The art or science of persuasion can be best understood by examining its core characteristics. Bainbridge et al describe six key properties of a persuasive message:

1. A shared symbol system (generally language, verbal and non-verbal)
2. Intent – Providing information alone does not necessarily mean there is intent to bring about change
3. Does not need to be successful – Not all persuasive messages have the desired effect
4. Involves at least two people
5. Involves attempts to change or reinforce attitudes, beliefs, or behavior
6. Involves attempts to shape responses

Persuasion can thus be defined as a method of communication between two or more people with the intent to change, reinforce, or shape attitudes, beliefs, and/or behavior of the receiver. A physician informing his or her patient to change or modify the behavior, or in the case of a broader message, a public agency merely providing information on the dangers of those behaviors do not fit these characteristics and therefore are not considered persuasion.

Social science research resolved long ago that in many situations providing information alone is an insufficient strategy, especially in cases when alternatives do not offer a foregone conclusion. Sometimes the risk benefit ratio is not a certainty and the result would be more subjective than objective. Smoking cessation provides an excellent example of how an information only approach can be an ineffective strategy. Although the surgeon general warned against the risks and dangers associated with cigarette smoking, the tobacco companies countered with such powerful targeted messages to youth that the warnings went unheeded and teenage smokers rose in epidemic numbers.

Clearly, in this case information alone was not a strategy that worked.

Since we are exposed to persuasive messages virtually on a daily basis, we may all be considered consumers of communication intended—wittingly or unwittingly—to influence in some fashion. Every commercial on television is created with the intent to persuade, whether it is to buy a product, switch brands, or watch a show. In healthcare, in most physician-patient interactions, the receiver is the patient. The doctor seeks to persuade the patient to give up smoking, for example. In the case of a public service appeal, an agency may be targeting youth to stop texting while driving.

We are all not only receivers of persuasive messages, we are all often on the other side of the interaction as the persuaders. By understanding the theory and practice of persuasion, we can be more astute communicators both as message givers and message receivers. And when we understand how to construct or deconstruct persuasive messages we can better identify methods which are effective and ineffective, those which are ethical and which are more in line with the sledgehammer approach.

The sledgehammer represents a persuasion technique which is, essentially, a scare tactic. On the surface, this may seem similar to a frequently used method which is referred to as a “fear appeal.” However, there are significant differences. How scare tactics and fear appeals are used directly correlates to whether they are ethical or morally reprehensible. How many of us have been told as children not to do something because we will get hurt? (Don’t go swimming right after lunch or you will get a cramp and drown.) This bit of persuasion, whether it is based on fact or not, is a mild form of fear appeal which is generally effective and not harmful.

Fear appeals are one of the more studied methods of persuasion, because they are employed on a very frequent basis and, perhaps, because the ethical and legal limitations (lines crossed) can be so compelling to discuss and analyze. Field experts Hovland, Feshbach, and Janis laid the groundwork for this field of persuasion research in their seminal works in the early 1950s advancing a “fear-as-acquired” drive model (Hovland et al 1953; Janis and Feshbach, 1953).

Although fear appeals are among the most studied method of persuasion, there are a multitude of other forms of persuasion. Gass and Seiter argue that persuasion is context based and that there are both “borderline” cases of persuasion and “pure” cases of persuasion (Gass and Seiter, 2007). Pure persuasion cases are those which are considered to be persuasion by a consensus. For example, few could effectively argue that a political debate is not specifically designed to persuade. The same holds true for product advertising campaigns. In these instances, one is overtly seeking to influence the behavior, attitudes, or beliefs of another. The lines blur, however, with a variety of other behaviors which may or may not be construed as persuasion. Those “borderline” cases are not clear-cut examples of persuasion. For example, Fred observes a stranger choosing a laundry detergent in the supermarket and then opts to buy the same one. Fred might have been influenced by the stranger’s choice but is that necessarily persuasion? An argument could be made either way. Here again, intention, is at the heart of this consideration.

The study of persuasion has application in a variety of fields as well as in everyday life. The proposed course would well serve students in Medical Humanities who have interactions with patients and/or providers as well as those who have responsibility for creating or disseminating health related messages to mass markets. The course curriculum would be broad enough to address the learning needs of a multitude of students across disciplines and specific enough to provide a basis for more in-depth studies.

- **Multi-Cultural Communication and Public Health**

Course Description

The challenges associated with communicating about health issues and problems that span multiple cultures can be daunting and can interfere with efforts to define those issues and manage them successfully. Communication theories, models, and concepts will be applied to public health problems and interventions. The course will examine the role of social, community, and cultural factors, in both the onset and solution of public health problems. Students will use real-life examples to consider and analyze the interrelationship between the media and community, and the media and culture.

Learning Objectives:

- Understanding of the need for a multicultural paradigm
- Understanding of how health communication evolved in the United States, with particular emphasis on multiculturalism
- Understanding the definition and role of cultural literacy and gaining skills in the practice of cultural literacy principles
- Understanding the importance of message and meaning in health campaigns in a multicultural society and developing an aptitude for related message and

campaign development

- Understanding of multicultural sensitivity and literacy during public health crises including panic avoidance strategies

Rationale

As we have become a global society, effective health communication is more challenging than ever. Individuals have been challenged to change lifestyle, and alter behavior due to potential risk. Societies have been challenged to examine cultural practices, customs, and norms in response to health events and health crises at home and abroad.

Populations are more mobile and have access and ability to travel more easily. Companies like FedEx make it possible to send packages from one end of the world to another virtually overnight. News reports and information sharing is instantaneous and not just limited to news organizations, but as we are in the era of the internet, there is an information bombardment. Internet access to information, vetted or not, has changed the face of mass media. Health information is no exception, indeed 35% of internet users look online for medical or health information (Fox, S. & Duggan, M., 2013).

But it is not just information that is shared; we are sharing in diseases that were once limited to continents or origin. For example, the AIDs (Acquired Immune Deficiency Syndrome) epidemic of the 1970s and 1980s has demonstrated clearly that what happens in Africa is no longer confined to Africa, and if we did not learn that lesson or had fallen into complacency, we learned that what happens in China is no longer confined to China when SARS (Severe Acute Respiratory Syndrome) broke out twenty years later in the early 2000s. The SARS outbreak pointedly illustrated that while a disease begins in a localized region, in this case Southern China, its impact can be swift and far-reaching as thousands of people across four continents contracted the disease through airline travel. Containment and control were thwarted by a lack of cooperation from affected countries.

U.S. government agencies played key roles in responding to SARS in Asia and controlling its spread into the United States, but these efforts revealed limitations. The Centers for Disease Control and Prevention provided public health experts to the World Health Organization (WHO) for deployment to Asia and gave direct assistance to Taiwan. It also tried to contact passengers from flights and ships on which a traveler was diagnosed with SARS after arriving in the United States. However, these efforts were hampered by airline concerns and procedural issues. The State Department helped facilitate the U.S. government's response to SARS but encountered multiple difficulties when it tried to arrange medical evacuations for U.S. citizens infected with SARS overseas (United States General Accounting Office, 2004).

The 2014 outbreak of the Ebola virus woke us up into a startling reality that we truly are one world. As of this writing, the spread of Ebola virus is largely contained and no longer considered a global threat, although, according to the World Health Organization there are still new confirmed cases emerging in Sierra Leone and safety protocols continue to be breached.

> Human-to-human transmission directly linked to the 2014 Ebola virus disease (EVD) outbreak in West Africa was declared to have ended in Sierra Leone on 7 November 2015. The country then entered a 90-day period of enhanced surveillance to ensure the rapid detection of any further cases that might arise as a result a missed transmission chain, reintroduction from an animal reservoir, importation from an area of active transmission, or re-emergence of virus that had persisted in a survivor. On 14 January,

> 68 days into the 90-day surveillance period, a new confirmed cases of EVD was reported in Sierra Leone after a post-mortem swab collected from a deceased 22-year-old woman tested positive for Ebola virus. The woman died on 12 January at her family home in the town of Magburaka, Tonkolili district, and received an unsafe burial. In the preceding 2 weeks the woman travelled from Port Loko, where she was a student, via the districts of Kambia and Bombali before arriving in Magburaka on 7 January. Reports indicate that her symptoms during travel included vomiting and diarrhoea. The Sierra Leone Ministry of Health and Sanitation (MoHS), with the support of WHO and other partners, responded rapidly to the new case, identifying approximately 150 contacts of whom approximately 50 are deemed to be at high risk. Vaccination of contacts and contacts of contacts is underway under the authority and coordination of the Sierra Leone MoHS. However, the woman's extensive travel history in the 2 weeks prior to her death, her presentation to and subsequent discharge from a health care facility at which health workers did not use personal protective equipment (PPE), her period of close contact with family whilst ill, and her unsafe burial indicate a significant risk of further transmission. One contact in Tonkolili remains to be traced. The origin of infection is under investigation (Ebola Situation Report, 2016).

The general public has a somewhat irregular reaction to threats of epidemic. It is posited here, that there are stages of reaction which are not always based on the actual threat. Reactions can range from benign interest to hoarding of supplies. Researchers at MIT studied public response to outbreaks comparing the H1N1 virus of 2009 to the SARS outbreaks in an attempt to determine factors which contribute to the differing responses.

One of the key elements the study considered was the effect of the media on social response relative to perceived versus actual threat. It was concluded that the media plays an enormous role in public response (Evans, J., Fast, S., & Markuzon, N., 2015). In late January 2016, a new threat to public health has been identified in the Zika virus, which is a mosquito-borne virus also originating in Africa but spreading rapidly in Brazil and, according to Al Jazeera news, “spreading explosively” across Central and South America (Mosquito-borne…explosively, 2016).

The article reported that the “World Health Organization expects infection of up to four million people as agency assesses level of global emergency” and WHO director-general, Margaret Chan, stated that the level of alarm was “extremely high.” A primary effect of the virus is on babies born to mothers who contracted the virus during pregnancy. Brazil documented over 3500 cases of microcephaly, a disease “involving brain shrinkage that severely limits a child’s intellectual and physical development – or death.”

Public health officials in El Salvador have even gone so far as to recommend that women delay becoming pregnant for two years since over 5000 cases were detected in the country in 2015. This is certainly an alarming recommendation which not only has the short-term effect of reducing potential cases but the long-term effect of population growth. Is the recommendation merely precautionary or is it likely to incite unnecessary panic? As of this writing, this remains to be seen.

How public health messages are created, worded, and disseminated have a direct impact on how they are received. The trajectory of follow-through can be linked to the power of the message. Messages on how to inform the public need to be carefully constructed so as not to induce panic but at the same time generate appropriate respect and caution for any inherent or impending danger. Because there are so many means of mass communication, there is a competitive aspect. All channels of communication seek to be the central disseminator and as a result sensationalism often rules the day.

There are a variety of factors which influence how these messages are received and especially during a public health crisis when the population is perhaps most vulnerable to mass media messages, these factors are an important consideration. Level of education, prior knowledge, age, socioeconomic status, are just a few of the factors which influence how messages are received. Those who are responsible for disseminating critical information during a health crisis have the obligation and responsibility to be aware of this dynamic of vulnerability juxtaposed against those influential factors. However, this is not always the case. For example, during the SARS epidemic, public reaction was disproportionate to the associated levels of risk. Pappas et al (2009) suggest that this might be attributed to the patient's status as both "victim and vector". The potential infringement of personal rights in order to control an outbreak leads to "stigmatization and discrimination" (Pappas, Kiriaze, Giannakis, & Falagas, 2009).

In fact, studies have shown that "public overreaction and panic can pose significant problems for a pandemic response [and that] ... unwarranted fear can undermine public health management and severely damage the health community's ability to respond (Person, Francisco, Holton, Govert, and Liang, 2004).

"When panicked," Lea explains, "people begin to take their own prescribed course of action, foregoing more well-reasoned and effective plans constructed by health experts" (Lea, 2011). Therefore, critical to management of these infectious disease epidemics is the need for effective communication. Precise, clearly articulated, and credible dissemination of accurate and useful information is key to successfully addressing these situations so as not only not to induce panic, but to promote systematic and productive courses of action. As mentioned, another by-product of misinformation and ineffective communication and information sharing is the marginalization and discrimination of segments of the population, which leads to an unspoken epidemic of fear, suspicion, harsh judgment, and stigmatizing of segments of the population.

The AIDS crisis provides a good example of how fear, anxiety, and miscommunication can manifest. Those afflicted with AIDs, early on, were dubbed members of the “4-H Club.” This moniker was not meant to conjure up images of cows and chickens happily roaming on farms and winning blue ribbons at the county fair. The four Hs were slanderous and malicious attacks on some of the affected groups: Heroin addicts, homosexuals (predominantly men), hemophiliacs, and the later addition to the group, Haitian people. This divided communities and targeted innocent people resulting in violence and tragedy. Indeed, in Haiti, an entire nation was subject to discrimination and their already tenuous economy suffered.

Similarly, SARS targeted Asian-American groups. Although, it is in a relatively nascent stage at this writing, the ZIKA virus is affecting Brazilians as well as others in more tropical climates. It is fascinating to watch how information about this virus is being transmitted and to see how the pattern is similar to past infectious disease outbreaks and at the same time, completely different. A notable similarity is in recommendations for impractical and wide-reaching responses, for example, asking women in afflicted regions to avoid becoming pregnant for two years.

The proliferation of mass media outlets has had an enormous impact however, and there tends to be more centralized pockets of information with the same message. Since infants seem to be the adversely affected population, the public response differs. In place of anger, albeit misplaced, there is a sadness which is embracing the world. It is not the lifestyle of a negatively viewed population which is attracting blame, but innocent children born to unsuspecting mothers who had the gross misfortune of becoming infected from the bite of a carrier mosquito.

Certainly, this is not the last infectious disease humans will face. How we respond, the messages we impart, the direction that response takes all have a direct impact on the trajectory of the disease. Is it controlled? Does it cause wide-spread panic and social unrest? Does in target specific populations and set those people up for ridicule and social ostracizing? Or, does it induce calm and provide clear, defined protocols and practical education? Does it stir us to act in unison for the common good? Does it invite those who can come to the aid of those who cannot? The influence of the medical humanist armed with knowledge and experience in the ways health communication can be effectively and proactively delivered can be a powerful and unifying force.

- **The Art and Science of Interpersonal Communication in Healthcare Contexts**

Course description:

This course combines didactic and clinical (interactive) methods of examining practices and principles of interpersonal communication. The emphasis is on dyadic and small group communication processes, with particular focus on listening skills, verbal and non-verbal communication, ethical implications, cultural contexts, conflict, and the role of perception in influencing communication conduct. Students will learn how to identify and overcome barriers to effective communication while engaging in scenarios based on real-life situations. A primary goal is to strengthen students’ self-awareness in order to understand their own personal styles and become more effective communicators.

Learning goals:

- Understanding of the multiple dimensions of communication and roles in interpersonal contexts
- Understanding the barriers to effective communication and gaining skill in overcoming them
- Understanding the importance of non-verbal communication and strengthening proficiency in its use
- Understanding how verbal and non-verbal messages need congruency
- Understanding of and becoming more adept at practicing empathy and listening skills
- Understanding actual as well as perceived cultural disparities and their influence on interpersonal communication
- Understanding the need for, and enhancing skills in, cultural literacy, awareness, and sensitivity
- Understanding the role of technology on interpersonal communication

Rationale

Although it might seem intuitive that effective physician-patient interactions correlate with good quality care and compliance with care directives, there is push back and an element of controversy over the teaching of these skills. Until very recently, no formal accounting of these skills was mandated. In general, medical students and residents have been evaluated by their mentors in a non-standardized fashion. Frequently, if students performed in ways similar to their mentors, they received high marks in that area. Another criterion, albeit unspoken, was judging communication skills by students’ medical acumen. This skill area has been relatively ignored, especially when there is evidence supporting its critical nature and benefit to patients.

Among the most critical of interpersonal skills, particularly in healthcare situations, is empathy. Much has been written about empathy and whether it is a learned or innate response. If it can be learned, then how best to teach it. If it is, rather, innate, can it be lost in medical training? Some studies show that empathy can be lost in the medical school process, (Hojat M, Vergare MJ, Maxwell K, et al. 2009).

However, as Rosenthal et al argue, effective intervention can serve to maintain, even improve upon, empathic skills. The authors examined the Jefferson Scale of Physician Empathy Medical Student Version (JSPE-MS) scores of two consecutive medical school classes to evaluate and assess the impact of an educational intervention on the preservation of empathy (Rosenthal, Howard, Schlussel et al, 2011). The findings of their study, conducted with third-year medical students at Robert Wood Johnson Medical School suggested that:

> … empathy may be preserved in medical school despite prior evidence that a decline in empathy is pervasive; we believe that the H&P [Humanism and Professionalism] intervention may have attenuated this decline. Future studies that employ a large controlled trial in multiple institutions are needed to confirm these findings. On the basis of our experience with two classes of students at RWJMS, we found that empathy may be preserved in third-year medical students. Furthermore, a curriculum that includes time for third year students to share feelings in a protected and familiar venue during their rotations may attenuate a decline in empathy. In addition, programs like the GHHS [Gold Humanism Honor Society], which validate humanistic behavior, may contribute to preservation of positive professional identity.

Hojat et al (Hojat, 2002) distinguish sympathy and empathy, citing an important distinction. Empathy, they write, has both cognitive and emotional (or affective) domains, whereas sympathy is primarily an emotional response. In the context of patient care, not maintaining an “affective distance” can interfere with objectivity and therefore can get in the way of proper diagnosis, treatment, and overall care.

Communication is complex, in that it is often layered and nuanced, and complicated, in that it is never one-sided. How a message is delivered has a direct impact on how it is received. It has been said that there are three sides to every story – the story teller’s, the listener’s, and the truth. There are two basic levels of meaning in interpersonal dynamics:

- Content-level meaning: the literal level of meaning conveyed; “well,” an issue of water from the earth; “well,” to rise to the surface; “well,” satisfactorily; “well,” a prelude to a remark; “well,” an expression of surprise (32 different possible content meanings in Webster’s Dictionary)

- Relationship-level meaning: Tells us how to interpret the content level, usually by conveying information about how we see ourselves, the other person, and most importantly, the relationship between the parties who are interacting ("Content and…content level. n.d.).

Very few, if any, communication interactions are black and white and it is in the murky grey area that meaning can be misconstrued, misunderstood, and misinterpreted. When the levels are not congruent and when confusion on one or both levels occurs, or when role conflict emerges, we may chalk it up to the over-used phrase “communication problems.” In the case of patients seeking medical care, such problems can be quite serious and the consequences can be at best life-affirming or life-changing, and, at worst, prematurely life-ending. When provider/patient interactions are ineffective:

- Patients may not feel trust
- Patients may not understand
- Patients may not comply with directives
- Patients may become frustrated
- Patients may not follow up with subsequent visits

- Clinical outcomes may suffer
- Predisposition to initiate medical malpractice suits increases
- Needless follow-up care-seeking activities can occur

Additionally, as Sullivan et al, explain, “enhancing communication practices may also benefit physicians through increased satisfaction with care and closer connection with those for whom they provide care” (Sullivan, A., Lakoma, M., Matsuyanma, R., Rosenblatt, L. Arnold, R., Block, S., 2007).

Why is communication so difficult especially in the context of health care? There are obstacles that challenge even the most well-intentioned among us. These barriers to effective communication and how medical professionals can overcome them is a central focus of this course. Particular emphasis will be on strategies and techniques health care providers can employ for greater effectiveness in communicating with patients and their families as they experience life during a vulnerable and stressful times.

Barriers

Pearson and Nelson (1991) define communication as “the process of understanding and sharing meaning.” Athena Du Pré explains that the significance of this definition becomes clear when we examine communication in terms of process, personal goals, interdependence, sensitivity, and shared meaning (Du Pré, 2010). Health communication, she writes, is shaped by the interdependence of many influences, including cultural orientation, skills, situational factors, and personal goals. The most effective communication encounters are collaborative, that is, the health care professional and the patient view themselves as a team, as having a consistent set of objectives that influence the actual medical care. These objectives include a desire for a clear and comprehensive exchange. Unfortunately, this is often not the case and there are many obstacles to that effective partnering. These barriers are problematic even in the most benign medical interactions and are certainly exacerbated and more pronounced in the context of a patient nearing the end of life.

Though we all take communication for granted, communicating effectively is a real challenge – in part because we do take it for granted! This is especially the case in health care contexts in which barriers specific to these contexts can produce significant adverse consequences. Manifestations include, for example, a patient's unmet needs for information or interpersonal sensitivity, which can lead to non-compliance with medical directives, non-disclosure of relevant details regarding the patient's condition, lack or loss of trust in the caregiver. By investigating and analyzing these barriers, we can break them down and establish an interpersonal environment in which the likelihood is strengthened for achieving more positive medical outcomes and increased patient satisfaction. Table 6 depicts a sampling of some of the barriers to effective communication, how they manifest, consequences, and suggestions for overcoming them.

Protocols Which Aid in Learning Empathic Communication

Whether or not empathy can or cannot be taught and whether it is an inherent human trait which is either present in the individual not is a topic which has been debated. There is evidentiary support on both sides of the issue. The value of empathic treatment of those at their most vulnerable states, however, ought not to be debated. Treating others with compassion and care is never a bad idea. To that end, *behavior that has essential characteristics of empathy,* can be taught, developed, and nurtured.

Teaching one how to communicate empathically is especially challenging in the health care setting. In addition to the barriers cited above, intrinsic in medical training is a scientific approach to care. Physicians are trained to diagnose and eliminate that which is causing ill health. The focus is on scientific evidence, test results, numeric values, blood levels, scans, monitors, and other technological indicators of a patient's health status. There is very little attention to the patient as a whole person in medical training. Physicians are not comprehensively educated in examining how illness impacts the patient's life and family. Perhaps this is not their role; however, a broader perspective on the effect of illness can only serve to help treat patients more completely.

Dr. Allen Frances, explains a doctor's reluctance to admit not always having the answers or ability to cure: "Doctors tend to be uncomfortable admitting uncertainty to themselves or to their patients. Too often, they feel it's a threat to their skill, authority, or expert status to say they simply don't know what's causing the symptoms and that there is no magic bullet to cure them" (Frances, A., 2013). This reluctance may be also be fueled, in part, by a predisposition toward defensiveness. Training in empathic communication addresses this issue, allowing physicians to let themselves "off the hook" acknowledging and recognizing that medicine, like the human body, has its limits, too.

There are protocols for empathic communication and some more specific to guide the process in delivering bad news, and they all actually do provide an excellent framework for the physician to follow. However, (and this author believes that this cannot be stressed enough) absent consistent modeling from supervisors combined with opportunities to practice these protocols, they are not very useful on their own. Providing sample phrases such as some described in the table above is useful in a limited way. However, communication is much more than just offering stock phrases, even in sympathetic tones. Sometimes it is holding a hand or offering a tissue. Sometimes it is a smile or a shared tear. Sometimes it is as simple as silence.

However, for many these are not instinctive and intuitive reactions; hence, the introduction of a variety of mnemonic devices for employment in medical contexts can be quite useful. One of the most ubiquitous of these devices by which medical students learn is the acronym, and, therefore, in keeping with that tradition, three protocols, BATHE, NURSE, and SPIKES are frequently employed to help guide them through the process of communicating with patients in various circumstances, from the basic patient history and interview to the more complex delivering of bad news. There are others, HEART (Communicate with HEART, n.d.) for example, used by the Cleveland Clinic, is useful when a patient or family member has a complaint about care. The acronym stands for:

- Hear the story
- Empathize
- Apologize
- Respond
- Thank

This is certainly another useful tool, and it is also easy to remember, however, the above cited three acronyms are more frequently utilized in training general communication skills or skills specific to delivering bad news.

BATHE (Stuart and Lieberman, 1993) is a suggested protocol for conducting a generic patient interview. It is intended to improve patient satisfaction and raise the quality of medical treatment. The emphasis is on the psychological and emotional aspects of the patient's concerns (See Table 7). A study testing effectiveness of this protocol when used by primary care physicians, demonstrated usefulness: "All participating physicians were experienced health care providers, and yet the BATHE intervention led to measurable improvements in patients' satisfaction" (Lieblum Schnall, Seehuus, DeMaria, 2008).

Employing BATHE when taking a patient's history can be effective in that it gives the patient the feeling that he is seen by the physician as more than a collection of symptoms. When a patient believes that his overall well-being matters to the physician, he begins to feel trust. When there is trust, patients are more likely to disclose information that might otherwise have been cloaked in an effort to appear as a "good patient." For example, a patient may under report the actual number of cigarettes he smokes or the actual amount of alcohol he consumes in order to be perceived in a more favorable light by the physician. In lieu of truthful responses which may have a direct impact on the diagnosis, prognosis, and care regimen, the patient alters the truth which may result in a less favorable outcome. Increased trust also increases the likelihood that a patient will comply with care directives.

When a patient believes that what a doctor is asking of him, from taking a prescribed medication to resting an impaired limb, comes from a place of sincere caring not only about the patient's medical condition but also the patient's general welfare, the patient is more likely to follow up in the prescribed manner. Following the BATHE protocol increases the probability that a doctor will engender trust in her patients but it is neither a quick-fix nor a stand-alone solution to complicated communication interactions.

The acronym, NURSE (Journal of Oncology Practice, 2008) is also useful in helping health care providers use verbal expressions of empathy (See Table 8). Focusing on what the patient is feeling and experiencing from an emotional perspective communicates to the patient that they are not alone and that the nurse or physician really cares about him. Sometimes patients are not able to articulate what they are feeling and by asking questions such as, “Does this frighten you?” or, simply, “Are you sad?” helps the patient recognize that what they might be feeling isn’t unusual. By communicating an “Understanding” of that emotion, the provider can demonstrate a non-judgmental attitude. Words of “Respect” recognize an understanding of the challenges the patient faces and provides an opportunity for encouragement. Often, patients may fear abandonment, and letting the patient know that someone on the medical team will be there, offers much desired “Support.” Finally, by “Exploring,” a provider can delve deeper into what the patient is experiencing; sometimes it is concern for family, sometimes it is a private and personal worry.

Pollak explains that the use of these comments, like “You've been so strong,” the patient “feels heard and can then go on. When the doctor goes right past it, the patient feels a sense of unrest and anxiety” (Journal of Oncology Practice). Providing the patient with a safe place to articulate and clarify his/her experience can go a long way toward reducing unnecessary interventions down the road.

The third protocol, SPIKES, was developed at the M.D. Anderson Cancer Center in Houston, Texas, and has proven to be an effective guide for delivering bad news to patients and their families (see Table 9). More specifically, this six-step aid can be useful in mitigating the stress a physician experiences when telling patients information which is likely to be difficult to hear. In providing a blue print for the conversation, SPIKES can be employed especially when a physician is uncomfortable or inexperienced in having these conversations (Baile, W. F., Lenzi, R., Glober, G., Beale, E. A., & Kudelka, A. P., 2000).

Every one of these protocols can be helpful as they are meant to be guides, roadmaps, to ensuring that practitioners have the conceptual framework and the vocabulary with which to interact empathically with patients and their families. However, understanding something on a conceptual, or theoretical level, does not guarantee that it can be executed behaviorally. It does not always translate into effective communication interactions. That takes practice and reinforcement.

Teaching, Training, and Evaluating Communication Interactions

When Dr. Rosenthal and I began our collaboration as inspired by the two actors turned medical students who are now practicing physicians, we hoped to have an impact on how communication skills are addressed in the physician-patient context. As discussed, we may think of communication fundamentally as a tool to overcome the powerful barriers that stand between caregivers and their patients. Once we appreciate that communication transcends the parties in the interaction, we become open to improving, learning, and growing. There is an increasing presence of humanities classes in medical school curricula. Health care professionals learn how to recognize the barriers to effective communication and how to break these barriers down. This is a positive trend; however, translating this into skill development is the challenge. As discussed, medical training applies “hands-on” methods to develop expertise, therefore, employing “hands-on” techniques to improve communication skills can be very effective.

In addition to discussing and analyzing the various protocols, such as SPIKES, residents are trained to recognize their own non-verbal behaviors which may be communicating unintended messages. For example, crossed arms may be perceived as an unyielding and inflexible. Open body language is explained and encouraged, for example, sitting eye to eye and leaning forward toward the patient indicates interest and engagement.

Once given a “common vocabulary” with which to dissect communication interactions, learners engage in the next step, the simulation, enacting a scenario with an FSEE trained actor. After the encounter, the facilitator and all learners share feedback and have opportunities for self-assessment. Communication is on ongoing process, we learn from our mistakes and our successes. FSEE interpersonal communication training is a process as well: one which provides a safe and harmless environment in which to practice, make mistakes, correct them, and try again. See Diagram 1 for an illustration of this iterative process.

Using actors to portray patients is not a new concept. However, what *is novel* is our approach to training residents in interpersonal communication skills is using actors who are trained using the exact same techniques as are used to train the residents. Teaching facilities have been using actors to stand in for patients for decades now; indeed, the term for these actors is “standardized patients” which implies that the actor’s performance is the same – standardized – for each interaction. The actor is provided with a set of symptoms, a summary of a back story, and is asked to relay the same information in the same way to each resident in the testing or training experience. Traditionally, this method is used to determine the resident’s medical acumen, more specifically, the ability to diagnose correctly and make appropriate recommendations for care.

But the descriptor, “standardization” takes on a new meaning when it comes to engaging actors to train or test the interpersonal communication skills of a medical professional. Because the communication experience does not lend itself to a straightforward cause and effect equation, the actors need to not only be consistent in cues, demeanor, and information provided but also flexible, and even inconsistent at times, behaving differently with different residents in response to the nuances of each interpersonal interaction.

One of the aforementioned actors-turned-doctors explained to me how he processes the link between acting and practicing medicine:

> Many times students are focused on algorithm, but in so doing they lose the attention to human emotions. Medicine doesn't do as good a job of teaching emotional intelligence. Helping foster attention to the "human" aspect of patient care is not emphasized enough in teaching. Students who are having difficulty with interpersonal interactions are similar to actors struggling in a role. The actor has the script memorized, but if s/he is just reading the lines and is feeling self-conscious about the impression s/he is making, or what he looks or feels like, he is unable to be present in the moment. When this happens, it makes for terrible theater, and, similarly, for a difficult interaction between a healthcare provider and a patient. Someone running down a lengthy list is not paying attention to the fact that a patient is close to tears, would be a good example of this.

The actors in FSEE are selected to interact with medical professionals only after completing the training session and after successfully demonstrating the requisite skills. The criteria for determining suitability of an actor to perform in FSEE are two-fold:

> 1. ability to portray and essentially embody a patient with a specific set of complaints or needs and be prepared with a personal history and background
>
> 2. ability to effectively articulate the experience on an intellectual as well as an emotional level in order to provide useful feedback to assess, evaluate and report on the interpersonal strengths and weaknesses of the resident with whom s/he is interacting (Eisenberg, Rosenthal, Schlussel, 2015).

Typically, when we think of actors we think only in terms of the first criterion, that they are "playing the part of a patient." But our actors are asked for more and are only selected after demonstrating competency in the second area as well. Once selected, actors are assigned to various scenarios for which their personal attributes are appropriate (age, gender, ethnicity, etc.). When applicable, they are asked to research the ailment discussed in their scenarios. Research may take the form of reading blogs of patients experiencing the illness, watching You Tube videos, reading scholarly material on the subject, etc. The leaders of the program also provide support in this area by directing the actors to appropriate matter and answering questions. For example, a prepared and FSEE trained actor, portraying the daughter of an elderly patient in the final stages of dementia, might bring a photo of a younger version of her “parent” to “remind” the resident that the patient was once young, vital, vibrant, and beautiful. This reminder is intended to elicit a more empathic response from the resident.

Training sessions for actors parallel the residents’ FSEE training sessions. Meeting initially in small groups of no more than 15 participants, training begins with an open discussion of personal experiences with the medical community and feelings and attitudes toward medical care that they or a family member have received:

Residents are asked to talk about why they chose medicine as a career. They are also encouraged to disclose how their attitudes toward the profession might have changed. Additionally, this phase of training asks residents to consider what their “ideal” doctor looks like and how they see themselves in comparison to that ideal.

Actors are asked to discuss personal (self, family, friend) experiences with illness or well-care and how the experiences made them feel at the time and afterwards. They are asked to explore their attitudes toward the profession, and articulate their current outlook as a result of personal experiences. Actors who express extremes, either overly negative or glowingly positive opinions, may be less likely to be selected since they may not be able to shed their bias to present an objective assessment of residents' interpersonal performance. There are other actors who have completed the training process but also not chosen to work with residents if they cannot articulate the experience and provide the resident specific feedback for growth and change.

The ability to understand and articulate human behavior in a medical context is essential for the success of an actor who is portraying a patient. In addition, the training provides actors with a language, verbal and non-verbal, for empathic communication in a medical context. Residents are given that same foundational training. The training emphasizes nuances in interpersonal interactions. While the verbal interaction is probably the most significant, the non-verbal behaviors have a powerful impact, qualifying, reinforcing, or potentially contradicting the verbal message. Additionally, residents are trained in knowing when to be silent. This is often very difficult for physicians, who have reported to me that silence feels like it might be a time waster. Residents learn that "silence is golden" as it gives the patient a chance to process the information, especially when that information was bad news.

As mentioned, intent is often conveyed in imperceptible ways. A furtive glance at a watch or the door, can speak volumes to another person. And, frequently, that message is not the message the sender intended. Misread intentions can have consequences and can impose further barriers to a productive encounter. In medical contexts, those consequences can be frustrating and potentially hazardous.

Prior to engaging in the simulation session, residents observe their Program Director (PD) modeling an interaction with the actor. The PD is asked for a self-assessment and is also given candid and detailed feedback from the actor and facilitator. Residents are also encouraged to offer feedback. During the simulation, actors and residents are provided with a scenario from actual cases. The interaction is performed in front of the group and lasts for three to five minutes.

Actors are trained to be aware of and sensitive to the barriers as well as those nuances in behavior which might misconstrue intent. They will often respond during the interaction by verbalizing the interpreted intent. A resident's furtive glance at his/her watch may trigger: "Am I taking up too much time?" or "I guess I can tell you about my other problem next time." This is one way the actor can "push" the resident inviting the resident to acknowledge his unintended action –"Oh, not at all. I have plenty of time for you, but I thought the nurse was going to return sooner with the packet." The simulation part of the training program cannot effectively occur without a full understanding of the cognitive aspects. They build upon, and, reinforce one another and need to be used in conjunction and not as separate entities. The effectiveness of each part is in direct proportion to the other.

During the debriefing segment, actors are asked to give feedback using "I" statements – "I felt that you were not fully engaged or listening to my complaints;" "I was completely comfortable disclosing what had previously felt like an embarrassing problem." Residents are asked to give feedback on how they believe the interaction went, what they might have done differently, or what they feel went particularly well, and why. Peers are asked to offer feedback as well. All are encouraged to use "I" statements. Residents are afforded the opportunity to repeat the scenario to improve skills and these "do-overs" are an excellent way to hone communication skills since they allow the resident to instantly apply the feedback to actual practice.

After residents have participated in the group sessions, they advance to the one-on-one training session, the OSCEE – Observed Simulation Communication Education and Evaluation. The actor and resident engage in a one-on-one interaction observed only by a “fly-on-the-wall” evaluator. Since evaluating communication interactions is subjective, faculty evaluators are offered training in order to mitigate subjectivity and normalize their observations.

Faculty are trained using videos showing the same scenario enacted three different ways demonstrating various levels of communication skills. A facilitated discussion follows the video to address nuances in the behaviors shown in an effort to ensure that faculty evaluators are judging the interpersonal interaction and not basing evaluations on the resident’s medical knowledge (which, we found, was a common practice). The discussion is guided by a checklist of specific behaviors which fall into one of four categories to determine if the behaviors fall below, at, or above expectations for the resident at his/her level of training.

The general domains on the checklist are:

- Begins Effectively
- Listens Actively
- Plans Collaboratively
- Closure

While there surely is a performing arts aspect to communication interactions, like medicine, there is also a science to it – if the practice is not in synch with the cognitive, the simulation becomes an empty exercise. Medical humanities students can be trained in the art of FSEE and whether they use the training protocols in practice with patients or just as a theoretical framework for addressing all situations, there will be benefits reaped for all.

Overcoming Cultural Differences

In all communication interactions, cultural differences hold the potential to be quite influential. In the context of interpersonal interactions, misunderstandings can have a ripple of negative effect, and in a healthcare setting those effects can run the gamut between benign and fatal. The phrase *cultural competence* is frequently used and is often confused with political correctness. While these concepts have overlapping features, there is a difference.

Competency indicates an ability to interact in an effective manner with those whose culture is different from one’s own. This ability includes a level of self-awareness, that is, an appreciation of one’s own views of other cultures as well as an awareness of one’s attitudes and personal biases towards people of other cultures. Competency also requires a real knowledge of cultural practices, taboos, rites, attitudes, and an understanding of how other cultures view the rest of the world. Finally, the culturally competent individual has the skills to understand, communicate with, and respectfully interact with those from other cultures.

On the other hand, political correctness, is more reflective of behaviors which do not necessarily require a deeper understanding of another culture. The expression refers to the avoidance of expressions or action that are perceived to exclude, marginalize, or insult groups of people, often those who are considered to be socially disadvantaged.

Though the term has historical origins rooted in ultra-liberal political contexts, it became popularized in the late 1980s and early 1990s. In May 1991, at a commencement ceremony for a graduating class of the University of Michigan, then U.S. President George H.W. Bush used the term in his speech: "The notion of political correctness has ignited controversy across the land. And although the movement arises from the laudable desire to sweep away the debris of racism and sexism and hatred, it replaces old prejudice with new ones. It declares certain topics off-limits, certain expression off-limits, even certain gestures off-limits" (George Bush).

From the time we are very young, we are taught the golden rule: Do unto others as you would have others do unto you. However, when it comes to culturally aware communication this practice does not prove to be universally effective. The essence of cultural competence can be thought of as a matter of respect. An important and useful mantra for health care professionals working with populations whose culture differs from their own is: "You don't have to get it, but you have to respect it." The point is that health care professionals, indeed *any* professionals, working with diverse populations, cannot be expected to have in depth awareness of every culture's norms, rituals, and taboos but all do need to be aware that there are differences and none are more correct or appropriate than another.

Consider the woman who is rushed to the emergency room in active labor. Her husband is by her side and clearly distraught over seeing his wife experiencing pain. While his wife is whisked away in a wheelchair, he tends to bureaucratic details with the admitting staff and then settles uncomfortably into a waiting room chair. After a short while, a nurse approaches and asks him to follow her into the delivery room. He balks and declines. Assuming he does not understand due to a language barrier, the nurse enlists the aid of an interpreter who also entreats him to enter the room. He clearly understands what they are asking yet continues to decline. Both the nurse and the interpreter chastise him for not being a supportive husband and shame him into entering the room. Upon seeing her husband, the woman becomes increasingly upset and the staff assume that her labor is progressing causing the obvious greater discomfort. The husband is doing his best to make himself invisible and feels helpless as he suffers the disdain of the staff for not comforting his wife during her apparent distress.

The assumption by the nursing staff that the husband wants to or ought to be present in the delivery room and a participant in the birthing process is not one that is culturally sensitive or aware. The couple in the story are Arabic and, according to Galanti (2015) men in Arabic cultures usually do not accompany their wives during labor and delivery, rather it is the wife's mother-in-law or the sister-in-law who have that role. While it has become common, even expected, in American culture for men to attend pre-natal visits and classes, and also to be active participants in the birthing process, other cultures do not share the same view of the experience. "For example, in Orthodox Jewish culture, the husband is typically not present in the room with his laboring wife because she is considered "unclean" at this time. Hispanic and Asian women typically prefer that their mothers attend to them in labor" (Galanti).

Another reason that husbands and wives do not share the birthing experience is that behaviors exhibiting outward expressions of pain are also often culturally defined. Some cultures ascribe to the notion that stoicism is preferable to overt displays of emotion. This phenomenon is not limited to childbirth. Expressions of grief or sadness are also varied and specific to culture. For example, men of Asian cultures (specifically, Chinese, Japanese, and Korean) "resist displaying these emotions [grief, sadness] through facial expressions, whereas ben from Mediterranean cultures, such as Greek and Italian, readily display these emotions and even exaggerate them (McCorry, Mason, 2011).

Non-verbal behaviors can often speak far louder than words and different cultures have very different perceptions of what these behaviors signify. Historically, outward displays of bravado are equated with strength and displays of emotion demonstrate weakness. There is a tendency to assume that non-verbal behaviors are relatively universal, that there is consensus and shared meaning behind most facial expressions, for example, but this is a false assumption. Even eye-contact, which is highly valued in American culture, can suggest disrespect in Mexican cultures (McCorry & Mason).

Greeting gestures differ in various cultures as well. While the hand-shake is nearly universal, the strength and vigor of that hand-shake varies. Among Latin American cultures, for example, a warm and soft handshake along with an embrace is comfortable and traditional among Mexican men and women, as well as Brazilian and Puerto Rican people, while Venezuelans go the extra step and include a kiss in the greeting (McCorry & Mason). In the United States, a firm hand-shake is a sign of respect and it would seem odd to most men to kiss one another upon greeting. In England, a hand-shake is generally considered appropriate only upon first making a new acquaintance, after that a simple “hello” is the norm. In Japan, it is customary to bow from the waist, there is no clasping of hands at all. Likewise, in Polynesia, the custom is to take the hands of the other person and stroke one’s own face. Intuits rub noses, and Tibetans stick their tongues out at one another to indicate there are no evil thoughts. In Russia and Egypt, there are three kisses on the cheek (left, right, left), and Italy adds one more kiss on the right cheek (Multicultural Planning and Development Officer, Cairns, AU).

Interpersonal communication is complex and multi-faceted. Acknowledging and recognizing that there are many layers to our interactions is an important first step in having more meaningful and effective relationships. Skills can be developed and achieved by practicing modeled behavior and participating in improvisational interactions using protocols as guides.

- **Health Communication Campaigns**

Course description

A health communication campaign can cross several audiences on an increasingly targeted basis and through increasingly strategic channels. Creating an effective health education campaign goes beyond raising awareness. Successful campaigns are carefully constructed and reflect much care in their design, development, implementation, and follow up. This course examines each of those stages and evaluates a comprehensive range of variables relevant to health education campaigns, including campaign purpose and goals, audience analysis, message development, campaign structure and sequence, campaign themes, channel selection and delivery strategies, selection, "voice" of campaign, message reinforcement mechanisms, and assessment of campaign effectiveness. The history of health campaigns will be examined, and students will review campaigns of historical as well as contemporary significance. Students will construct their own campaign addressing a current day issue and predict effectiveness based on established paradigms.

Learning Objectives

- Understanding the history of public health campaigns
- Identifying a broad range of stakeholders associated with health communication campaigns
- Understanding how to identify and analyze need for a health communication campaign
- Understanding how to choose and target audience
- Understand and apply the use of social influence principles
- Analyze a variety of campaigns to understand structure and dynamics
- Recognize and analyze cultural influences in campaigns to determine effectiveness
- Students will be able to evaluate health communication campaigns based on the formative and summative model (Table 10)

Rationale

Public information campaigns have become a relatively ubiquitous part of the media landscape. On any given day, a television viewer, a radio listener, even someone browsing the internet will be exposed to at least one such campaign. These messages are receiving increasing attention from the academic community and there are a number of theories which seek to explain the phenomenon. The sheer number of campaigns in a wide variety of venues addressing an array of issues is certainly one reason for interest. Another factor is the increased sophistication of the campaigns, recognizing that information alone ("Drink milk – it is good for you") is not likely to influence behavior change.

The messages of today are carefully researched and demonstrate an appreciation for the notion that human behavior is complex and motives are driven by far more than just intention. We have become a society that expects more information and we have multiple avenues for acquiring that information. The downside of having so many ways to get information is that much of the material is incomplete at best and incorrect at worst.

For example, there are a multitude of web sites which offer diagnoses based on the input of a few symptoms. This may lead to self-diagnosis and self-treatment instead of taking the newfound information to parse with a health professional. Thus, the proliferation of information is a double-edged sword. On one hand, factual and clearly worded information can encourage better choices, but on the other hand, that same information, clear and precise though it may be, may have the effect of placating worry and resulting in lack of follow-up with a health professional. The other side of that coin is the incomplete and inaccurate information which may be construed as factual and lead down hazardous pathways.

Scientific analyses of public information campaigns began as an outgrowth of the political climate in the aftermath of World War II. The United States faced fears and paranoia never before encountered. The nation saw that Germany systematically sought, and in large part succeeded, to annihilate an entire race of people; Japanese people were viewed as a new enemy after the attack on Pearl Harbor; and perhaps the greatest threat came from the Soviet Union.

Paranoia constituted a societal backdrop and concerns about the growing threat of propaganda precipitated a closer and more targeted look at how false or exaggerated messages were received. Thus, in 1944, Lazarsfeld and his colleagues were among the first to question what they considered to be an overreaction to propaganda arguing that opinion leaders bore a greater responsibility for the effect of mass media messages on the public (Lazarsfeld, P., Berelson, B., Gaudet, H., 1944) . The outgrowth was the model of two-step communication (Katz and Lazarsfeld, 1955). The model theorizes that opinion leaders essentially mediate the messages between the mass media and the public (see Diagram 2).

While this theory soon proved relatively limited, even primitive, it did lead the way in examining the role of how messages to a general public are sent as well as how they are received. One of the key findings was an understanding that this type of communication was far more complex than a pure information exchange. Another finding was that the typical recipient is more than a sponge for that information, indeed playing a more dynamic role in the process. Thirdly, the research led to greater appreciation for the use of persuasion as a more appropriate and credible approach to this field of study. Propaganda became a sub-unit in that overall study.

In the 1960s and 1970s, Lazarsfeld’s theory gave way to a more sophisticated model, understanding how information campaigns needed to acknowledge a greater complexity of how target audiences were processing that information. Where previous campaigns could be perceived as paternalistic, even condescending, the emerging campaigns were based on more credible and clear about the issues. For example, restrictions on accessibility to oil in the 1970s (oil shortages leading to skyrocketing oil prices) led to a new generation of campaigns about the need for conservation.

President Nixon declared a “war on cancer” which opened the door to a greater public profile of the disease. Once a whispered and stigmatized diagnosis, the heightened awareness led to campaigns which informed the public on prevention strategies. Thus began a new wave in campaign strategies. Never before had the language of public information campaigns been of a scientific, yet accessible, nature. Encouraging objectivity was a departure from campaigns of the past, giving the recipients credit for being rational and thinking decision-makers, as opposed to purely visceral response to affect. The public conversation about prevention behaviors, as well as treatment options, came out of the closet and were openly discussed and debated for the first time.

The culture of “free love” which came to fruition in the 1970s experienced a sober awakening in the next decade when a serious and mysterious health threat reared its frightening head. AIDS was a misunderstood and terrifying disease which, in the beginning, was identified in the gay community and thought to be a result of homosexual behavior. If having cancer was stigmatized, those who were perceived as carriers, i.e. homosexual men, suffered considerably greater discrimination.

Early on there were no medical solutions and the only strategy for addressing the concerns of the public were health information campaigns. Educating the public without exacerbating fear and hostility of the gay community was an exercise in overcoming the learning curve; however, targeted prevention campaigns ultimately did help to change behaviors and stem the advance of the disease as medical treatments were developed.

In addition to the gay community, intravenous drug users were susceptible to the disease. Promiscuous, casual sex with unknown partners began to abate and needle exchange programs began to emerge. Recognizing an enormous challenge in stemming drug abuse, in 1986, Partnership for a Drug-Free America was founded. The alliance was comprised of a variety of organizations and interested media groups including advertising agencies, television networks, trade associations, and publishers. The goal was to use the “power of advertising through the mass media to prevent drug abuse” (Backer & Marston, 1993).

The genesis of the non-profit organization began two years prior when advertising executive Philip Joanou had the idea that the advertising world, in conjunction with the media availability, could team up to play a “unique role in preventing and reducing the abuse of drugs, such as marijuana and cocaine” (Backer & Marston). The Partnership produced the iconic 1980s campaign which began with a man holding up an egg saying, "This is your brain," then picking up a frying pan adding, "This is drugs." He then cracks open the egg, drops the contents into the sizzling pan, and says, "This is your brain on drugs." Finally he looks up and asks, "Any questions?"(Partnership for a Drug-Free America, 1987).

The campaign was initially deemed a powerful and effective message and drug use actually declined over the next few years (Block, Morwitz, Putsis Jr, Sen, 2002). However, subsequently, its efficacy diminished as it became the butt of many jokes and parodies specifically by the audience for which it was intended (Fishbein, 2002). What it did do, though, was facilitate the national conversation on the subject and, as a result, reached a broader audience than initially targeted. In this way, it can ultimately be considered a highly effective appeal (Alexander, E., 2000).

It can be argued that the “Brain on Drugs campaign was couched in a fear appeal. Witte's (1992) Extended Parallel Process Model (EPPM) **(**Diagram 3) attempts to explain both when and why fear appeals work, as well as when and why they fail. According to this model, the variable that tends to be most problematic in fear appeals is fear. Fear can be a barrier to behavior change, as when people are so frightened that they cannot act (so they deny or defensively avoid a threat), or a motivator to change, as when people perceive a risk and are motivated to reduce it. Witte’s model illustrates the difference between danger control and fear control. Danger control occurs when people believe they can avert a threat by facing it and taking action. Fear control occurs when they face the threat but turn inward and focus on the fear. A fear appeal works when it encourages the recipient to respond by going into the danger control mode.

In order to mitigate the possibility of getting stuck in the fear control mode, the fear message must be constructed carefully with a specific recipient or recipient group as the target. Additionally, campaigns must take into account that people other than targeted groups are likely receive the message as well.

This is an inherent problem in the marketing of public service campaigns. Not only is the efficacy at issue, there is an ethical dilemma as well. If the marketing is not grounded in an understanding of the science of motivational appeals, the results can backfire. With fear, people can be so frightened that they become immobilized to do something about the danger.

As mentioned earlier, many patients feel, or believe they are, invulnerable – it happens to “others,” not to them – to a specific disease. Or they perceive themselves to be invulnerable to the danger. For example, “I’m a nurse, and therefore I know all about the effects of smoking and the danger signs. I won’t get lung cancer.” This nurse, who is a smoker, will continue to smoke since her perceived vulnerability to the dangers of smoking constitutes a shield through which a fear message cannot penetrate. A failed persuasive effort can, in fact, fortify the shield, thus strengthening the perceived invulnerability (Perloff, 2010).

This issue of perceived vulnerability is at the heart of the discussion of the ethical use of fear to achieve compliance. The creators of public health campaigns as well as individual health care practitioners need to be cognizant of the potential pit falls of an ill-constructed message. Additionally, the messages need to conform to a generally accepted code of ethics. This includes not knowingly doing harm, not giving misleading or fictional information, not targeting vulnerable groups in ways that may be detrimental to their well-being, and finally, ensuring that the means and the ends are not in a state of conflict.

It is important for Medical Humanities students have a working understanding of health campaigns since they both reflect and inform societal views of illness and wellness. By studying the forces behind mass-message construction and dissemination, students can acquire the skills to recognize what contributes to messages successfully reaching and influencing their target audience and what contributes to others failing. This ability can prove to be a valuable tool as they progress in their careers.

- **Interprofessional Communication**

Course Description

There is a large and growing body of research that suggests that collaborative efforts contribute favorably to quality of care and operational efficiency. However, there are a multitude of obstacles which obscure effective communication interactions between and among the different health professions. Understanding the difference between team-based practices and team work, and the inherent barriers to and objectives of each is an essential first step in implementing strategies and techniques for effective implementation. Students will engage in a variety of exercises which will afford them the opportunity to identify and analyze barriers to effective collaboration as well as to learn how to improve their own collaborative skills and contribute to the goals of interprofessionalism.

Learning objectives (students will be able to:)

- Describe the concepts and principles of interprofessional healthcare and their relationship to developments in the healthcare field
- Identify core competencies of interprofessional communication
- Explain the benefits of interprofessional practice
- Describe the role that each health care profession plays in managing a person's illness
- Identify a unique contribution of each health care profession in managing a person's illness
- Articulate an understanding of the ethical principles associated with interprofessionalism
- Identify and gain practice in skills needed to work in teams
- Articulate effective communication and collaboration skills
- Understand the barriers to successful interprofessional communication and collaboration and the management and staff roles relative to overcoming them (Westhus, N., Accessed 3/2017)

Rationale

With the passage of the Patient Protection and Affordable Care Act, healthcare providers have new incentives to improve the quality of care and to strive for better outcomes as the federal government links reimbursement to a variety of factors including cost reduction, quality measures, and heightened efficiency. These incentives are expected to endure modifications to national health policy. The Centers for Medicare and Medicaid Services (CMS), have implemented programs to encourage providers to create interprofessional care teams to foster greater coordinate of care and patient education. Among the goals is the identification and treatment of chronic health conditions early on in the diagnosis. Ultimately, the hope is to improve overall health (Nester, 2016).

Collaboration and cooperation between and among the health professions is increasingly important and gaining momentum in practice, especially in light of these developments in healthcare and the impetus to tie reimbursements to outcomes. Building and maintaining these relationships to foster interconnectivity can be challenging as long-standing healthcare models favor specialization and silo-orientations which can slow the rate by which interprofessional goals can be achieved. Overcoming these barriers is a first step in changing the paradigm.

We all recognize that the work of any healthcare organization, regardless of size, demands coordination, integration, and collaboration. There is simply no viable way to accomplish the work required; the vast majority of processes require an interdependence that organizational culture often tacitly works to sabotage. This is not to suggest that it is intentional, actually, far from it. Though we all can agree on and appreciate the importance of teamwork and collaboration, achieving team effectiveness is not easy in large part because the forces that underlie “silo” tendencies are so strong. It is likely that fragmentation could emerge as a most central issue associated with cost over the coming years.

Our health delivery system focuses on specialization. Indeed, this is not by accident. Specialization has evolved as clinical advancement has evolved. No one would dispute the necessity of specialization with respect to providing medical care. But when specialization sets the tone for how a system's components fit together, fragmentation, by definition, could occur. It can promote a sense of separateness that extends to operational processes and practices. And today, more than ever before, the notion of working on an interdependent basis extends beyond the walls of an institution; collaboration is increasingly required between and among different institutions as they coalesce into continua of care.

So, a key question for healthcare managers is: How do we continue to encourage what is clinically essential and create environments in which the delivery of health services fully serves the interests of patients (through specialization), while at the same time create environments that are efficient and integrated? Fragmentation—not integration—is the more naturally occurring phenomenon in healthcare contexts; for example, people tend to cluster with others who have the same or similar functions or who have similar backgrounds or who are located more closely. Combating this tendency toward disconnectedness is heavily dependent on the capabilities and priorities of management.

For a long time, the expense associated with a fragmented model was not especially problematic for healthcare institutions. After all, it was built into the cost base of a healthcare organization’s activity and passed along to third party payers who, until very recently, did not exercise the meticulous scrutiny over cost that present-day reimbursement models require. Consider, for example, how a fragmented environment can easily translate into an additional day in a patient's stay. How much does that cost the hospital? The patient? The third-party payer? And for the rest of us, in the form of taxes or premium hikes?

Shifting from a fragmented model to an integrated one will constitute a significant and important challenge for leaders of healthcare in the coming years. The skills associated with building and sustaining an integrated environment are quite different from those that sustain a fragmented environment. Over the coming years, we are very likely to see organizations demanding that the managers they hire possess the skills necessary for creating climates in which efficiencies and improved outcomes can be achieved through collaborative models. This is a complex set of competencies to master.

Environments lacking collaborative communication cultures and practices are more susceptible to error. Lingard, et al, reported that "communication failures were commonplace, occurring in 30% of procedurally relevant information exchanges among OR [operating room] team members" (Lingard, L., Espin, S., Rubin, B., Whyte, S., Colmenares, M., Baker, G. R., . . . Reznick, R. 2005). A hospital operating room is frequently a high-pressure environment and lapses in information sharing are bound to occur. Mistakes can be relatively minor or catastrophic, such as wrong site surgeries. Lingard, et al, reported on a Toronto based team, who implemented a prototype of a checklist to encourage focused communication among members of the surgical team.

In an effort to reduce medical mistakes and enhance patient care, the Toronto hospital implemented the checklist in the operating room before eighteen surgical procedures. This was done as part of a study to examine ways to promote interprofessional communication.

The checklist was piloted for three medical professions whose members act as a team in the operating room (OR): surgeons, nurses, and anesthesiologists and was designed to be completed in a short time (average 3.5 minutes per professional) just prior to the patient's arrival in the OR before the medical procedure.

The point of the checklist was to act as a focus for a team conversation to ensure that all were clear about one another's roles and requirements. Respondents reported positive feedback as they were given a chance to articulate concerns and make decisions as a group. Essentially, the checklist forced a conversation that might otherwise have gone by the wayside in favor of expeditiousness. By elucidating the specific individual roles, the team vision gained new clarity.

Westhus outlines four premises of Interprofessional Education (IPE):

- IPE occurs "when two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes" (WHO, 2010)
- Embedding IPE within existing curricula allows aspects of patient-centered care and IP team practice to be an expected part of professional practice
- IP collaborative practice occurs with deliberate planning and implementation of learning and practice, not by good will, intent, desire, or chance alone
- IPE must have interactive learning experiences, didactic and experiential, that include critical reflection

Because all members of a healthcare team bring different skill sets, knowledge, expertise, and their individual professional identities, working as a team can be challenging. There are barriers which impede team-based efforts, for example, the perception of a hierarchical power disparity and "profession-centric role models" (Keller, Eggenberger, Belkowitz, Sarsekeyeva, Zito, 2013).

Most would agree that the overarching goal of healthcare is to optimize patient care and health-related outcomes. There is a large body of evidence, which is ever increasing, that suggests that "collaborative interprofessional practices promote greater patient satisfaction, improved efficiency and enhanced job satisfaction among healthcare professionals (Keller et al). Additionally, as noted, collaborative efforts significantly decrease medical errors (Leonard, Graham, Bonacum, 2004).

Organizations categorize and number interprofessional core competency domains differently, but the Interprofessional Education Collaborative Expert Panel identified convergence into four domains based on a variety of sources including "national literature and global literature, among health professions organizations in the United States, and across American educational institutions" (Interprofessional Education Collaborative Expert Panel, 2011).

Each of the four general domains contain a subset of more specific competency values (Interprofessional Education Collaborative Expert Panel, 2011):

1. **Values/ethics for interprofessional practice**: Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. **Roles/responsibilities**: Use the knowledge of one's own role and of other professions' roles to appropriately assess and address the health care needs of the patients and populations served.
3. **Interprofessional communication**: communicate with patients, families, communities, and other hath professionals in a responsive manner that

supports a team approach to the maintenance of health and the treatment of disease.

4. **Teams and teamwork**: Apply relationship-building values and principles of team dynamic to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

These competencies provide an important framework for effective collaboration. The proper implementation of these techniques has the power to transform how healthcare is delivered. However, and this is critical, if these practices are not modeled and consistently and continuously demonstrated in the clinical experience they become meaningless. Understanding a concept does not automatically translate into the ability to employ it. This takes time, practice, and effective top-down modeling.

There are a variety of pedagogies which can be used to teach and train adult learners to be able to achieve interprofessional competencies. There is still much to learn about which pedagogy or combination of pedagogies are ideal methods for helping learners to acquire these skills. Sometimes, how information is imparted can be key to its being absorbed. Cooke, et al, explain that “A variety of adult learning characteristics are relevant including active (versus passive) learning, self-directed (versus faculty-directed) learning, and situated (versus classroom) learning. Recommendations for rethinking pedagogies used in undergraduate medical education toward more active, clinically integrated and developmentally progressive learning are also key to interprofessional learning (Cooke, Irby & O’Brien, 2010).

Incorporating the competency strategies early on in the core academic curricula for students in health professions, as well as reinforced through continuous demonstration (the hidden curriculum) can significantly mitigate the barriers to effective collaboration efforts and eventually contribute to better patient outcomes as well as professional job satisfaction.

- **Health Communication in the Arts**

  Course description

  This course will explore the representation and treatment of health and illness through the lens of communication, in film, television, and theater. In this course, we will examine how the arts influence our definitions of health, wellness, illness, and medical care. This exploration is intended to broaden our understanding of society's views of health as depicted in the arts and how this influences the healthcare experience of patients and their families as well as health professionals. The goal of gaining insight and empathy into the circumstance of the other constitutes a principal learning objective. Among the topics that will receive focus are the hidden curriculum, medical malpractice, delivering bad news, interprofessional behavior, professionalism, grief, the respective roles of caregivers and patients definitions of illness and health, cultural diversity, gender issues, and medical errors. Students will view and/or read relevant historical as well as contemporary source material to analyze and interpret messages and their meanings.

  Learning objectives:

  - Explore, through the arts, the history and evolution of the culture of medicine and healthcare in the United States
  - Understand the role the arts (film, television, theater) play in shaping contemporary views of health and illness

- Gain insight into how communication reinforces role assignments in healthcare contexts, serving the needs of some and depriving the needs of others, and how the caregiving community can use communication to promote more meaningful and dignified experiences for all stakeholders
- Identify and analyze the hidden curriculum in film, television, theater and discover ways of integrating the lessons to promote humanistic approaches to caregiving

Rationale

The arts both reflect and explain social themes, mores, and opinions of the times. Literary characters give voice to societal perspectives on everything from religion and politics to education, sex, and psychology. Film has contributed to the wealth of story-telling characters. Popular music, from folk to rock and beyond, has long been a strong reflector of events and attitudes. Since the early 1600s, opera has told stories with morality and personal hubris or frailty as central themes. Television dramas which center on hospitals and doctors bring the medical experience of others directly into our living rooms. These art forms not only enlighten and entertain, they can educate and serve as teaching tools for students of medicine, Medical Humanities, as well as the lay public.

Television

The doctor miraculously appears at the bedside of a suffering woman. The kindly, bespectacled physician arrives at her home, black medical bag in hand, to provide comfort, care, and hopefully a cure. Gently pushing a stray hair or two away from her face, he holds her hand promising that everything will be all right. And, within the space of an hour, it is. He is off to the next patient's home. Fiction? Of course. *Marcus Welby,* *MD*, was a television program about the fictitious, eponymous doctor which aired in the United States from the late 1960s to the mid-1970s (Marcus Welby, M.D.).

The program centered on a doctor whose practice of making house calls let patients know that their personal health and well-being was his one and only priority. This popular program came at a time when medicine was becoming highly specialized, and house calls, once *de rigueur*, were rapidly becoming a thing of the past. The Emmy award winning show aired its pilot episode in 1969 as a movie of the week entitled *A Matter of Humanities*. In addition to demonstrating the positive effects of patient-centered care, it also showed the conflict between paternalistic treatment (Doctor knows best) and the emerging use of technology to mediate physician-patient interactions:

> An interesting theme in the show is the mentor relationship between Welby and his young associate, Dr. Kiley. In spite of his youth, fashionable (for his time) hair and motorcycle, the younger physician represents a more conservative view than Welby. The older physician is more liberal, less distrustful of human nature, and more altruistic than his protégé (Marcus Welby…relevant today, 2015).

As depicted in the television drama, the humanities can weigh heavily in the practice of medicine and health care in general. As discussed, the health care industry is much greater than the sum of its parts. By examining how entertainment media portrays health-related situations we can learn much about ourselves and others. Stanek, et al (2015) studied episodes of three popular medical dramas on television. They “conducted a summative content analysis that was both inductive and deductive in nature, to identify depictions of the hidden and informal curriculum in the television medical programs” (Stanek, Clarkin, Bould, Writer, Doja, 2015). The examples in those television dramas, as well as most others, offer clear examples of the hidden curriculum and can serve as valuable teaching tools for training in the medical field.

Television medical dramas have become ubiquitous over the past several decades and issues relevant to our everyday lives are confronted. They started out slowly; Marcus Welby M.D. was preceded by Drs. Kildare and Ben Casey, who were rival physicians in the 1960s. *Chicago Hope* and *ER* then joined the growing roster. The public responded well and the networks obliged. *House, Scrubs,* and *Grey's Anatomy* became hugely popular with the most recent addition of *Chicago Med* to the roster.

From ethics to palliative care and paternalism to deontology, issues are tackled which mirror and reflect our experience. True, most matters are resolved within the hour, but questions are raised and beg discussion and examination. A relatively recent television drama, The Knick, proved not to be a critical success, however, while the program took liberties with actual historical events it was an excellent example of historical fiction that brought to light the evolution of the hospital as we now know it. The opening episodes introduce the audience to an overview of some of the major trends in healthcare in the beginning of the 20th century. The Knick tackled opium addiction, the emerging need for sterilization, the tuberculosis epidemic, the plight of medical students, racism, and a host of ethical dilemmas. Episodes of this drama will be used to encourage debate as well as discussions of historical accuracy.

Theater

From Greek tragedies to more modern day theater, the experience of illness provokes audiences to not only examine the experience of others, but to have a visceral reaction. “Sounds of agony pour from the man at the front of the room, his face red and convulsed with pain. “Death!’’ he shouts, imploring someone, anyone, to end his life, his shrieks filling the amphitheater. “Death! Why after all these years have you not appeared?’’ The wailing man is an actor. His part is that of a Greek hero-warrior begging to be euthanized as a burning poison eats away at his flesh. His lines were written more than 2,000 years ago by Sophocles, the Greek playwright (Lee, 2010).

The audience, primarily physicians, were taking part in a program called *End of Life,* which “uses ancient Greek tragedies to spark discussion among medical students and professionals about the ethics of treating patients facing painful, prolonged deaths” (Lee). The project’s founder, Bryan Doerries believes that if more medical schools employ ancient Greek drama it will help strengthen their medical ethics programs. For example, the two scenes used in the *End of Life* readings illustrate the ethical dilemmas and emotional baggage that complicate medical situations for the terminally ill, their families, and caregivers (Lee).

Doerries also founded Theater of War, which is a project that uses well-known actors to present readings of ancient Greek plays as a tool and springboard for conversation “to help individuals and communities heal from suffering and loss” (arts.princeton.edu/people/profiles/bryandoerries/). I had the opportunity to be in the audience for one of these presentations which took place in one of Kentucky’s Appalachian communities. The presentation stimulated conversations and surprising personal disclosures from the audience about the visible as well as the unseen effects of addiction, one of the potentially devastating consequences of war. The conversations were more than just cathartic for those who shared their stories; they were eye-opening for many in the audiences. Doerries included counselors in the audience to act as resources for those who chose to take advantage of the opportunity.

Shakespeare’s plays centered around complex characters, many who contend with a variety of afflictions, mental as well as physical. Although recent evidence suggests that Julius Caesar suffered from Transient Ischemic Attacks (TIA) more commonly called mini-strokes (Andrews, E., 2015), Shakespeare's Cassius described Julius Caesar experiencing what was originally believed to be an epileptic seizure:

when the fit was on him, I did mark
How he did shake: 'tis true, this god did shake;
His coward lips did from their colour fly,
And this same eye whose bend doth awe the world
Did lose his lustre: I did hear him groan (Shakespeare).

Throughout the ages, the issues we face in healthcare are depicted on the stage through characters with whom we can identify, either in ourselves or in others. For example, there are numerous plays about AIDS, including *The Normal Heart* by Larry Kramer, to Tony Kushner's *Angels in America*, to *Rent* by Jonathan Larson, and *Falsettos* by William Finn. Each of these, and the many others, brought the plight of individuals to the forefront and shed new light on what was a highly-stigmatized disease.

The Normal Heart "centers around the start of the AIDS epidemic in the early 1980s, which felled many of Kramer's friends and former lovers. The play focuses on a writer named Ned Weeks, who's trying to nurse his partner back to health from a then-unknown disease, all while pleading for the government to take action" (Wilson, E.F., 2015).

Angels in America won the 1993 Pulitzer Prize. The play is set in "New York City in 1985. The drama takes you on an unforgettable journey, touching on AIDS, sexuality, and religion (Wilson). The musicals, *Rent* and *Falsettos*, both depicted individuals who represented thousands of others living and dying with AIDS.

Wit, a stage-play by Margaret Edson, is an oft-used work in teaching medical students. The lessons of empathy abound and it is rare that lively discussion of the practices depicted does not ensue (once tears are wiped and noses cleared). The play centers on Dr. Vivian Bearing, a distinguished poetry professor, whose expertise is the study of the poetry of John Donne, whose work is frequently cited. Bearing, somewhat of a loner, is diagnosed with Stage IV metastatic ovarian cancer. Readers and audience members are swept along on her journey of experimental chemotherapy and treatment by insensitive and aloof medical professionals (Edson, 1993).

Wit was written and adapted for television by Mike Nichols (who also directed) and aired on HBO in 2001. The television film enabled the story to be accessible to a greater number of viewers. Playwright Margaret Edson explains

> *Wit* is not a story of survival. Instead, the film deconstructs the typical tale of staying strong through cancer treatment, overcoming the odds, and surviving. The film skillfully constructs a story of repair and restoration of the individual not through treatment of the body ravaged by cancer, but by admitting one's weaknesses, exposing oneself, and, perhaps most frightening of all, relinquishing control and, in the process, becoming vulnerable. In the end, one is left with the feeling that the main character of the play is being "healed, not cured" (Larson, S. A. 2015)

Film

There are lists of films, including *Wit*, which are touted to be "a must see" for anyone in or planning to enter the medical profession. They range from comedy to tragedy and everything in-between. Some of the most frequently suggested films include:

- Awakenings, 1990

  Starring Robert DeNiro and Robin Williams. Directed by Penny Marshall

  Based on Oliver Sacks' 1973 memoir, Awakenings is the story that takes place in 1960, of the victims of an encephalitis epidemic many years prior who have been catatonic ever since. A new drug, L-dopa, offers the prospect of reversing the effects of the disease. A research physician speculates that the patients might respond to L-dopa since the symptoms align with an extreme form of Parkinson's disease. He has to convince his superiors to allow him to treat the patients. (Sacks, n.d.).

- Patch Adams, 1998

  Starring Robin Williams and Phillip Seymour Hoffman, Directed by Tom

  Shadyac

  Based on Hunter “Patch” Doherty Adams, who founded the Geshundheit! Institute, a hospital with the following stated policy: 1) no charge 2) no health insurance reimbursement 3) no malpractice insurance 4) three to four hour initial interview with the patient 5) home as hospital 6) integration of all the healing arts 7) integration of medicine with performance arts, arts and crafts, nature, agriculture, education, recreation and social service 8) the health of the staff is as important as the health of the patient (Patch Adams).

  Synopsis: In 1969, Hunter Adams was a troubled man who voluntarily committed himself into a mental institution. Once there, he finds that helping his fellow inmates there gives him a purpose in life. Thus inspired, he leaves the asylum and vows to become a doctor to help people professionally. However, what he finds at medical school is a sickeningly callous philosophy that advocates an arms-length attitude to the patients that does not address their emotional needs or the quality of their lives. "Patch" Adams is determined to find a better way to help them, although the consequences of his defiance of the rules and the authorities are severe. (Chisholm, K.).

  One of the most powerful quotes which lends itself to discussion:

  Dean Walcott: Our job is to rigorously and ruthlessly train the humanity out of you and make you into something better. We're gonna make doctors out of you (Quotes).

- The Hospital, 1971

  Starring George C. Scott, Diana Rigg, Barnard Hughes. Directed by

  Arthur Hiller.

  Dr. Herbert Bock (Scott) is chief of medicine at a large New York City hospital. His personal life is in tatters: He's left his wife and broken relations with his "shaggy-maned Maoist" son; he plies himself with

> vodka and has suicidal fantasies. The hospital is also in disarray; as Bock says, "The incompetence here is absolutely radiant!" The body count is mounting among wrongly diagnosed patients, as well as some nurses and doctors. Enter Barbara Drummond (Rigg), an ex-nurse and former druggie who's been living with her father among an Indian tribe. The stories Bock and Drummond share move the film from farce to a higher level, and the chaos within the hospital suggests a broader societal problem in which people are overlooked, at times with fatal results (Finger, A., 2013).

Each of these films support the thesis that how we communicate is as important, if not more so, than *what* is actually being communicated. The teaching moments are manifold and astute learners may see their reflection in the faces of the characters.

Musical Theater

Musical theater is one art form which has been significantly less explored with respect to how it reflects and informs us about popular culture. According to Heide, Porter, and Saito:

> Musicals clearly serve an entertainment function, but their effect on audience attitudes has not been studied. Extensive research in the field of entertainment-education demonstrates that other narrative forms can affect attitudes and behaviors. Musicals share many features with nonmusical plays, but differ in ways that may enhance their power to affect viewers. The addition of melody to text has the potential to make dramatic moments more memorable. The choreography, costumes, and sets used in this art form are arresting and add perceptual salience.

We have relied far more extensively on other art forms – like literature, film, television, visual art, plays, and music to provide a window into how we, as a society, view, interpret, and make judgments about human experience. For example, exploring the portrayal of use and abuse of mind-altering substances in musical theater we can examine perceptions about the role and function of such substances. The goal is to demonstrate that the study of musical theater holds considerable scholarly value in helping us to enhance our understanding of human conduct and the underlying motives that shape our values and influence our sense of right and wrong. The application of such study to the subject of mind-altering substances can shed light on how we come to see intoxication, inebriation, as acceptable or unacceptable, as a force of good or a force of evil.

Perceptions about the function and influence of drugs and alcohol have changed over the course of recent history. Stanton Peele (1999) writes, “Just as there is a pluralism of political attitudes in a democracy, there remains a range of attitudes about alcohol and its effects and a considerable spectrum of views about what constitutes appropriate drinking.” He asks, “How could attitudes not change, with the degree of public education on the dangers of alcohol that every American now receives from childhood on?” (Peele, 1999).

This course will trace this evolving nature of these perceptions over the course of the last several decades. Students will examine a selection of popular musicals, beginning with the innovative and pioneering *Oklahoma!* (Rodgers and Hammerstein II, 1943) in the early 1940s until the end of the twentieth century, in order to discover how the use of drugs and alcohol feature in each and in this genre in general, and how the use reflects changing societal views over the course of that time. The progression of these selections reflects how cultural sensibilities have shifted, and have done so quite dramatically, with regard to the use of drugs and alcohol over time.

Experts in the field of substance abuse and addiction would hardly be surprised by the trajectory of perceptions revealed in these musicals. According to David Musto, M. D., public views of substance use are subject to change:

> …the broadly antidrug attitude of 1930 to 1950 did not prevail through the 1960s. Yet, our physiology remains the same: Every generation is ready to respond similarly to the effect of drugs. The rise and fall is largely due to what we learn about the substances and it is this learning that we have found difficult to convey effectively to later generations. Our approach to the drug issue is evolving; whether we repeat the cycles of the past or evolve to a more stable, settled position remains to be seen (Musto, 1995).

As we move from one generation to the next and new musicals take to the stage it will be prudent to evaluate how the depiction of substance use and abuse evolves in this art form. By exploring the views of substance abuse as rendered, either intentionally or not, in works of musical theater fresh light can shine on core aspects of human activity, thought, and behavior. This is also a way to build an informed and aware audience, and, by extension, society.

Using a variety of performance-related media, students will explore the history and evolution of the culture of physicians, medicine, and healthcare in general in America. Students will gain a deeper understanding of how society viewed the role the health and ill-health in the past and how those views helped shape current day practices. Examining portrayals of individuals and groups in various media will provide a greater insight into how communication is key to medical interactions.

Conclusion

Now that the field of Medical Humanities is over forty years old, it has secured its place in academe. But, given the immense complexity and size of the healthcare field, and the rapid rate by which it changes, it is not unusual for a field like Medical Humanities to continue to strive for definition and identity. One reason for this is that there is such a multitude of stakeholders, each assessing the health experience from a particular point of view.

While the following examples are clearly reductive, they are offered to signify rather than define. Using a hospital patient to illustrate the point: the hospital administrator sees the incoming patient not only as a person in need but as a consumer whose revenue contributes to the hospital's viability; the doctors see the patient as a great responsibility whose welfare depends on the administration of their training, knowledge, and skills; the family sees the patient as a loved one whose well-being has become an emotional preoccupation and, potentially, as a disruption in general life activity; and the patient sees herself as vulnerable, possibly at the mercy of a large system, frustrated at this interruption of her life, and anxious about what lies ahead.

We all communicate, but we cannot easily separate communication from these varied, often discrepant perspectives. That is why patient care can be a daunting endeavor—it is not as though the various stakeholders do not have the patient's well-being in mind; rather, it is that different emotional, social, professional, cultural, and environmental forces act on each stakeholder in different ways. The perspective each brings to the caregiving situation is shaped and colored by different influences. Sometimes the differences are small, sometimes quite large, even insurmountable. We do not often begin our communication with others with a recitation of the forces that influence how we approach one another. That occurs on a meta-level, almost always tacit. Yet, they are always with us, greatly influencing how we engage with one another. We go about our business assuming that our communication is correct, clear, and fault-free. And within the context of our own internal logic, it is. But human drive and motivation is complex, and we lack easy mechanisms to overcome differences in the internal logics that are foundational to our communication.

There is a long history of communication faultiness in healthcare. It reveals itself in the interpersonal realm that has occupied the bulk of the discussion in this dissertation. But it also occurs on the organizational level as well. Barry Eisenberg, a former administrator of a community hospital put it well:

> We came to recognize that our hospital, like the vast majority of hospitals in the United States, functioned too much like a collection of small businesses rather than a coherent, highly integrated and coordinated organization. Such an organizational dynamic is not surprising in light of the tendency for boundaries to proliferate among functions, professions, programs and services in an organization when it lacks a compelling, overriding reason for those divisions and distinctions to be blurred. It's not that patients didn't get what they needed; it's that they might not have gotten it in as coordinated a manner as possible. Strong mechanisms were not in place to ensure that radiology, nursing, dietary, respiratory, rehabilitation and other clinical services were consistently delivered to patients in a synchronized fashion. For example, a transporter goes to a patient room to escort the patient for a CT scan only to discover the patient would be returning in 10 minutes from an appointment with the physical therapy department. The transporter waits, and when the patient returns she says she has to use the restroom. The total wait for the transporter is now 20 minutes. Then there's the effect on others, like the nurse who is called away from another patient to assist in readying this patient to leave the floor. What is the price of this seemingly small coordination mishap … in money, in patient comfort, in staff frustration? What is the cumulative impact when this is multiplied across the thousands of similar activities that occur each

year? (Eisenberg, B., 2011)

As long as managers of hospital departments view their role as task-oriented and emphasize accomplishment of those tasks, they will be challenged to create an environment in which broad-spectrum care can be provided to the patients in their charge. A hospital culture that promotes an integrated, collaborative, and coordinated work environment will more fully foster a social environment in which the patient's perspective is more fully integrated into how each manager thinks about and executes his work.

We are beginning to see a fundamental reordering of incentives in healthcare that are influenced by Medical Humanities principles. This includes, for example, the inclusion of interpersonal and communication competencies in graduate medical education (ACGME) as well as the instituting of HCAHPS, Medicare and Medicaid's nationally utilized patient survey which quantifies patients' accounts of their care. These and many other initiatives are encouraging the assimilation of multiple, and often competing, demands to build a workforce capable of exercising operational efficiency as well as empathy, cultural competency, and communication effectiveness. This newer model of prioritization to include communication proficiencies is heartening.

Medical Humanities, as a field, demands that we gather and celebrate the stories, cultures, histories of people as individuals and as communities. It is about understanding each of these components through the lens of health and illness and how each individual and each community frames the experience. It is about using that understanding to paint a global mural to encompass and embrace the effect that health issues have on our lives.

If we cannot necessarily agree on a precise definition of the term "Medical Humanities" and to a larger extent, the field, perhaps we can agree that Medical

Humanities at its very core, puts the patient at the center of the conversation. If we start there and move outward, Medical Humanities can provide a deep understanding of the role empathy plays in the deliverance of health care. Given the roadmap to a desired destination of patient-centered care, we then need to determine the means to travel that path.

Those means, vehicles, and tools are rooted in communication studies and skills. Incorporating theories and processes from communication studies into the discipline of Medical Humanities can serve to elevate the field and expand the relevance in real world application. The hope is that by using the tools of communication, we can better employ the lessons and tenets that Medical Humanities provides.

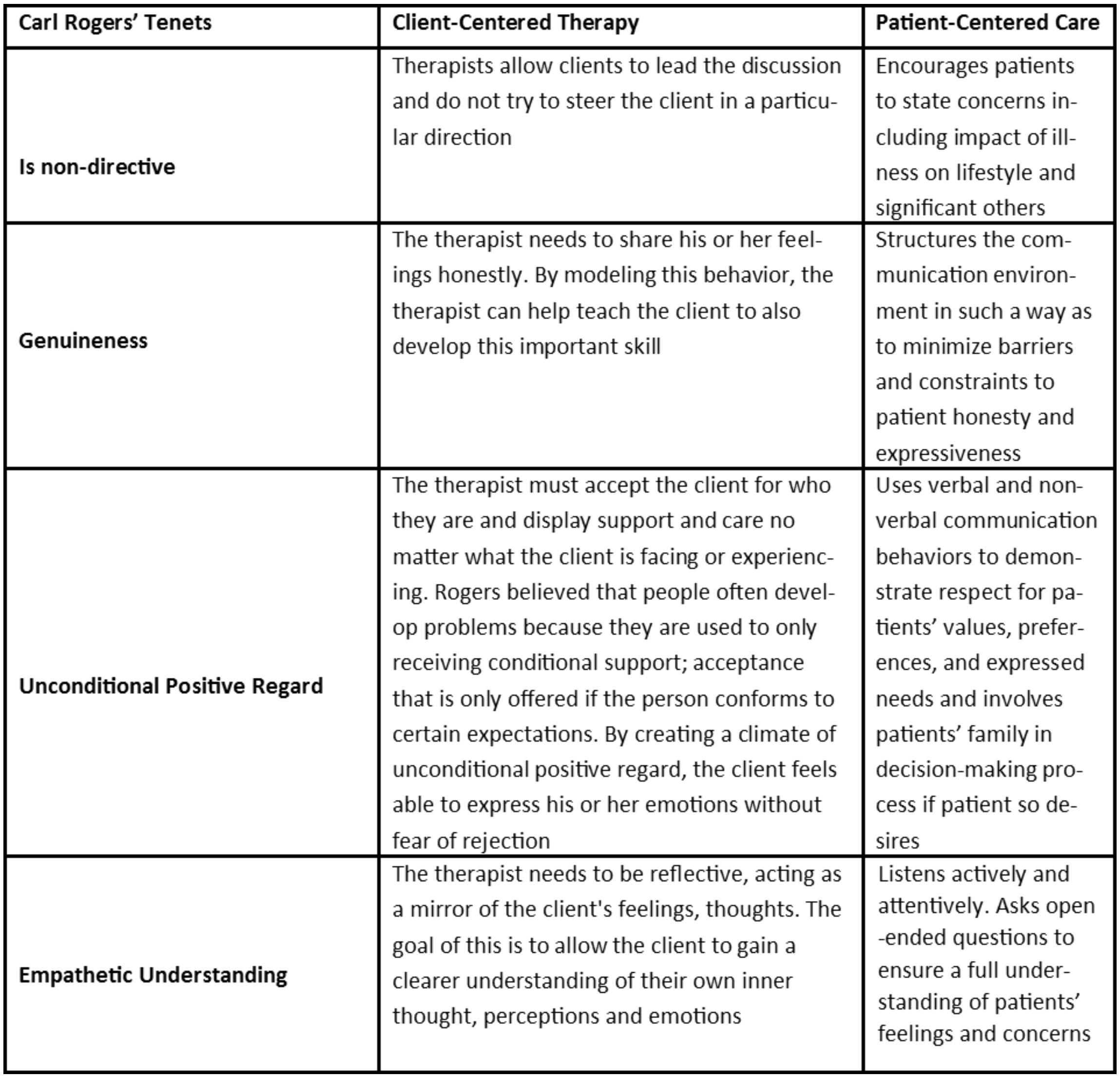
Drew University has an established graduate degree program in Medical Humanities, which is poised to be the premier graduate program in the field. The university boasts a highly-accomplished faculty as well as a wide array of relevant courses in ethics, history, literature, narrative, as well as practical internships. A primary purpose of my dissertation is to demonstrate how the achievement of this goal will be better served by including a comprehensive concentration in Health Communication which, I believe, can directly enhance the study of each of the individual areas of study. What is the benefit of understanding the philosophical reasoning behind an ethical decision if the details cannot be effectively communicated? Wherein lies the value of an ability to dissect a narrative without the ability to share its meaning?

There are only a handful of universities in the United States which offer degreed programs in Medical Humanities. Drew University has one of the most comprehensive programs in the country and is thus very well-positioned to be at the forefront of a movement to elevate the field to even higher ground. Communication studies support the theoretical lessons of Medical Humanities. By incorporating a variety of courses in communication studies, Drew will provide its students of Medical Humanities an invaluable academic experience replete with strategies and techniques to apply their deep understanding of healthcare to real-world experiences.

Tables

Table 1

The Tenets of Carl Rogers' Client-Centered Therapy Applied to Patient-Centered Care (Rogers, 1963)



Carl Rogers' Tenets	Client-Centered Therapy	Patient-Centered Care
Is non-directive	Therapists allow clients to lead the discussion and do not try to steer the client in a particular direction	Encourages patients to state concerns including impact of illness on lifestyle and significant others
Genuineness	The therapist needs to share his or her feelings honestly. By modeling this behavior, the therapist can help teach the client to also develop this important skill	Structures the communication environment in such a way as to minimize barriers and constraints to patient honesty and expressiveness
Unconditional Positive Regard	The therapist must accept the client for who they are and display support and care no matter what the client is facing or experiencing. Rogers believed that people often develop problems because they are used to only receiving conditional support; acceptance that is only offered if the person conforms to certain expectations. By creating a climate of unconditional positive regard, the client feels able to express his or her emotions without fear of rejection	Uses verbal and nonverbal communication behaviors to demonstrate respect for patients' values, preferences, and expressed needs and involves patients' family in decision-making process if patient so desires
Empathetic Understanding	The therapist needs to be reflective, acting as a mirror of the client's feelings, thoughts. The goal of this is to allow the client to gain a clearer understanding of their own inner thought, perceptions and emotions	Listens actively and attentively. Asks open-ended questions to ensure a full understanding of patients' feelings and concerns

Table 2

Communication Studies Journals (University of Kentucky)

General Resources

Communication Currents: a publication by the National Communication Association that translates the latest communication scholarship into everyday language.

Online Access to Journals with Articles Published by our Faculty

The following journals contain a mixture of free articles and articles that must be purchased.

Atlantic Journal of Communication
Communication Education (National Communication Association)
Communication Monographs (National Communication Association)
Communication Quarterly (Eastern Communication Association)
Communication Research Reports (Eastern Communication Association)
Communication Studies (Central States Communication Association)
Communication Teacher (National Communication Association)
Cyberpsychology, Behavior, and Social Networking
Health Education Research
Human Communication Research (International Communication Association)
International Journal for the Scholarship of Teaching and Learning
Journal of Social and Personal Relationships
International Journal of Art & Design Education
Journal of Applied Communication Research (National Communication Association)
Journal of Broadcasting & Electronic Media
Journal of Health Communication
Kentucky Communication Journal
Qualitative Research Reports in Communication (Eastern Communication Association)
Review of Communication (National Communication Association)
Rhetoric & Public Affairs
Sex Roles: A Journal of Research
Southern Communication Journal (Southern States Communication Association)
Visual Communication Quarterly

Online Access to Other Journals

The following journals contain a mixture of free articles and articles that must be purchased.

Communication and Critical/Cultural Studies (National Communication Association)
Communication Reports (Western States Communication Association)
Communication Research
Communication Theory
Critical Studies in Media Communication (National Communication Association)
Howard Journal of Communications
Journal of Communication (International Communication Association)
Journal of Communication and Religion

Journal of Family Communication
Journal of Interactive Advertising
Journal of International and Intercultural Communication (National Communication Association)
Philosophy and Rhetoric
Quarterly Journal of Speech (National Communication Association)
Text and Performance Quarterly (National Communication Association)
Western Journal of Communication (Western States Communication Association)
Women's Studies in Communication

Table 3

Journals specific to health communication (Health Communication Journals – as of 9/2015)

<u>Health Communication Science Digest</u>

From CDC, this series is designed to enhance awareness of emerging health communication and marketing scientific knowledge by providing you easy access to recently published articles and reports with particular relevance for the public health communication community.

<u>The American Journal of Public Health</u>

From the <u>American Public Health Association</u>, the journal includes articles on public health research, research methods, and program evaluation.

<u>Journal of Health Communication</u>

Scholarly, peer-reviewed journal that presents the latest developments in the field of health communication including research in new media, health literacy, social marketing, communication (from interpersonal to mass media), public private partnerships and public health campaigns.

Health Communication

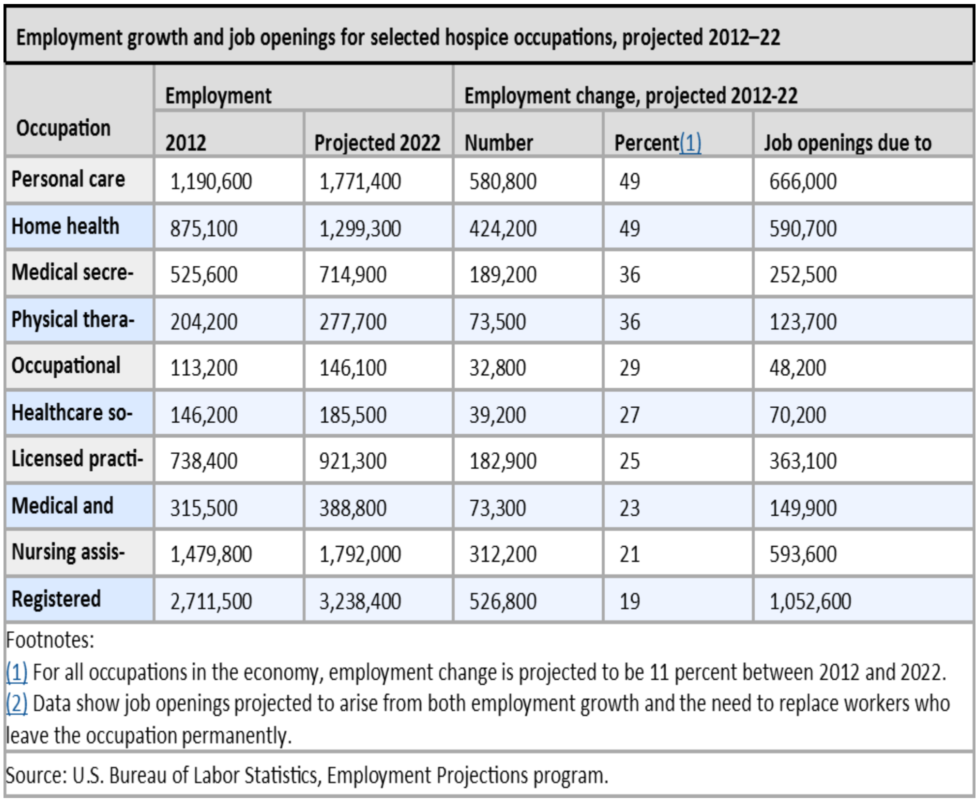
Focus on scholarly exchange between medical and social sciences, with emphasis on communication between health providers and patients and institutions and the public.

Journal of Communication in Healthcare

Peer-reviewed journal analyzing issues, theories, research findings, and evidence-based interventions across different areas of strategic health communication.

Table 4

Employment Growth and Job Openings for Selected Hospice Occupations, Projected 2012-22 (Green, 2015)



Employment growth and job openings for selected hospice occupations, projected 2012–22

Occupation	Employment		Employment change, projected 2012-22		
	2012	Projected 2022	Number	Percent(1)	Job openings due to
Personal care	1,190,600	1,771,400	580,800	49	666,000
Home health	875,100	1,299,300	424,200	49	590,700
Medical secre-	525,600	714,900	189,200	36	252,500
Physical thera-	204,200	277,700	73,500	36	123,700
Occupational	113,200	146,100	32,800	29	48,200
Healthcare so-	146,200	185,500	39,200	27	70,200
Licensed practi-	738,400	921,300	182,900	25	363,100
Medical and	315,500	388,800	73,300	23	149,900
Nursing assis-	1,479,800	1,792,000	312,200	21	593,600
Registered	2,711,500	3,238,400	526,800	19	1,052,600

Footnotes:
(1) For all occupations in the economy, employment change is projected to be 11 percent between 2012 and 2022.
(2) Data show job openings projected to arise from both employment growth and the need to replace workers who leave the occupation permanently.

Source: U.S. Bureau of Labor Statistics, Employment Projections program.

Table 5

Universities with Graduate Programs in Health Communication (Graduate Programs In Health Communications**)**

Below is a list of programs, although not comprehensive, that offer graduate degrees in health communication (listed in alphabetic order):

1. Barry University
2. Boston University
3. Chapman University
4. Colorado State University
5. Cornell University
6. East Carolina University
7. Emerson College
8. George Washington University
9. George Mason University
10. IUPUI
11. James Madison University
12. Johns Hopkins University
13. John Hopkins University - Communication
14. Kent State University
15. Michigan State University
16. North Carolina State University
17. Northwestern University
18. Ohio University
19. Penn State University
20. Portland State University
21. Purdue University
22. Rutgers University
23. Texas A&M University
24. The Ohio State University
25. Tufts University
26. University at Albany, SUNY
27. University at Buffalo, SUNY
28. University of Cincinnati
29. University of Florida
30. University of Georgia
31. University of Houston
32. University of Illinois at Urbana-Champaign
33. University of Iowa
34. University of Kentucky
35. University of Maryland
36. University of Memphis
37. University of Miami

38. University of North Carolina - Chapel Hill
39. University of North Carolina - Charlotte
40. University of Oklahoma
41. University of South Carolina
42. University of Texas-Austin
43. University of Utah
44. University of Wisconsin - Madison
45. Western Kentucky University

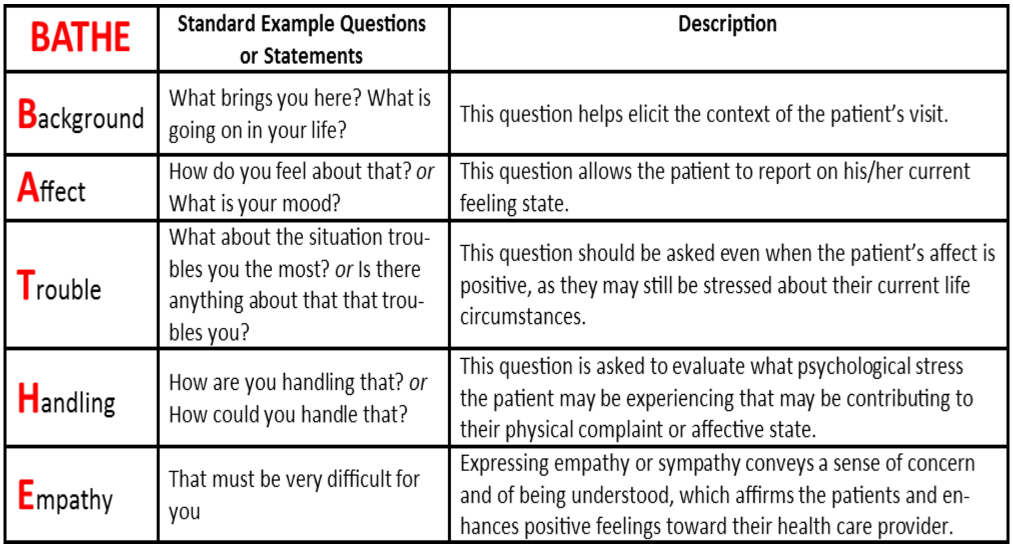
Table 6

Barriers to Effective Communication in the Healthcare Setting (Du Pré, 2005)

BARRIERS	MANIFESTATION	CONSEQUENCES	WHAT TO DO	WHAT TO SAY
Time is different for patients and providers	*Time for PTS begins at onset of symptoms Time for MDs begins when meeting with pt*	*PT builds up anxiety and apprehension*	*Be prepared when entering room. Peruse the chart and know the basics.*	*Hello, Mrs. Doe. I'm glad to finally meet you. I understand you have had a severe headache for the past week.*
Managed care imposes time constraints on visit	*MD feels compelled to address only chief complaint*	*PT may have to wait before being seen Both feel rushed and may not allow for disclosure or explanation*	*Treat the patient as though she is your only patient. Apologize for any wait time.*	*I'm sorry if you had to wait. We have a solid 15 minutes together this visit so please tell me what's been going on and how I can help you.*
Geography	*PT is unfamiliar/ uncomfortable with surroundings MD is on familiar and comfortable turf*	*Contributes to an "outsider" feeling on pt's part and a feeling of superiority on MD's part*	*Be aware that the patient is unfamiliar ground.*	*This place is a maze! I used to get lost here all the time. If you get confused, just ask any one of us for help.*
Privacy	*Curtains often separate PTs wear flimsy gowns Conversations are overheard*	*PTs feel shy/unlikely to fully disclose MDs can't express emotion*	*Treat the patient as you would anyone in another context. Don't touch without asking permission or announcing your intent to do so.*	*I am going to listen to your heart now and need to lift your shirt a bit. Is that ok? Sorry if my stethoscope is cold!*
Culture	*Taboos and superstitions about symptoms and care*	*PTs may be reluctant to submit to tests or treatment.*	*Explain the reason for any intervention and ask if they have any objections and why. Respect their culture. Know your population and potential obstacles.*	*I understand that it is Friday and you need to get back to your family before sundown. I will do my very best to help.*
Language	*Even when directly translating, meaning can change*	*Gross misunderstanding and miscommunication can result.*	*Use the resources available. Medical interpreters or phone interpreters. To the best of your ability, arrange this prior to meeting the patient.*	*I am sorry my Spanish is not good. I have arranged for an interpreter so we can really understand each other.*
Gender	*Discordance between patient and provider may affect disclosure*	*PTs may be reluctant to discuss intimate details*	*Have another staff member in the room of the same gender as PT*	*Would you like a member of our staff to be in the room during the exam?*

Table 7

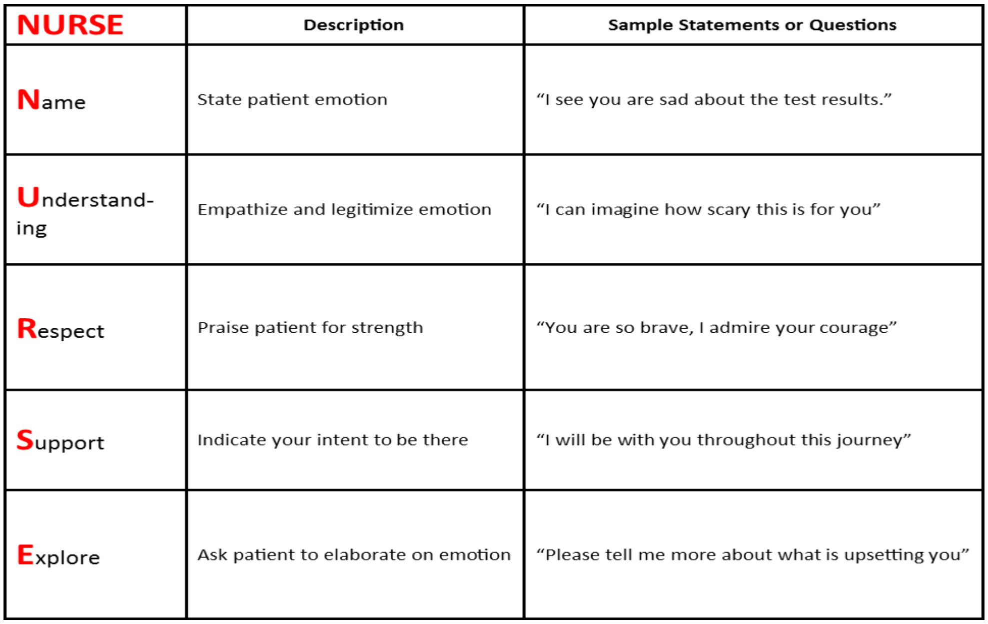
BATHE Protocol for Taking Patient History (Stuart and Lieberman, 1993)



BATHE	**Standard Example Questions or Statements**	**Description**
Background	What brings you here? What is going on in your life?	This question helps elicit the context of the patient's visit.
Affect	How do you feel about that? *or* What is your mood?	This question allows the patient to report on his/her current feeling state.
Trouble	What about the situation troubles you the most? *or* Is there anything about that that troubles you?	This question should be asked even when the patient's affect is positive, as they may still be stressed about their current life circumstances.
Handling	How are you handling that? *or* How could you handle that?	This question is asked to evaluate what psychological stress the patient may be experiencing that may be contributing to their physical complaint or affective state.
Empathy	That must be very difficult for you	Expressing empathy or sympathy conveys a sense of concern and of being understood, which affirms the patients and enhances positive feelings toward their health care provider.

Table 8

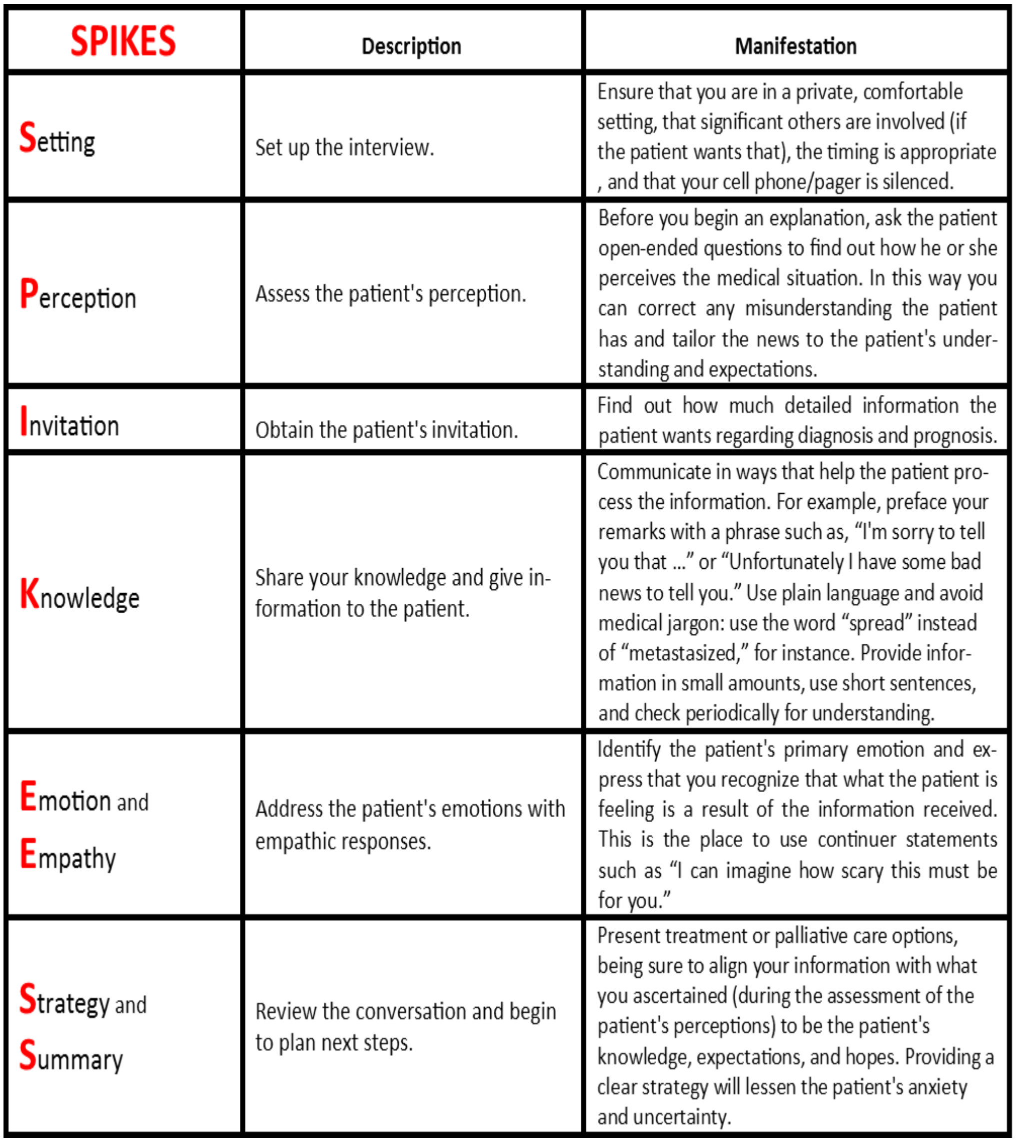
NURSE Protocol for Providing Expressions of Empathy (Journal of Oncology Practice, 2008)



NURSE	**Description**	**Sample Statements or Questions**
Name	State patient emotion	"I see you are sad about the test results."
Understanding	Empathize and legitimize emotion	"I can imagine how scary this is for you"
Respect	Praise patient for strength	"You are so brave, I admire your courage"
Support	Indicate your intent to be there	"I will be with you throughout this journey"
Explore	Ask patient to elaborate on emotion	"Please tell me more about what is upsetting you"

Table 9

SPIKES Protocol for Delivering Bad News
(Baile, WF., Buckman R, Lenzi, R., Glober, G., Beale, EA., & Kudelka, AP. 2000)

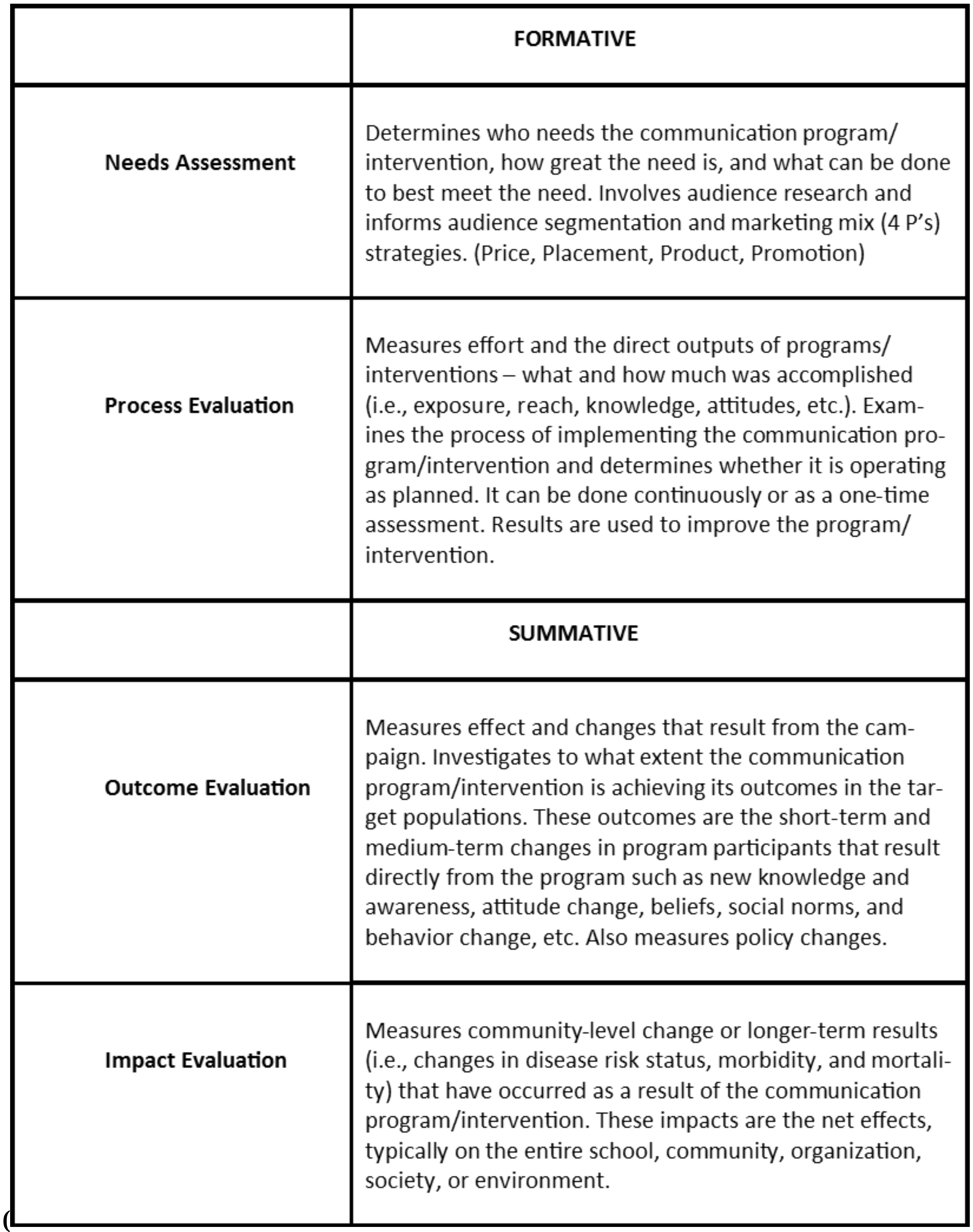


SPIKES	Description	Manifestation
Setting	Set up the interview.	Ensure that you are in a private, comfortable setting, that significant others are involved (if the patient wants that), the timing is appropriate , and that your cell phone/pager is silenced.
Perception	Assess the patient's perception.	Before you begin an explanation, ask the patient open-ended questions to find out how he or she perceives the medical situation. In this way you can correct any misunderstanding the patient has and tailor the news to the patient's understanding and expectations.
Invitation	Obtain the patient's invitation.	Find out how much detailed information the patient wants regarding diagnosis and prognosis.
Knowledge	Share your knowledge and give information to the patient.	Communicate in ways that help the patient process the information. For example, preface your remarks with a phrase such as, "I'm sorry to tell you that ..." or "Unfortunately I have some bad news to tell you." Use plain language and avoid medical jargon: use the word "spread" instead of "metastasized," for instance. Provide information in small amounts, use short sentences, and check periodically for understanding.
Emotion and Empathy	Address the patient's emotions with empathic responses.	Identify the patient's primary emotion and express that you recognize that what the patient is feeling is a result of the information received. This is the place to use continuer statements such as "I can imagine how scary this must be for you."
Strategy and Summary	Review the conversation and begin to plan next steps.	Present treatment or palliative care options, being sure to align your information with what you ascertained (during the assessment of the patient's perceptions) to be the patient's knowledge, expectations, and hopes. Providing a clear strategy will lessen the patient's anxiety and uncertainty.

Table 10

The Types of Evaluation with Formative and Summative

(Evaluation Planning, n.d.)



	FORMATIVE
Needs Assessment	Determines who needs the communication program/ intervention, how great the need is, and what can be done to best meet the need. Involves audience research and informs audience segmentation and marketing mix (4 P's) strategies. (Price, Placement, Product, Promotion)
Process Evaluation	Measures effort and the direct outputs of programs/ interventions – what and how much was accomplished (i.e., exposure, reach, knowledge, attitudes, etc.). Examines the process of implementing the communication program/intervention and determines whether it is operating as planned. It can be done continuously or as a one-time assessment. Results are used to improve the program/ intervention.
	SUMMATIVE
Outcome Evaluation	Measures effect and changes that result from the campaign. Investigates to what extent the communication program/intervention is achieving its outcomes in the target populations. These outcomes are the short-term and medium-term changes in program participants that result directly from the program such as new knowledge and awareness, attitude change, beliefs, social norms, and behavior change, etc. Also measures policy changes.
Impact Evaluation	Measures community-level change or longer-term results (i.e., changes in disease risk status, morbidity, and mortality) that have occurred as a result of the communication program/intervention. These impacts are the net effects, typically on the entire school, community, organization, society, or environment.

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Diagrams

Diagram 1

Iterative Process Model (Eisenberg, A., Rosenthal, S., Schlussel, Y., 2015).

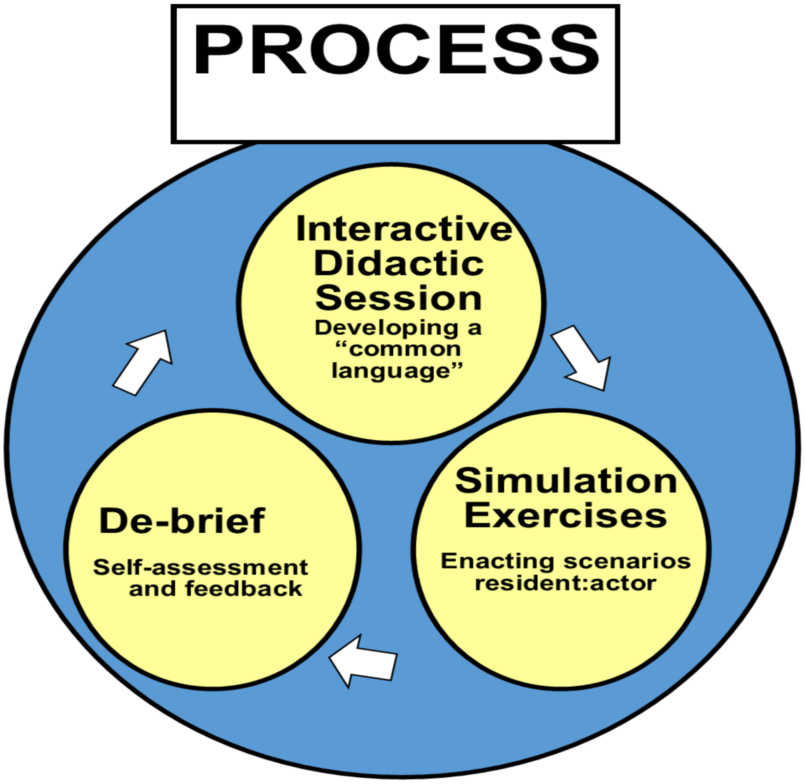


Diagram 2

The Two-step Flow Model (Lazarsfeld, P., Berelson, B., Gaudet, H., 1944)

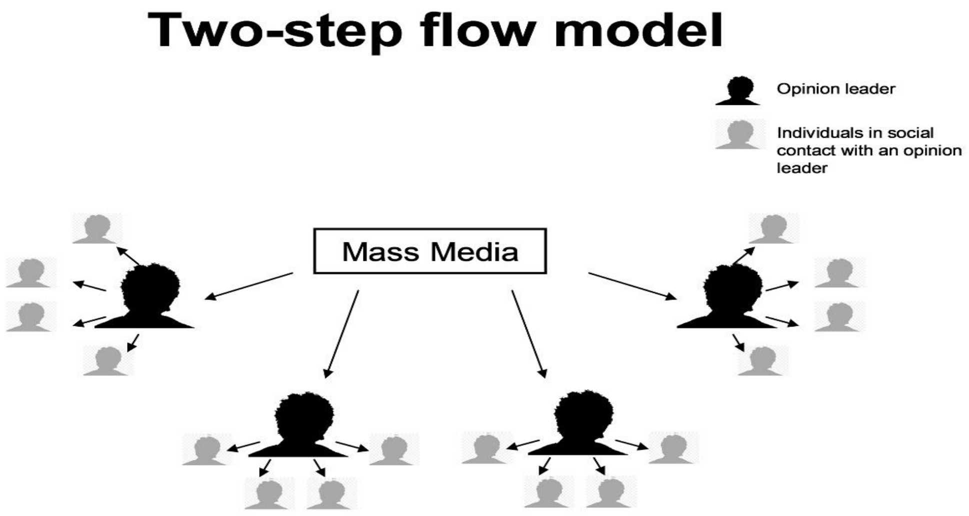
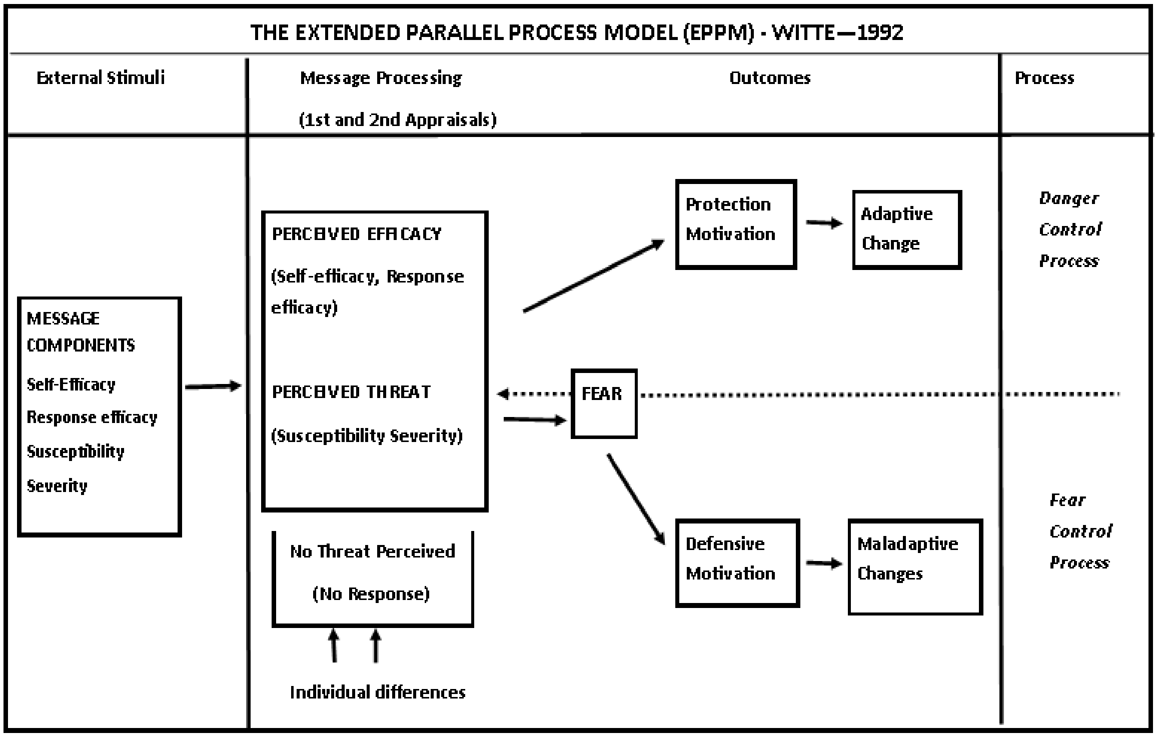


Diagram 3

The Extended Parallel Process Model (Witte, 1992)



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