

Physician and Patient Communication: A Grounded Theory Analysis of Physician and Patient  
Web-Logs

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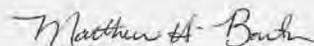
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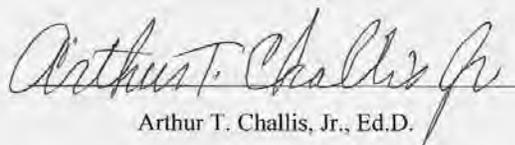
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We certify that we have read this thesis and that, in our opinion, it is satisfactory in scope  
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**Abstract**

The purpose of this research was to study the web-logs of physicians and patients, to determine the communication habits of both study groups. Published material has focused on the communication skills of doctors; however, with the study of the physician and patient web-logs it is clear that effective communication is the responsibility of both the patient and physician. Using grounded theory and through open, axial and selective coding, six themes were identified during the analysis of physician and patient web-logs. The themes that emerged were: empathy and compassion, third-party involvement, the role of medical schools, the patient hand-off, patient responsibility and physician honesty. The narratives that were shared in web-logs reflected the need that both doctors and patients were equally responsible for the quality and quantity of information exchanged through interpersonal communication. It also became clear that if effective communication did not occur between the physician and the patient, there were mistakes made that resulted in injury or death.

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## Chapter 1: Introduction

The purpose of this study was to examine the narratives of physicians and patients through grounded theory method, discover emergent themes and with those themes, attempt to fill in gaps of knowledge regarding physician/patient communication.

Physicians, who are employed in the health care industry, in hospitals, clinics, nursing homes or other recognized locations, communicate with thousands of patients and family members in the course of their respective careers. Physicians who communicate effectively provide the best medical treatment for patients. According to Fallowfield (2010) good communication can help patients understand complex information; make appropriate choices between treatment options; be more aware of the side-effects and the potential hazards of some procedures; be clearer about likely therapeutic gains and the purpose of treatments and help patients keep to drug regimens and diets.

Physicians who miscommunicate or who do *not* communicate effectively are subject to embarrassment and loss of professional image. According to Waxman (2009), the decision to disclose medical errors is one that causes many providers a great deal of anxiety. In some cases, poor communication is the precursor to a medical malpractice suit, filed against a physician, who used poor communication while practicing medicine. Hochman, Itzhak, Mankuta and Vinker (2008), make a connection between communication and malpractice suits, they write: “Good communication skills are in positive association with reduced malpractice claims among primary care physicians and surgeons—an extreme manifestation of patient dissatisfaction” (p. 880). However, if a medical mistake has been made, effective communication can be used to resolve the situation. Waxman (2009) states that most patients and families will be more likely to move past their anger and on to forgiveness if the physician is honest and up front.

The purpose and reasoning for this thesis is to identify themes and patterns of communication between physicians and patients, as demonstrated by the use of physician and patient web-logs or blogs. Physicians use verbal and non-verbal communication on a daily basis with patients, nurses, and staff members. In the course of a day, effective communication practiced by a physician increases the chances of good, medical treatment. Miscommunication by physicians also occurs, resulting in medical mistakes that could have been avoided. I have found that in the process of analyzing the patient and physician web-logs, that these web-logs enable both doctors and patients to be candid and truthful, as they discuss the dos and don'ts of communicative behavior between physician and patient. I have also noticed that web-logs enable doctors and patients to write powerful and thought provoking narratives that strike an emotional chord in the reader.

It will be detailed in the chapters of this thesis, that in the context of a physician's day-to-day duties, there are themes and patterns (as revealed through Grounded Theory) of what constitutes effective communication. This thesis will use grounded theory to identify themes and patterns of communicative behavior as practiced by both doctors and patients. This will be done by examining a sample of web-logs, looking for threads of commonality in any of the narratives given in the web-logs. Then, once these commonalities, patterns or themes are identified, I will look for themes that reappear or repeat and use these themes as part of the analysis.

This thesis will outline the communication habits of physicians and patients, as described in some detail by scholarly researchers in chapter 2—the Literature Review. Then, in chapter 3, I will discuss the method used to analyze the raw data—the method being grounded theory. Chapter 4 will constitute the analysis and application found in the doctor and patient web-logs. Then, in chapter 5, an analysis will be provided and suggests that the issue of patient and physician communication is not only an important topic of research to academic scholars, but

communication is also an important topic of discussion with actual doctors and patients, via the Internet and web-logs. The goal being: To identify themes or patterns that can shed light on the doctor/patient relationship in the context of interpersonal communication.

There is a connection between ineffective communication and lawsuits. According to Noland and Carl (2006) losses, due to medical malpractice have increased and research suggests that practicing physicians do not have the communication skills needed to decrease malpractice litigation. Noland and Carl (2006) also state that when a patient decides to file a lawsuit against a physician, it is because there was a lack of effective communication. This thesis will attempt to make a connection between effective physician communication and good medical care received by patients. Based on published research, medical errors and many lawsuits are the result of ineffective communication. The thesis will attempt to demonstrate that effective communication leads to positive treatment outcomes. This thesis will attempt to build a bridge of understanding--connecting effective and ineffective physician communication on one side and the consequences of both types of communication on the other side.

### **The Scope of Communication Problem**

To introduce the scope of the problem, the following report was issued by the Institute of Medicine (IOM). According to the IOM which advises the government on health care policy, errors made by hospital staff kill up to 100,000 people each year and injure roughly a half-million more (Consumer Reports, 2005). According to *Consumer Reports* (2005) miscommunication is responsible, in part, for these medical errors. Miscommunication not only makes patients feel helpless, but also contributes to errors with prescriptions and errors made while performing medical tests (Consumer Reports, 2005).

Medical errors that are the result of miscommunication have a range of consequences, from a simple misunderstanding to a fatality. According to Robinson, Gorman, Slimmer, and

Yudkowsky (2010), medical errors that are the result of poor communication result in “...significant patient mortality” (p. 206). Miscommunication in medicine, and the effects thereof, are not limited to the serious injury or death of a patient. If miscommunication is connected to an injury or death, the result in some cases, is a medical malpractice lawsuit. According to Waxman (2009), when there are breakdowns in communication, these breakdowns “...lead to upset patients at one end of the spectrum and malpractice claims at the other” (p. 37). Hochman et al. (2008), make a connection between communication and malpractice suits. They write: “Good communication skills are in positive association with reduced malpractice claims among primary care physicians and surgeons—an extreme manifestation of patient dissatisfaction” (p. 880).

Some researchers have argued that physician miscommunication starts in medical school and continues when residents start practicing medicine as resident physicians. According to Arnold (2003), fewer than 10% of medical schools have an integrated four-year curriculum in doctor-patient communication (Arnold, 2003, p. 190). According to Arnold, it also appears that teaching students about effective communication is not a high priority for medical schools.

### **The Need for Research**

Over the years, researchers have evaluated the role of physician communication in medicine, and have found the need to conduct research in this area. Research demonstrates that as communication quality decreases, medical error increases. Numerous studies have found the necessity of effective communication is supported by data, showing an association between poor communication and medical errors (Alvarez & Coiera, 2006; Gandi, 2005; Gawande, Zinner, Studdert, & Brennan, 2003; Sutcliffe, Lewston, & Rosenthal, 2004). Some studies have documented the importance of effective communication, showing a correlation between poor communication and medical errors. According to Hendel and Flanagan (2009), there is evidence demonstrating a relationship between system errors, breakdowns in communication and adverse

patient events (p. 847). Hendel and Flanagan (2009), based their findings on the case of a 51-year-old patient, who was given three times the intended dose of intravenous human immunoglobulin. The error went unnoticed for seven hours and was the result of a series of communication breakdowns by key staff members. Fortunately the patient survived. They found that part of the communication problem was the use of abbreviations and acronyms that were not universally understood by the key medical staff previously mentioned. For example, the abbreviations IV1g, IVIG, and Intragam were all used interchangeably to describe what was actually meant to be 10 g in 200 ml formulation of Intravenous Human Immunoglobulin (marked as Octagam). Hendel and Flanagan (2009) explained that nowhere in the medical records were these non-standard abbreviations explained.

Hendel and Flanagan (2009), in the context of this case, also determined there was a problem with the acronyms that were used in the medical treatment. Hendel and Flanagan (2009) state that APP is not a widely accepted acronym on drug charts. Hendel and Flanagan (2009) state that APP was most likely intended to mean as per protocol, which would be applicable in an Intensive Care Unit, but APP could also mean as per plan. They determined that the use of acronyms is acceptable if it can be assured that all involved in their use have a shared understanding of their meaning. This problem with the use of abbreviations and acronyms is not only common in medicine; there are businesses and other organizations that use abbreviations and acronyms, and these businesses and organizations do so for the sake of brevity, but at the expense of clarity (Strunk & White, 2000, p. 80).

### **Why Study Communication in Medicine?**

In the field of medicine, researchers, imbedded in the health care industry, state that when it comes to the doctor-patient relationship, communication is essential to good, medical care (Arnold, 2003, p. 189). Consider the following: A doctor will speak with more than 200,000

patients in his or her lifetime and a doctor will communicate with patients more than he or she will prescribe medications, give shots or perform any other professional activity (Arnold, 2003, p. 189). Therefore, a focus on how a physician communicates with his or her patients is crucial. According to Arnold (2003), effective communication is correlated with improved patient satisfaction, understanding, and adherence to a physician's instructions. Studies have shown that effective communication leads to improved patient outcomes and decreased malpractice claims (Arnold, 2003, p. 189). Indeed, effective communication given by doctors and received by patients, benefits everyone involved.

Good communication, practiced by doctors includes non-verbal communication. Cooper (1979) has studied this branch of interpersonal communication and has found that issues such as spatial orientation, posture, facial expressions and overall body language are worthy of serious study. The findings of Cooper (1979) will be mentioned more extensively in the literature review.

Effective communication is a priority to professional medical societies. The Accredited Counsel for Graduate Medical Education lists communication as a basic skill for all resident doctors (Arnold, 2003, p. 189). Arnold (2003) states that the American Board of Internal Medicine stresses the use of effective communication and a recent article from the American Academy of Hospice and Palliative Medicine stated communication as a "critical skill" (p. 189).

Despite what these, and subsequent studies have shown, the teaching of effective communication skills has largely been ignored (Arnold, 2003, p. 189). According to Arnold (2003), medical students spend hundreds of hours studying biochemical and historic facts, of which they will never use. Few, if any schools, spend any time teaching the basic science of communication. Physicians do not understand the power of words (Arnold, 2003, p. 189). The dilemma, according to Arnold (2003), is that medical schools are not teaching communication skills to students. Arnold (2003) asks: "Why shouldn't schools include 10 hours in the first year

of learning the basic science of communication?” (p. 189). With such training, medical students will communicate better with patients, other physicians and hospital administrators (Arnold, 2003, p. 189). Arnold (2003) is one of the few scholarly articles that have addressed medical schools and their role in teaching communication skills to medical students. However, more recent research has determined that medical schools have recognized the need for communication training in their curriculum. According to Leigh (2013), Virginia Tech Carilion, located in Roanoke, Virginia, is one of the newest US medical schools. This medical school has added a communication component to their admission interview process. Great grades alone will not prepare prospective students for this part of the interview process; great people skills are needed. The recent findings regarding medical schools and what they are doing with communication will be discussed in chapter 4.

In aviation, the (PIC) or pilot-in-command has the last word--is the final authority of and is ultimately responsible for the operation of the aircraft, according to federal aviation administration rules. The role of the medical practitioner or medical doctor is no different. It is the physician who conducts the first in-depth patient interview. It is the physician who makes the diagnoses, writes the prescriptions and advises the patient as to the best and most up-to-date treatment options. The concept of responsibility is summed up by a licensed, practicing physician. Dr. Steve Waxman states, “...the physician is ultimately responsible” (Waxman 2009).

Chapter two will provide a literature review of the different areas of physician communication research that have been conducted. The literature review will attempt to summarize and synthesize the applicable findings, discovered by researchers, as early as 1979 and as recent as 2011, from both outside and inside the medical community. The literature review will also include recent information regarding web-logs and their use for this thesis. With the advent

of social media and the potential it has for communication, web-logs will be used as the basis for the original research.

A very brief review of the Hippocratic Oath will be included at this point. The Hippocratic Oath is an oath students swear to abide by once they graduate from medical school. Because, changes have been made to the oath that *may* have an influence on physician communication. In brief, the Hippocratic Oath was originally written in the 5<sup>th</sup> century B.C. and was rewritten in 1964 and the contents of the 1964 version and other versions have disregarded many of the tenants of the original 5<sup>th</sup> century oath. The reasons there were changes in the oath, stems from the need of current medical associations to have an oath that can be adapted by nurses, paramedics and other health professionals. For example, the British Medical Association in March of 1997 states that, “The Oath,” is a set of ethical principles derived from the writings of the ancient Greek physician Hippocrates, has been updated to put patients first. The revised oath aims to be a unifying force, superseding national, ethnic, religious and cultural boundaries by focusing on widely shared values. The Hippocratic Oath has been changed, but whether the changes in the oath have changed physician communication is yet unknown. I have included a copy of the Hippocratic Oath (both the “classical” version and the “modern” version) in Appendix A and Appendix B of this thesis for comparison purposes. I would like to point out (in the context of treating patients) that the original Hippocratic Oath contains the words “I will keep them from harm...” However, in the modern version of the oath the words “I will keep them from harm...” is nowhere to be found.

### **The Use of Web-Logs**

Web-logs or online journals will be used as the source of original research. Web-logs or online journals are an ideal medium for this study because web-logs allow anyone with Internet access to post comments and read what others have commented. This thesis attempted to use web-logs to dig down, as opposed to digging out, in uncovering information that may be useful to the

reader. As web-logs are analyzed, I will focus on how they are used as a communication medium by doctors and patients—as these doctors and patients discuss certain serious medical conditions and treatments.

For example, instead of looking at web-logs that address the effects and treatment of arthritis, or the proper use of the medication Zantac, the web-logs chosen for this study will focus on the doctor-patient communication regarding medically-related issues such as heart bypass surgeries, brain aneurisms, or some other serious medical condition. I believe that if I focus on 30 web-logs (15 physician related and 15 patient related) that deal specially with a specific serious medical condition, rich and informative dialogue will be found.

Web-logs have several advantages, over interviews. Web-logs are void of the power imbalance that can exist between an interviewer and an interviewee. Web-logs also allow a person to post a comment at a time and place of their choosing, and people are not under pressure to answer the questions of an interviewer. In addition, those who choose to post web-log comments can remain anonymous; this allows commenters to be completely honest, without fear of retaliation.

According to Mostaghimi and Crotty (2011) physicians, like other professionals, are expanding their use of resources that are Internet-based, while at the same time, physicians are developing their individual digital lives by sharing thoughts, journals, and media online. Siegert (2005) gives an informative overview of what web-logs are, how web-logs are used and have grown in use over the years. According to Siegert (2005), a web-log (or 'blog') is a web-based form of communication that consists of periodic articles, ranging in scope from personal journals to corporate or political opinions and even news. Web-logs can range in scale from the writing of one author to the writing of a number of writers (Siegert, 2005, p. 130).

The use of web-logs will be the key element, in terms of original research needed for this thesis. According to Siegert (2005) many web-logs allow others to leave public comments, which in turn, can create a group of readers. The journal format of web-logs helps authors reflect on how their position on an idea evolves and the journal format makes it easier to read large collections of entries at one time, so readers do not have to check back every day (Siegert, 2005, p. 130). The use of web-logs is important because of the transparency afforded by those who use them. Web-logs allow writers to reflect on what they have written. I have noticed that when a doctor or patient has blogged about subjects such as cancer or honesty, those comments are read and supplemented by additional comments from the original blogger. Then, as the comments are read by others, additional bloggers join the online conversation. In essence, a well-placed comment about an emotionally charged topic such as cancer, on a web-blog, can produce a wide variety of opinions.

Mehta (2007) states that web-logs constitute an emerging public domain space that permits the free expression for individuals and allows the public access to the same information (p. 422). According to Mehta (2007) “Blogs are an example of ‘social software’ that allows interaction of the patient with family and friends and creates a sense of a larger community” (p. 422). Mehta (2007) states that physicians may benefit by being able to monitor progress and tailor therapy via web-logs. Web-logs are accessible to everyone—giving all who may have a concern, to state their concerns in a public forum, and these concerns could solicit the help from patients, doctors and other health care professionals. The use of web-logs allows users to openly express their opinions, in an environment where the information is free and accessible. Caution should be exercised, and assumptions should be avoided, where web-logs are concerned. Web-logs are used by those who have access to a computer and to the World Wide Web. Computers and the Internet are used by those who are computer literate; therefore, these individuals have more access to web-logs.

According to Mehta (2007) all of the web-logs written in Mehta's study were written by younger, computer literate patients within developed countries.

Siegert (2005) explains how diverse and abundant web-logs have become. According to Siegert (2005), there are an abundance of rich and vibrant web-logs for news, medicine, science, literature, religion, politics and corporate life. More than nine million web-logs exist currently, with a new web-log being created every 7.4 seconds. One reason that web-logs have grown so dramatically is the fact that there has been a proliferation of web-log technology, in the form of increased simplicity (Siegert, 2005, p. 130). Siegert (2005) further explains, that the primary motivation for many bloggers is the desire to create a place for people to share ideas, and researchers are finding that web-logs can be used to record the development of ideas, increase the flow of information and provide inspiration for new ideas and directions. A particular benefit to physicians is the aspect of peer-reviewed web-log journals. Electronic journals or 'e-journals', such as the Public Library of Science ([www.plos.org](http://www.plos.org)), streamline the peer-review and publication process (Siegert, 2005, p. 130). Siegert (2005) states that web-logs are becoming a valuable and growing tool for not only the public, but also those professionals and researchers that wish to be informed of recent developments in their respective fields.

Doctors are also concerned about what patients are saying about them via social media. Web-logs are an economical vehicle for doctors because, through the use of web-logs, doctors can subscribe to electronic or e-journals, which are offered at little or no cost, as opposed to material in nationally recognized and published medical journals, which have expensive subscription costs. Through the use of web-logs, physicians can read what their patients are saying in real-time, but they can also read what other physicians are discovering in the field of medicine.

The use of electronic journals are a benefit to the international medical community by improving information access for all physicians, and healthcare professionals. This faster and

improved access increases the overall efficiency and quality of research. Electronic journals allow physicians and researchers to consult with their colleagues as they pursue their work, and this will avoid costly mistakes and strengthen their line of inquiry by addressing online criticisms (Siegert, 2005, p. 130). The access to e-journals provides current research findings to the public. These e-journals have been an added benefit in helping people become better informed and more literate concerning medical matters (Siegert, 2005, p. 130). Therefore, I will examine the use of web-logs as communication tools, by physicians, patients and other health care professionals.

Chapter 3 will explain the research method used to analyze the research findings. A grounded theory approach will be used to determine themes, patterns and common categories, (Babbie, 2010) that were extracted from the data provided. The grounded theory method was developed by Anselm L. Strauss, a pioneer qualitative researcher and principle founder of the grounded theory method (Babbie, 2010). Chapter 4 will discuss, interpret and explain the results of the analysis and why the findings are important. Chapter 5 will conclude this thesis by explaining the importance of the results, the implications of the findings, the limitations of the study and the directions for future research to pursue.

The overall goal is to fill a gap of knowledge regarding effective and non-effective communication practices by licensed physicians, this in turn will help doctors communicate better, save lives and avoid embarrassing and costly lawsuits. I will attempt to contribute to the ongoing body of knowledge about patient-provider interaction, by analyzing comments posted on web-logs or blogs, by physicians, patients and other health care professionals. I will attempt to demonstrate that physicians use web-logs to monitor the progress, evaluate the therapy, and view comments about themselves, concerning patients under their direct care. I believe, that patients use web-logs to solicit the opinions and experiences (recorded as comments which are accessible to the public on social media) of others who may be suffering from a particular disease or injury.

I will attempt to show that patients use web-logs to become more medically literate and in the process of becoming more medically literate, patients can evaluate their doctor's medical practices to determine if they are receiving the best medical attention possible. I will identify themes and patterns of effective, non-effective communication; determine what constitutes good and bad communication; discuss what medical schools can do to teach their students communication skills; demonstrate how issues such as interpersonal relationships, management hierarchy and human factors play an influence on physician communication.

## **Chapter 2: Literature Review**

In the introduction, the theme of physician communication (effective or ineffective) was briefly reviewed. This chapter will review some of the research performed regarding physician communication. The Literature Review will be divided into six sections: Physician verbal and nonverbal communication, physician disclosure, effective communication, non-effective communication, medical schools, e-mails and web-logs. This chapter will include the rationale for this thesis and research questions I seek to answer.

This chapter gives an overview of the research that has been conducted by a variety of researchers regarding the verbal and non-verbal communication practices of licensed physicians. The research findings will show that there are various environmental and personal factors that have an influence on the daily communicative behaviors of practicing physicians. This chapter will also show the role medical schools play in physician communication. And, this chapter will explain what web-logs are, how web-logs have been used in previous studies and how web-logs will be used in this study.

### **Physician Verbal and Non-Verbal Communication**

In the context of physician communication, the research exposes many issues. One such issue is that of the doctor/patient interview. The first interview can either make or break the doctor/patient relationship. Researchers have found that patients were less satisfied with the doctor, when the doctor dominated the interview (Hochman, Itzhak, Mankuta, & Vinker, 2008). Patients have pre-determined expectations regarding the conduct of the doctor (Hochman et al., 2008). According to *Review of Optometry* (2007) 78% of patients want to shake the hand of their physician, 50% of patients want their first name used in conversation, 56.4% want to know their doctor's first name as well, only 7.2% want to use their doctor's first name only. In addition, physicians should be encouraged to shake hands with patients but remain sensitive to nonverbal

cues that might indicate whether patients are open to this behavior (Review of Optometry, 2007). The use of questions by a doctor is an important element in interpersonal communication. When a doctor has his or her first initial interview with a new patient, the physician's use of questions can aid in the "free flow of information" from patient to doctor (Osborne & Ulrich, 2008, p. 12). Osborne and Ulrich (2008) have determined that after a doctor uses open-ended questions, he or she can transition to close-ended questions, which are used to summarize the patient's concerns in such a way that the physician understands what is communicated.

Osborne and Ulrich (2008) also suggest that at the beginning of a new patient interview, the physician could use open ended questions such as, "Tell me more," or "Then what happened?" As the interview progresses, the doctors can transition to close-ended questions. The objective of the close-ended questions is "...to paraphrase or summarize the client's concerns in such a way that they will recognize that we empathically understand them" (Osborne & Ulrich, 2008, p. 12). Fry and Mumford (2011) point out, "Questioning, is not just summarizing, as a means of showing/checking understanding" (p. 184). The manner in which the patient speaks is also important and a good doctor should be able to interpret the meanings and feelings behind the words. Arnold (2003) emphasizes that how the patient verbally communicates is just as important as the actual words that are spoken by the patient. Arnold (2003) describes how the clinical implications of tone, speech rate, pitch, volume, articulation and word choice all convey meaning. Arnold (2003) also states that "controlled" anger is conveyed by a slow speech rate, slow pitch and frequent pausing. Indeed, a patient's use of tone and speech rate should give a doctor an idea of what the patient is feeling.

Non-verbal communication is also important in the context of the doctor/patient relationship. Cooper (1979) looked at spatial orientation, in connection with non-verbal communication as research material. According to Cooper (1979), physicians show their respect

for the patient's personal space by knocking on the door or announcing their presence before opening a curtain or simply greeting the patient before approaching them. He also mentions that a doctor or nurse should vary the distance they are from the patient, he states: "Some conversations with patients... would produce very different results if the distance zones were understood" (p. 116). Cooper (1979) states, "According to psychologists, each of us thinks of the space around us as an extension of our bodies. The space serves as a buffer zone between us and other people, and we may grow uncomfortable or resentful when others intrude in it" (p. 116). This researcher also states, "The size of the personal space varies, but you can often pick out a rough boundary line by noting where the patient has placed his personal belongings" (p. 116).

Cooper (1979) also suggests in order to relieve a patient's anxiety, physicians and nurses can sit down where the patient can see them. He suggests that physicians lean forward while the patient is speaking, thus communicating to the patient that what the patient is saying is important. He also studied the roles of varied hospital staff and shared his findings of how hospital staff used the interpretation of non-verbal communication as a way to treat patients. For example, one staff member spoke about how children communicate effectively, through body language (Cooper, 1979, p. 114). He continues by stating that children "...learn the posture that communicates pain—muscle rigidity, facial contortions, crying, and restlessness—and they may use that same posture to convey all their needs, once they find out that their nurses react to it quickly" (p. 114). According to Osborne and Ulrich (2008) non-verbal factors such as body position, facial expression and personal appearance are key components when a doctor is listening to his or her patient. They insist that facial expressions can reflect how a physician is interpreting the information they are receiving. These researchers say, "Our face often reflects how we feel...without a word spoken, our face can convey indifference, disgust, perplexity, amazement or delight" (p. 12). Osborne and Ulrich (2008) recommend the use of the "...warm smile," which

tells others we feel kindly toward them. Osborne and Ulrich (2008) go a little deeper in the understanding of facial cues when they address the issue of eyes and what role(s) the eyes play in that first doctor/patient interview.

Osborne and Ulrich (2008) add that the eyebrows, along with the eyes, both communicate attitudes such as surprise, compassion, fear, doubt or dislike. They state: “Maintaining friendly eye contact with others often promotes trust. On the other hand, our clients may doubt our sincerity or competence if we avoid respectful eye contact during conversation” (p. 12). Fry and Mumford (2011) have also addressed the role of eye contact and the use of language, as used by a physician. They say: “Simply slowing down their speech and maintaining good eye contact significantly improved understanding” (p. 183) and for understanding to occur the art of listening is essential for both doctors and patients.

Researchers who have studied physician communication believe that listening is also important. According to Osborne and Ulrich (2008), “Effective communication involves more than just mastering speech. It is vitally linked to our desire and ability to listen” (p. 10). These researchers also say that “...the first step in collecting diagnostic information typically begins with listening to our clients concerns” (p. 10). They also mention that good listening skills are not only essential to receive accurate information, but empathic listening conveys our interest in the overall well-being of the patient.

Osborne and Ulrich (2008) argue that when physicians listen it can be for two primary reasons. First, physicians listen with the intent to render a reply. The second reason, to provide responses that convey the physician’s point of view about clients concerns (Osborne & Ulrich, 2008, p. 10). When physicians are listening to patients, it is important not to interrupt, unless there is a good reason for the interruption. Osborne and Ulrich (2008) explain that the act of interrupting someone while talking is considered to be a barrier to good communication. They

found that physicians interrupted 69 percent of their patients before they could complete their opening statements and once interrupted, fewer than two percent of patients went on to complete their statements. Effective listening is empathic listening and empathic listening shows the patient that the doctor is concerned about the patient's well-being. (Osborne & Ulrich, 2010, p. 12).

There are barriers to good physician/patient communication and these barriers can cause problems, which in turn can lead to a lawsuit. Waxman (2009) states, with the advent of electronic charting, the physician or assistant may face the keyboard to input data rather than look the patient in the eye to obtain his or her history...this degrades the physician-patient relationship, and it also results in sub-optimal interpersonal communication, where important facts may be missed. According to Waxman (2009), when there are breakdowns in communication they "...lead to upset patients at one end of the spectrum and malpractice claims at the other" (p. 37). Hochman et al. (2008), state "Good communication skills are in positive association with reduced malpractice claims among primary care physicians and surgeons—an extreme manifestation of patient dissatisfaction" (p. 880).

If a doctor has made a mistake when treating a patient, it has been found that communication does indeed have a role to play in the outcome. According to Waxman (2009), the disclosure of medical errors or medical mistakes causes health care providers a great deal of anxiety. Waxman (2009) states, medical errors should be reported to the risk management office of the physician's respective health care organization and then the physician needs to decide whether to disclose error(s) to patients and/or family members (p. 37). He also says that if physicians have a good relationship with their patients and they can level with them if mistakes have been made. Most patients and their families are more likely to move past their anger and forgive, if the physician is honest and up front about a medical mistake (Waxman, 2009, p. 37). However, when physicians admit to mistakes when confronted by patients, hospitals, or licensing

boards, physicians are seen as arrogant, deceptive and unprofessional (Waxman, 2009, p. 37). According to Waxman (2009) the following adage is true, “A patient is less likely to sue a physician he likes” (p. 37).

Effective and ineffective communication can take many forms. These previously mentioned researchers have examined issues such as the doctor/patient interview, asking questions, interpreting non-verbal communication signals and listening. It has become increasingly evident, by examining the literature, that effective communication is a shared responsibility or partnership between physicians *and* patients.

### **Physician Disclosure**

Physician disclosure has also been the topic of research regarding doctor/patient interaction. Beach, Roter, Larson, Levinson, Ford and Frankel (2004), define physician disclosure as “Statements which describe the physician’s personal experience in areas which have medical and/or emotional relevance for the patient” (p. 912). Beach et al., (2004) explain the physician disclosure is a controversial communication behavior, which has been labeled as a form of boundary violation. Beach et al., (2004) explain that disclosure is a “slippery slope” toward a sexual relationship with a patient. It was also found that high self-disclosure is protective, whereas low self-disclosure increases the risk of medical malpractice (Beach et al., 2004, p. 911).

In one study, researchers found that patients were not interested in their doctor’s personal experiences (Review of Optometry, 2007). According to this study, physician self-disclosure occurred in one-third of patient visits and 86% of patients did not feel that the disclosure was helpful (Review of Optometry, 2007). Often the patient thought the physician disclosure was disruptive (Review of Optometry, 2007).

As we consider physician disclosure and determine its boundaries, author Paul Nisselle (2004) found that in frightening situations, such as surgery, patients respond more positively to

self-disclosing paternalistic statements. In one case, a surgeon said, “My brother had this surgery last year and has done very well: If I had your condition, I’d have no hesitation” (Nisselle, 2004, p. 984). Nisselle (2004) argues that this level of disclosure is appropriate, and not a legal issue. Therefore, Nisselle (2004) deemed it appropriate to disclose such a statement, when the object of the physician is to lessen the fear of a surgery patient, by relating a personal experience that is appropriate for the situation.

According to Beach et al., (2004) disclosure by physicians can be assigned to one of the following categories: Reassurance (short), reassurance (long), counseling, rapport (humor), rapport (empathy/legitimation), casual, intimacy (emotional/physical), intimate (relationship), and extended narrative. Examples of these disclosure categories will be given later. The common theme, in the context of physician disclosure, is that physicians can and should disclose, if their aim is to unselfishly relate to a patient, with the sole purpose to comfort the patient. If a physician discloses in order to invite the patient to become the physician’s counselor or therapist, then the disclosure has crossed the line, is inappropriate and unprofessional.

The following is a table which represents samples of physician disclosure statements, provided by Beach et al., (2004) and classified according to the following categories: types of disclosure, the definition of each disclosure statement and an example of each disclosure type.

**Table 2.1**

<b>Type</b>	<b>Definition</b>	<b>Example</b>
Reassurance (short)	A short statement indicating that the physician has personally shared the same experience as the patient.	“I sometimes do that.” “Same thing with me.” “Sure I do. Everyone does.”
Reassurance (long)	A statement providing information about the physician’s personal experience.	“I found that in my knee when I had the same thing happen.”

Counseling	A statement about the physician's personal experience that could guide patient action.	"I just got one. Yeah, and it works pretty well. I think it's a pretty good idea for a knee brace if you're going to ski."
Rapport (humor)	A humorous personal story.	"Like my dad told me, when I was getting on him about smoking when he had the bypass, he said, 'You know I see a lot of old jazz musicians, but I don't see too many old doctors.'" [laughs]
Rapport (empathy/legitimation)	An expression of empathy or legitimation of patient experience.	"They usually give you a little something to help relax you a lit bit. Cause I know I'd be nervous."
Casual	A short statement that has little obvious connection to the patient's condition or state.	(after compliment on sutures) "You know, I was kind of sickly as a child. And my parents, my twin brothers and I, they had us doing embroidery."
Intimacy (emotional/physical)	An intimate emotional or physical revelation.	"I cried a lot with my divorce, too. You know, when our bodies say we need to cry, maybe there's something that needs cleansing."
Intimate (relationship)	Any indication of a desire for a personal relationship with a patient.	"I like to think that my patients are my friends. I like to think that if I happen to run into you here in town. I know who you are."
Extended narrative	A lengthy description of physician's personal experience that has seemingly little relevance for patient.	"Crunches. And what I do...I dedicated myself...if I'm going to watch a basketball game or football game, for one quarter I'm going to do a..."

As can be seen, disclosure statements from physicians can range from the reassurance/disclosure type, to an extended narrative type of disclosure. Nisselle (2004) has determined that medical paternalism has all but disappeared. According to Nisselle (2004), doctors have adopted the other extreme—the doctor who plays the role of technician who provides data, but not advice. Nisselle (2004) further explains that though this role of technician is thought to be safer, in a legal

sense, it not surprising that doctors who care about their patients seek to influence their decisions. Self-disclosure is an important issue for doctors because many believe that self-disclosure is a boundary violation (Nisselle, 2004, p. 984). For example, self-disclosure through empathic validation with statements such as “I’m sure I’d feel just the same if that happened to me” is not a boundary violation, but establishes rapport and builds stronger doctor/patient relationships (Nisselle, 2004, p. 984).

Nisselle (2004) argues that there are situations where physician self-disclosure can be “self-protective” and should be condemned (p. 984). The following would be an example of a self-protective statement, of which should be avoided by doctors: “When I saw your latest cervical cancer smear report I felt bad that you hadn’t taken my advice and returned earlier for a repeat smear” (Nisselle, 2004, p. 984). In addition, Nisselle (2004) states that self-disclosure can also be a boundary violation, if the physician turns the doctor-patient relationship around, and invites the patient to become the doctor’s therapist. The following is an example of such a statement, “I know; I have the same problem myself. What are you doing for it?” (Nisselle, 2004, p. 984). The following statement would also be considered a boundary violation, “I really understand how you feel—I’ve been very lonely since my divorce” (Nisselle, 2004, p. 984).

Nisselle (2004) relates the following narrative how physician self-disclosure can substantially reduce patient anxiety. Nisselle (2004) said:

When I was in family practice in suburban Melbourne, Australia, a single mother came in with a 1-week-old baby who clearly had what we were then allowed to call “colic.” The young mother was beside herself with anxiety. I had photos of my children in the desk. I pointed to one of my daughters, then aged in her mid-teens, and said, “I know how distressing this is for you—she had colic for the first four weeks of her life.” The young mother’s relief was almost palpable. I could see her thinking, “If ‘The Doctor’ and his

wife had trouble coping with their baby's colic, then maybe I'm not a bad mother" (p. 984).

Nisselle (2004) says that the Spin Meister is king (p. 984). Nisselle (2004) states, "Physician self-disclosure can be used both positively and negatively in the doctor-patient relationship. Like any 'drug,' it should be used carefully, consciously, and always transparently in the patient's best interest, not the physician's self-interest" (p. 984). In the next section, we will discuss the role of effective communication in medicine.

Physician disclosure has its merits and if used appropriately can enhance the communication between the doctor and the patient. Physician disclosure is obviously a skill that the physician can practice and appropriate disclosure can strengthen the doctor/patient relationship.

### **Effective Communication**

What does constitute good and effective communication and what are the results? A group of researchers traveled outside the United States for answers. They studied the medical practices of Israel's Navy. These researchers found there to be a correlation between effective communication and good medical care. According to Hochman, Itzhak, Mankuta and Vinker, (2008) the "Patient's perception of physician communication skills was more likely associated with patient satisfaction than with documentation" (p. 880). According to Hochman et al. (2008) patients considered communication to be of the top three competencies for doctors to possess (p. 880). Communication problems with physicians, is a major factor when a patient switches from one doctor to another (Hochman et al., 2008, p. 880). They also state that good communication skills are in positive association with reduced malpractice claims among primary care physicians and surgeons.

Robinson, Gorman, Slimmer and Yudkowsky (2010) have also looked into effective communication in the practice of medicine. They discovered five themes when they conducted a focus group study. The following themes associated with effective communication were discovered by Robinson et al. (2010), they were: “Clarity and precision of message that relies on verification; collaborative problem solving; calm and supportive demeanor under stress; maintenance of mutual respect and authentic understanding of the unique role” (p. 209). Clarity and precision were desired by the participants because, as Robinson et al. (2010) wrote “the most common theme expressed by participants was a need for straightforward unambiguous communication” (p. 210). Robinson et al. (2010) give an example of clarity and precision, “I think you have got to be...clear, and time is of the essence” (p. 210). They also say that effective communication was enhanced when participants were confident that what was being heard or said was accurate” (p. 209). Based on the themes identified by these researchers, it is clear that doctors have the responsibility to ensure that everyone is on the same page and that everyone involved in a patient's treatment understand what needs to be done.

Robinson et al. (2010) identified another theme, collaborative problem solving. Robinson et al. (2010) state: “Participants felt that effective communication included coming together to problem solve as a team” (p. 210). According to Robinson et al. (2010) collaborative problem solving included teamwork and where everyone was “...on the same page” (p. 210). The next theme identified by Robinson et al. (2010) was a calm and supportive demeanor under stress (p. 211). Being calm and supportive was important to participants—many participants mentioned the need for calm communication which included “attention to a collegial tone and normal volume” (Robinson et al., 2010, p. 211). These researchers emphasize the need for physicians to really be careful with how they speak.

Robinson et al. (2010) share the following quote—stressing the importance of calm communication, “And it looked like we knew we were not going to be able to have a positive outcome in this situation, but the doctor was calm” (p. 211). Effective communication is not just when someone is being told what they are doing wrong, but like children, adults need to be told what they are doing right. Physicians have the authority and can use the respect they have earned to lift others up, via positive reinforcement. Robinson et al. (2010) found this recognition of good behavior, as part of effective communication when the study participants stated “It is important to let the other staff know that they have indeed done what was expected of them and provide them with positive reinforcement” (p. 211). The next theme identified by Robinson et al. (2010), was maintenance of mutual respect (p. 211). According to Robinson et al. (2010) the elements of trust and respect were key to effective communication. One of the participants stated, “The point of communication is that they will talk to you...that you can express your sense of humor and that was probably the most important thing anybody told me...” (p. 211). Physicians can play the role of a calm administrator—setting the tone for any given doctor/patient interaction.

The last theme identified by Robinson et al. (2010) is the authentic understanding of the unique professional. According to these researchers, nurses were particularly vocal in the context of the authentic understanding theme. For example, one nurse stated “I think one of the problems is that most doctors have no idea what nurses actually do...” (Robinson et al., 2010, p. 211).

I have discussed the role of verbal and non-verbal communication, physician disclosure and effective communication. These points have been mentioned to draw attention the role doctors play in the communication relationship. I believe it is necessary for doctors to incorporate some aspects of effective verbal and non-verbal communication and disclosure, in order to practice medicine that produces the best results. In the following section I will discuss medical

errors. I will explain why they are included in the study of doctor/patient communication and why addressing errors is so important.

### **Medical Errors and Communication**

Waxman (2009) says that a malpractice suit prevents physicians from disclosing a medical error. He mentions that breakdowns in communication do occur at many levels. In the context of breakdowns in communication—the use of electronics has been shown to be a hindrance.

Waxman (2009) said “Health care providers relay information to each other via oral, written, and electronic means. It is up to the provider, to ensure that information is properly and accurately sent and received” (p. 34). Sutcliffe, Lewton and Rosenthal (2004) have also performed research on medical errors and have determined that the relationship between doctors, nurses and other medical staff does have an influence on medical errors.

A study conducted by Sutcliffe, Lewton and Rosenthal (2004) involved interviewing medical residents about their routine work activities, medical mishaps and the influence of their employers (p.1). Sutcliffe, Lewton and Rosenthal (2004) reported that 70 mishap incidents occurred and that aspects of communication were a common and contributing factor. They determined with the interviews that residents were embedded in a complex network of relationships, which placed a pivotal role in patient management. They also found that communication failures are far more complex and relate to hierarchal differences, concerns with upward influence, conflicting roles and role ambiguity and interpersonal power and conflict.

Robinson, Gorman, Slimmer and Yudkowsky, (2010) shed a little more light regarding the influence of relationships. For example, when doctors and nurses maintain a relationship of mutual trust and an authentic understanding of each other’s unique professional role, there will be good communication. According to Robinson et al. (2010) respect for one another was tied to the establishment of a good relationship between doctors and nurses and as stated by the researchers,

“Good communication would be enhanced by that nurse having a good relationship with the physician” (p. 211). Robinson et al. (2010) have identified the theme of trust was important in effective communication and patients are best served, when the members of the profession could rely on each other. Robinson et al. (2010) found that nurses were particularly vocal, concerning the lack of understanding by doctors, regarding the unique and professional role of nurses.

Effective communication is essential in many varied medical relationships. These relationships include doctor-patient, doctor-nurse and doctors-surgical staff. Waxman (2009) points out that communication between surgeons and operating room personnel has come under close scrutiny. According Waxman (2009) the “time out” is an important step in verifying the correct patient, procedure, and operative site prior to beginning the operation. Indeed, when it comes to a surgical procedure it is important that everyone be on the same page (p. 37).

In the eyes of many, the physician is ultimately responsible for the medical treatment of a patient. However, we cannot ignore the role of others, such as office personnel. The manner in which a doctor’s staff treats and/or communicates with patients, can make or break a physician. Patients and family members who are treated in a pleasant and timely manner are less likely to file claims against a doctors should adverse events occur (Waxman, 2009, p. 37). Waxman (2007) states that when it comes to patient satisfaction, it pays for an office staff to practice the Three A’s, “affable, available and able” (p. 37). Based on the Three A’s that were previously mentioned, I suggest that if office personnel are aware of the verbal and non-verbal messages they are sending, they are more likely to be perceived by patients as affable, available and able.

As I have discussed communication, in its many forms, and how doctors use communication, we circle back to written communication or written documentation, as used by physicians. Waxman (2009) emphasized the need for accurate written documentation, obtained from the patient, to ensure that adequate medical care is received. He states “Good physician-

patient communication begins with a comprehensive intake sheet that the patient completes before the initial office visit” (p. 34). This comprehensive intake sheet is critical, in the event of a lawsuit and the details of the patient’s medical history can be scrutinized. He argues that from a legal standpoint, that it is imperative for a physician to keep good records. Waxman (2009) states “Judge and juries are likely to believe a physician who has properly recorded his findings, diagnoses, and plan in the patient record” (p. 37).

### **Ineffective Communication**

Previously, I looked into what contributes to good, effective communication. Now, I will examine miscommunication in medicine. Ineffective communication, or the cause thereof, is partially based on the organizational hierarchy that exists in hospitals, clinics and other medical facilities, where doctors and nurses work together. According to Robinson et al. (2010) a major problem with miscommunication and the medical profession is the “...well-entrenched hierarchal authority structure and sexism (even though women make up over one-third of the physician workforce) that complicates nurse-physician communication. They also say that disruptive communication occurs with alarming frequency in both nurses and physicians, and both sets of professionals agree that such ways of communicating decrease patient safety ” (p. 206).

According to Robinson et al. (2010) when focus groups were formed at a large, urban medical university, located in the United States, the researchers found mild resistance when nurses and doctors were questioned together. This “mild resistance” was the need for the participants to be “politically correct” (p. 207). When Robinson et al. (2010) conducted their research with their focus groups they found three ineffective communication themes common with physicians and nurses (p. 209). The three themes found were making someone less than (derision), dependence on electronic systems and linguistic and cultural barriers (p. 209). Ineffective communication involved making someone feel less of a human being. Robinson et al. (2010) state that ineffective

communication included humiliating colleagues and making them feel incompetent. For example, a physician was quoted as saying in front of a patient “It is amazing on this floor; the nurses don’t know what they are doing” (Robinson et al., 2010, p. 212). Robinson et al., (2010) found that a dependence on electronic systems contributed to ineffective communication. Participants felt that the use of electronic devices replace the needed face-to-face communication that is so vitally needed to avoid incomplete or fragmented messages from being sent and received (Robinson et al., 2010, p. 212).

The final ineffective communication theme reported by Robinson et al., (2010), was the linguistic and cultural barriers that exist in the hospital setting, where there are many different nationalities represented by the nursing and physician staff (p. 212). Through education, and an emphasis for tolerance of the customs of others, ineffective communication can be minimized (Robinson et al., 2010, p. 212). I will now address what role medical schools plays in physician communication.

### **Medical Schools**

As I continue the review of the literature, I now focus on medical schools and attempt to identify the steps medical schools are taking or not taking, to further effective communication for future doctors. There are medical schools that demonstrate that communication is taught as part of their curriculum. The Warren Alpert Medical School at Brown University has established a nine-step competency based curriculum, and is called The Nine Abilities. The first of these nine abilities is Effective Communication. In essence, under effective communication, the competent graduate demonstrates effective verbal, nonverbal and written communication skills in a wide range of activities including patient care, consulting and teaching. In addition, the graduate must also have the communication skills to establish rapport with and have the ability to counsel patients and their families (Medicine & Health/Rhode Island, 2012, p. 318).

Other researchers have determined that although there is an effort by medical schools to teach communication skills, there is resistance from medical students to learn effective communication techniques. In their research, Fadlon, Pessach and Toker, (2004) found that trying to teach students something they already know (in this case, inter-personal communication), there is resistance exhibited by students. According to Fadlon, Pessach and Toker, (2004) students subjectively believed that their interpersonal/interviewing skills are part of one's personal make-up. When students were enrolled in non-structured course teaching communication, the course quickly lead to a lack of interest in the subject matter and a resistance to learning was the result. Faldon, Pessach and Toker (2004), found that students believed that their communications skills came naturally and when instructors attempted to teach students about interpersonal communications skills, students lost interest and became defiant.

du Pre (2005) has also studied the role medical schools play, when communication and student learning are involved. In medical schools, the sciences are the dominate subject matter. Science's such as physiology, anatomy, biochemistry, microbiology, pathology are the meat and potatoes of student curriculum. Some argue that this focus on the sciences is dehumanizing medical students. In traditional medical schools, medical students learn about the human body by the use of cadaver's and not living human beings (du Pre, 2005, p. 90). When medical students work on cadavers they do not need to treat the cadaver with sensitivity, or wonder about the cadavers feelings. In essence, the medical student learns to treat the human body as an inanimate object (du Pre, 2005, p. 90). The concern for du Pre (2005) is that when medical students graduate and start working with living patients, doctors may have the mindset to treat living patients as dead cadavers—without sensitivity for the feelings and concerns of their patients.

According to du Pre (2005) medical school is a grueling experience for aspiring doctors. What students experience during those many years in medical school may have an effect on the

way students treat future patients. After graduating with an undergraduate degree, the student then attends four years of medical school with textbook science taught the first two years, followed by two years of clinical experience. This is followed by a one year internship, then two years of medical residency. The medical school process has been referred to as “the longest rite of passage in the western world.” Medical students are subject to long hours, hazardous situations (like drawing blood from AIDS patients) and abuse from a strict and carefully structured hierarchy of veteran physicians and instructors (du Pre, 2005, p. 94). From these findings, the hardships and frustrations experienced by a student in medical school can be transferred to the patient, when that student becomes a licensed physician.

According to du Pre (2005) medical school reform is making some progress. Harvard Medical School requires students to participate in a three-year course on doctor-patient relationships. This “humanistic approach” by the Harvard Medical School, among other things, emphasizes the development of medical student communication skills.

The manner in which medical schools approach communication has been examined by other countries. In Great Britain, the curriculum for medical students has included a focus on communication. According to Fragstein et al., (2008) the Communication Curriculum Wheel has been developed to teach medical students the science of communication. The curriculum wheel includes the following. First, is the concept of Respect for Others. Respect for others includes the student’s ability to embrace respect for all patients and to remember that the world in which we live is composed of varied social, cultural, ethnic backgrounds or disabilities. The second concept is Theory and Evidence of communication skills. With theory and evidence, medical students should be aware of the evidence and frameworks that need to be understood for good communication. Evidence and frameworks include such things as patient satisfaction, well-being and reduction of error. All of which should be understood by the student.

The third concept of the curriculum wheel is the Tasks of the Clinical Interview. Some of the tasks needed for effective communication include establishing relationships, explaining, and prioritizing. Some of the skills that are emphasized include the use of eye contact, attentive listening, empathic reflection, summarizing and checking the patients understanding. The fourth concept is how to deal with Specific Issues. This spoke of the curriculum wheel included things such as cultural diversity, difficult questions, sensitive issues and communication impairment. The fifth concept for the wheel is Media. This concept includes a student's understanding of spoken, written and electronic communication. The sixth and last concept of the wheel is Communicating Beyond the Patient. Students are expected to consider the following four areas as they attempt to communicate (using different mediums) with other people related to or associated with the patient. These include relatives and care givers, advocates and interpreters, intra-professional and inter-professional communication.

It is apparent that medical schools are now paying more attention to communication. Medical schools are developing and implementing communication based curriculum into their programs. I believe that the previously mentioned medical schools have taken a proactive approach to physician communication and this proactive approach will benefit both the physician and the patient.

### **E-mail and Web-Logs**

Roter, Larson, Sands, Ford and Houston (2008) suggest that the use of e-mail by patients can be a way for patients to express worries and concerns, to physicians. According to an online survey conducted by Harris Interactive (March to April 2, 2002) "...90% of respondents want access to their physicians online and more than half indicated that the availability of e-mail access would favorably influence their choice of competing health plans and selection of a particular doctor" (Roter et al., 2008, p. 81). In addition, it should be noted that physicians are hesitant to

use e-mail because of the confidential nature regarding the content of e-mails. Physicians feel that with the use of e-mail, there is an increased possibility of malpractice suits. However, even with the availability and use of encryption protocols, doctors are hesitant to use e-mail (Roter et al., 2008, p. 81). They state that the asynchronicity of e-mails affords patients the option of using this mode of communication to convey sensitive, embarrassing, or especially distressing information that may be withheld during the face-to-face interview.

These researchers found that when e-mails are contentious in nature, most physicians would reply with empathy or an apology, and then suggest to the patient that they meet with them in-person or contact them by telephone to discuss the contentious issue. They also found that patients wrote more information in e-mail communications, than did physicians. Roter et al. (2008) conclude, "Indeed, an advantage of e-mail often is noted by patients in surveys is that the lifting of time constraints allows them to gather thoughts, articulate concerns, and ask questions" (p. 85). This gathering of thoughts and articulating of concerns of patients and doctors, is exactly why web-logs will be used as the primary source of the original research for this thesis.

According to Wilkie (2009), when the Internet came into existence in 1991, this event transformed education. People who work in healthcare are now facilitating their learning by engaging instant messaging, social networking sites and podcasts (Wilkie, 2009, p. 423). The use of online resources has also changed learning. Questions can be posted online and can be answered immediately and then that question can become the foundation for further exchanges of opinion or discussions regarding healthcare (Wilkie, 2009, p. 423). According to Wilkie (2009), highly educated and devoted web-log writers are faithful to their sources and readers. Web-log writers share practical knowledge and skills and influence the way other people think. In addition,

medical web-logs are frequently picked up by the mainstream media; these web-logs are an important vehicle that influences medical and health care policy (Wilkie, 2008, p. 423).

The Internet or the World Wide Web has produced new communication media, which people can use to share ideas and transfer information. Along with e-mail and individual websites, the number of web-logs or blogs (as they are more commonly known), has grown tremendously. Web-logs are online journals that can be written, reviewed, and commented upon by the public. According to Siegert (2005), there is an abundance of rich and vibrant web-logs for news, medicine, science, literature, religion, politics and social life. According to Miller and Pole (2010) a web-log is a site that contains dated entries or posts and presented in reverse-chronological order. Miller and Pole (2010) mention that web-log features commonly include archives, a web-log roll and a reader comment section. Miller and Pole (2010) state “The term blog was first introduced in 1997 to describe a log of links that chronicled visits to various web sites. Web-logs once required programming knowledge to create, but with the emergence of free software such as Blogger and Wordpress, virtually anyone with an Internet connection can create a blog” (p. 1514). Miller and Pole (2010) elaborate on the popularity of web-logs—stating that 12.0 to 26.4 million Americans blog and 57.0 to 94.1 million are web-log readers. The Miller and Pole (2010) study states that the exact number of health care web-logs are “...unknown,” but these health care related web-logs have the potential to “...provide interactive support networks for caregivers and patients, generate real-time discussions about health news or policy, extend social and political mobilization efforts, and offer providers another forum in which to collaborate and consult” (p. 1514).

These researchers focused their efforts in understanding web-logs that were related to health care. Miller and Pole (2010) analyzed the content of 951 health web-logs and found that health bloggers tend to be younger and better educated than the general population. More web-

logs are written by women than by men and health web-logs rely more on text than on audio and video (p. 1516). Many of the analyzed web-logs were more personal than informative and the web-logs were used to share stories. Miller and Pole (2010) point out that “Producing personal narratives can increase self-awareness, which can, in turn, promote active coping” (p. 1516). They state, “These online communities might serve to empower patient-consumers, providing people with the information necessary to care for themselves and bringing more equality to the provider-patient relationship” (p. 1517). Miller and Pole (2010) mention that nearly half of the health related web-logs were written by health professionals, including a large number of physicians.

According to Mostaghimi and Crotty (2011) physicians, like other professionals, are expanding their use of Internet-based resources at work while at the same time, developing digital lives marked by sharing thoughts, journals, and media online. However, the use of social media by doctors presents the unique challenge of being able to use social media (such as web-logs) for medical information, and physicians by the same token, need to protect the privacy of their patients (p. 560).

According to Mehta (2007) web-logs constitute an emerging public domain that permits free expression for individuals and allow public access to the same information. Web-logs are an example of “social software” that allows interaction amongst patients, families, friends and medical professionals (p. 422). Physicians may benefit from web-logs by monitoring the progress of their patients and tailor their therapy via web-logs. The Mehta (2007) study, in a way, parallels some of the findings we seek to find in our qualitative study. They conducted a study with the use of web-logs of patients that suffered from Ocular Inflammatory Disease. The use of web-logs allowed patients to express perceptions and anxieties regarding Ocular Inflammatory Disease and in turn allowed medical professionals to initiate better counseling and therapeutic management techniques that improved the patient experience (p. 421).

Mehta (2007) used a variety of materials and methods to choose the web-logs for their studies. They used a dedicated search engine ([www.blogsearch.google.com](http://www.blogsearch.google.com)) to identify possible web-logs using terms such as “uveitis,” “choroiditis,” and “iritis” (p. 421). They excluded web-logs that were commercial or academic in nature and the researchers studied web-logs that dealt with the experiences of single patients with intraocular inflammation. Mehta (2007) identified web-logs for their study with respect to age, sex, and geographic location of the blogger, the type of uveitis described, symptoms described, and the specific sources of anxiety.

Mehta (2007) found the following themes regarding commentary on selected web-logs. Themes included difficulties in accessing physicians and ophthalmologists; non-availability of early appointments, unsympathetic office staff and the inability to contact physicians at a time of perceived emergencies. These researchers found that few patients complained about the expense or the medial treatment they received. They also learned that most of their web-log users were well-educated and insured.

In another study, Lowney and O’Brien (2011) wrote that web-logs are the main contributors to the large number of new websites created each year. The term “blog,” a contraction of the words “web” and “log,” came into usage in the late 1990s and is basically an online diary. Posts are displayed in reverse chronological order and may additionally engage in real-time conversations with other users. These researchers state that the medical blogosphere is used by a variety of people—people with varied personalities who want to share their experiences, impart knowledge to others and hope to have an influence on the ways others think about their world, as information is consumed and interpreted (p. 858). Web-logs are composed of a highly connected digital network of medical commentary that is freely accessible but unedited (p. 858). The system is devoid of safeguards, but has become an increasingly popular tool with enormous potential, with some risk (p. 858).

Some of the particulars found in the Lowney and O'Brien (2011) case contain a few of the themes this thesis has discovered. In the Lowney and O'Brien (2011) case, a 30-year-old retail manager was admitted with an eight-month history of pontine glioma (a lesion on the brain stem). His communication with the hospital staff was done with an iPad, which he used his left hand to operate, because his right hand had been disabled by his lesion. This patient established a web-log to assist him during his treatment and the web-log was used as therapy during his treatment. With the web-log, this patient would keep a record of his medical treatment, receive words of encouragement and support from others and publish his determination to fight his disease (Lowney & O'Brien, 2011, p. 858). According to Lowney and O'Brien (2011) with the completion of this web-log, the patient drew comfort from the fact that he was leaving a lasting legacy for his family and friends. The patient postulated that the web-log would allow his son to get to know him. The patient also believed that the web-log would encapsulate his spirit in the event of his death and his family felt an enormous sense of pride thinking his was reaching out to other cancer patients and their families (Lowney & O'Brien, 2011, p. 859).

For this thesis, web-logs will be examined as the primary source of original information and research. A total of 30 web-logs will be examined with 15 web-logs representing the opinions of patients and 15 representing the opinions of doctors. This leads us to the last subject of this literature review, as I argue what constitutes and what contributes to both good and bad forms of communication amongst physicians. In the next chapter, which is the Method section, I will discuss the use of grounded theory and how grounded theory will be used to analyze the information found in the patient and doctor web-logs. I will explain grounded theory; why I am using this theory, how this theory will be used and I will give examples how other researchers have used this theory in their own research.

Based on the information previously given in this literature review, it is clear that web-logs have become a valuable tool for not only those who desire to read and make comments on web-logs, but web-logs are evolving into an integral communication network between doctors and patients; each sharing narratives, thoughts, feelings and factual information in real-time, regarding medically related issues. Web-logs facilitate honesty because of the confidential nature of web-log entries. Web-logs allow both the patient and the doctor to express their feelings and thus each party appears more human. These observations have led to the following research questions:

RQ1: In the context of effective interpersonal communication do the physician and the patient share responsibility regarding how information is communicated and what is done with the information received?

RQ2: Do patients believe that communication is important and how can patients take responsibility for the manner in which they communicate with physicians?

RQ3: Through the use of web-logs, are doctors and patients building a bridge of mutual understanding, empathy and appreciation for each other, as they communicate with each other?

### **Chapter 3: Method**

This chapter begins with an explanation of grounded theory, with a description of open, axial and selective coding. Then, a more detailed and historical use of grounded theory will be included as used by the originators of grounded theory, Barney Glaser and Anselm Strauss (1967), with an explanation of Glaser and Strauss's four stages of Constant Comparative Analysis. Then, I will include Babbie's (2010) five guidelines for grounded theory research. I will then present an example of grounded theory use, by Mills, Bonner and Francis (2006) and include details of their research steps that include: open, theoretical and constant comparative methods. Then, I will include the Reinke et al., (2008) method of using grounded theory to identify themes with medically-related issues. At the end of this chapter, the reasoning behind the use of web-logs and narratives will be given, along with the procedure for the data collection.

#### **Grounded Theory Framework**

Babbie (2010) introduces grounded theory as the collaboration of Barney Glaser and Anselm Strauss (1967). Based on the work of Glaser and Strauss, Babbie states that grounded theory is "...the attempt to derive theories from an analysis of the patterns, themes, and common categories discovered in observational data" (Babbie, 2010, p. 307). Grounded theory was first developed by Glaser and Strauss (1967) in an attempt to come to grips with their clinical research in medical sociology (Babbie, 2010, p. 396). Since then, grounded theory has evolved into a method, with the founders taking the method in slightly different directions. The data analysis of grounded theory involves the following steps: open coding, axial coding and selective coding. The descriptions of these steps will follow and will be used in this thesis.

#### **Open coding.**

Babbie (2007) defines open coding as "The initial classification and labeling of concepts in qualitative data analysis and in open coding; the codes are suggested by the researchers

examination and questioning of the data.” According to Reinke et al., (2008) open coding involved the development of a coding framework designed to capture the meaning of participant’s speech (p. 603). Open coding appears to be the first of many filters in which meanings and themes are extracted from raw data.

### **Axial coding.**

Babbie (2007) defines axial coding as “A reanalysis of the results of *open coding* in grounded theory, aimed at identifying important, general concepts” (G1). Axial coding was used to identify relationships between codes (Reinke, 2008, p. 603). According to Babbie (2007) axial coding is used to identify core concepts in a study. Axial coding involves the regrouping of data, in which a researcher uses the open-code categories and looks for more-analytic concepts (Babbie, 2007, p. 402). After collecting the data in the open coding stage, axial coding is used to identify themes or patterns that keep re-appearing while looking at the data.

### **Selective coding.**

Babbie (2007) defines selective coding that “...builds on the results of *open coding* and *axial coding* to identify the central concept that organizes the other concepts that have been identified in a body of textual materials.” Selective coding was used to develop theoretical constructs using open and axial codes (Reinke et al., 2008, p. 603). Basically, “...selective coding seeks to identify the central code in the study: The one that the other codes are related to” (Babbie, 2007, p. 402). Selective coding is used to build on the results of open-coding and axial coding to identify the central concept that organizes the other concepts that have been identified in the body of data examined (Babbie, 2007, p. 402).

Open, axial and selective coding can be likened to a series of filters. These filters strain raw data through open coding and remove impurities (unimportant and unrelated information) and

then the information flows through the filters of axial and selective coding and the data is refined into identifiable and applicable themes, which can be used to build a sustainable thesis argument.

For example, when Glaser and Strauss (1967) looked into the concept of “social loss” with nurses, and when “social loss” appeared in one case, they looked for the same phenomenon in other cases (Babbie, 2010, p. 396). Then, as the concept of social loss was explored, Glaser and Strauss (1967) began to take note of the relationships amongst the concepts and in the case of the nurses, Glaser and Strauss (1967) began to take notice of the age, education and family responsibilities of the nurses patient’s (Babbie, 2010, p. 396). Then, Glaser and Strauss (1967) focused on concerns that were relevant to their inquiry and disregarded those concerns that were no longer relevant (Babbie, 2010, p. 396). Then, in the final step for Glaser and Strauss (1967) and for any other researcher using grounded theory, they wrote down their theories—putting their findings down in words to be shared with others (Babbie, 2010, p. 397).

Grounded theory, properly applied, is found in the Reinke, Engelberg, Shannon, Wenrich, Vig, Back, and Curtis, (2008) study. Reinke et al. (2008) conducted a qualitative study using grounded theory to examine participants’ perspectives on the experiences of key transitions in the context of living with advanced Chronic Obstructive Pulmonary Disease (COPD) or cancer (p. 601). Reinke et al. (2008) began their study with the selection of participants, which included: Physicians, patients, and family participants. Physicians were chosen because of their expertise as leaders in their field. Patients were selected based on how advanced their cancer was and if those patients had a life expectancy of less than and up to one year (Reinke et al., 2008, p. 603). Family members were selected because of their roles of caregivers. Data collection of the Reinke et al., (2008) study was based on semi-structured interviews. The Reinke et al. (2008) analysis was done qualitatively through grounded theory and divided into three analytical steps: open coding; axial coding and selective coding (Reinke et al., 2008, p. 603). According to Reinke et al. (2008) open

coding involved the development of a coding framework designed to capture the meaning of participants' speech. Axial coding was used to identify relationships between codes and selective coding was used to develop theoretical constructs using open and axial codes.

According to the Reinke et al. (2008) study, several themes were identified. The first theme was: *new or different treatments* (p. 604). Patients with COPD or cancer experienced a transition where the patient was notified of new or different treatments. The next theme was: *No more treatment/curative to palliative care*. Patients with cancer and those with COPD described this transition when they realized there were no further treatment options. The next theme was: *Activity limitations/functional decline*. Patients had to accept limitations to their everyday life. The next theme was: *Initiation of oxygen therapy*. This transition was labeled by one patient as "starting on oxygen" (p. 606). The next theme was: *Illness exacerbation or hospitalization*. This transition included going to the hospital. The last theme identified by Reinke et al., (2008) was: *Improvement from illness*. What is important about the Reinke et al., (2008) study is the fact the grounded theory was used effectively and the use of this method uncovered not one, but five different themes, that provided an overall view of COPD patient treatment processes. The discovery of the five themes provided the ground work for a more effective treatment program for COPD.

Instead of using the open, axial and selective coding method, Glaser and Strauss (1967) described grounded theory as a method that involves four stages of analysis. The first stage of the constant comparative method is "*comparing incidents applicable to each category*" (Babbie, 2010, p. 396). As with this thesis, Glaser and Strauss (1967) used grounded theory to analyze a specific aspect of the medical field. Glaser and Strauss (1967) observed the reactions of nurses regarding the death of patients under their care. Glaser and Strauss (1967) found that the nurses were assessing the "social loss" connected with the death of each patient (Babbie, 2010, p. 396). Once

the theme of “social loss” emerged, the researchers looked for the social loss theme with other nurses. And when the theme of “social loss” was common with several nurses, they compared the different incidents to arrive at their conclusions (Babbie, 2010, p. 396).

The second stage of constant comparative method is the “*integrating of categories and their properties*” (Babbie, 2010, P. 396). At this stage of the analysis, the researcher begins to note relationships among concepts and in the assessment of social loss.

The third stage of constant comparative method is “*delimiting the theory*” (Babbie, 2010, p. 396). Eventually, as the relationship among patterns or themes becomes clearer, the researcher can ignore some of the concepts that were noticed originally, but have not become irrelevant to the study (Babbie, 2010, p. 397). At the same time, the number of categories is being reduced and the theory becomes refined and simpler (Babbie, 2010, p. 397).

The fourth and final stage of constant comparative method is “*writing theory*” (Babbie, 2010, p. 397). At this point, the researcher must put his or her findings down into words that can be shared with others and in grounded theory; the writing stage is regarded as part of the research process (Babbie, 2010, p. 397). Here are the guidelines this thesis will follow:

- *Think comparatively:* This researcher will think comparatively, as suggested by Babbie, (2010), by comparing the web-logs of both physicians and patients in order to avoid bias.
- *Obtain multiple viewpoints:* This researcher will include data from physician and patient web-logs. These web-logs are open to anyone with a computer, access to the Internet and wish to contribute constructive dialogue pertaining to a specific topic in medicine.
- *Periodically step back:* This researcher will frame interpretations based on the raw data analyzed and this researcher will continue to refer back to the data in order to formulate correct interpretations.

- *Maintain an attitude of skepticism:* Babbie (2010) suggests that as a researcher begins to interpret data, the researcher should regard all interpretations as provisional, using new observations to test those interpretations and not just confirm them.
- *Follow the research procedure:* According to Babbie (2010) grounded theory allows for flexibility in data collection as theories evolve, but Stauss and Corbin (1998) stress that three techniques are essential: “Making comparisons, asking questions, and sampling.”

Contained in the following paragraphs are examples of grounded theory use, as researchers used this method to provide information regarding communication in medicine. Mills, Bonner & Francis (2006) give an in-depth explanation of the current use of grounded theory.

According to Mills, Bonner and Francis (2006), grounded theory had proved to be a popular choice since its development in the 1960's. According to Mills, Bonner and Francis (2006), more than 3,650 journal articles have been published using grounded theory method (p. 2). According to Mills, Bonner and Francis (2006) grounded theory is a method that seeks to construct theory about the issues that are important to people. For example, grounded theory was first developed by Glaser and Strauss (1967) to examine the “social loss” a nurse felt when a patient under their care had died. Relevant theories then started to develop regarding the death of patient's and how these patient deaths affected others.

Grounded theory has been chosen as an appropriate method for this thesis because of the versatility of the method, and grounded theory's capacity to identify themes based on the coding of raw data. This is coupled with the fact that grounded theory shouldn't be used unless existing theory cannot explain the phenomenon under study. Now we turn our attention to the use of web-logs and why web-logs are being used for the original research of this paper.

## Web-Logs and Narratives

Web-logs have been chosen as the source of the original research for this thesis. Web-logs are a dependable source of honest and unedited information. Web-log comments are written by a variety of individuals, on a variety of subject matter, important to those who use web-logs to express opinions. According to the *Journal of Visual Communication in Medicine*, a web-log (or 'blog') is a web-based form of communication, which consists of periodic articles that range in scope from personal journals to corporate or political news and many web-logs enable visitors to leave public comments, which can create a group of readers (Siegert, 2005, p. 130). There are an abundance of rich and vibrant web-logs for news, medicine, science, literature, religion, politics and corporate life and there are more than nine million web-logs in existence, according to the (Siegert, 2005, p. 130).

There are several reasons for the proliferation of web-blogs. A web-log can be created in a few easy steps using [www.blogger.com](http://www.blogger.com) or [www.wordpress.org](http://www.wordpress.org) (Siegert, 2005, p. 130). The power in web-logs lies in the speed and efficiency of information exchange by the use of words, sound and video files and the primary motivation for many bloggers is the desire to create a place where people can share ideas (Siegert, 2005, p. 130).

In addition, more current research has provided details regarding the increased use of web-logs. For example, Miller and Pole (2010) point out the popularity of web-logs should not be underestimated and data shows that 12.0 to 26.4 million Americans blog and 57.0 to 94.1 million are blog readers (p. 1). Miller and Pole (2010) vary that the number of web-logs that focus on health care are "...unknown" (p. 1514). However, web-logs have "...the potential to provide interactive support networks for caregivers and patients, generate real-time discussions about health news or policy...and offer providers another forum in which to collaborate and consult" (Miller & Pole, 2010, p. 1514).

According to Lowney and O'Brien (2011) web-logs came into common use in the 1990's and fundamentally describes a form of online diary (p. 858). Posts are displayed in reverse chronological order and a person may engage in real-time conversations with other users who are on-line (Lowney & O'Brien, 2011, p. 858). The medical blogosphere is populated by a host of personalities with the main goals being to express oneself creatively, share experiences, impart knowledge and ultimately influence how others think (p. 858). According to Lowney and O'Brien (2011) the information in web-logs is continuously requested, consumed and interpreted (p. 858). Web-logs represent a highly connected digital network of medical commentary that is freely accessible, but not edited. In addition, the system is devoid of safeguards in relation to the quality and accuracy of the information provided (p. 858). Now we turn our attention to a study by Mostaghimi and Crotty (2011), who have looked into the use of web-log technology by physicians.

According to Mostaghimi and Crotty (2011), the omnipresence of the Internet at work, at home, and via mobile devices has led to the birth of the modern information age. Physicians, like other professionals, are expanding their use of the Internet for both work and personal reasons by sharing thoughts, journals and media online (Mostahimi & Crotty, 2011, p. 560). Mostaghimi and Crotty (2011) argue that with the inherent openness of social media and self-publication, combined with improved online searching capabilities, can complicate the separation of a physician's professional and private life. Mostaghimi and Crotty (2011) argue that as more medical providers and trainees use social networks and web-logs, health care professionals need awareness of what is being posted and how that information is presented.

The issue of using the Internet and in this case, web-logs, is the issue of patient privacy and how to protect that privacy if a physician uses web-logs. Physicians, bloggers and anyone else

using the Internet via web-logs, need to keep in mind that anything written on the Internet is written in ink, so to speak.

According to Mostaghimi and Crotty (2011) a review of physician web-logs revealed that "...17% contained information that could identify the patient or his or her physician, including 3 blogs with identifiable photographs" (p. 560). Physicians must be aware of the unintentional online disclosure of patient information and online posts can create a "sense of community" between writer and the audience, but participants should not expect privacy or exclusivity within this network (p. 561). However, Mehta (2007) states that physicians may benefit by being able to monitor progress and tailor therapy via web-logs. Mostaghimi and Crotty (2011) have given a brief overview of the use of web-log technology by doctors.

The Mostaghimi and Crotty (2011) study reflects our previous discussion regarding physician disclosure and how disclosure can be used, if only used cautiously and with the intent to benefit the patient. It appears from the results of the Mostaghimi and Crotty (2011) study, that a degree of balance and discretion should also be used by doctors, as doctors use social media such as web-logs, to discuss serious medical issues in a public forum. This is why doctor patient web-logs will be used in this thesis.

I will attempt to identify and classify themes and patterns that should be generated from the web-log entries of both doctors and patients. For example, we know from published material, that physician disclosure is important and that medical schools have an important role to play in the context of the doctor/patient communicative relationship. However, with the use of web-blogs, I will be able to analyze the honest and real-time web-log comments—written by persons who really want the most current information regarding physician disclosure, medical schools or any other medically related subject, that have a profound effect on the individual blogger and their

family members. The following paragraphs will discuss the procedures and parameters that were established to collect and analyze the data for this thesis.

### **Data collection.**

The data collection procedure began with the selection of 30 web-logs. Of these 30 web-logs, 15 should be physician-centered and 15 should be patient-centered. These 30 web-logs include narratives that focused on a serious medical problem. Using Google, the following words were used to locate web-logs for this thesis: “blogs,” “patients,” “physicians,” “serious medical condition,” and “communication.” My initial inquiry on Google, using the previously mentioned word search, yielded approximately 7,020,000 results. I also narrowed my search by excluding those web-logs that were created for commercial purposes. At this point, my search was narrowed significantly by selecting those web-logs that were used by patients and physicians; by selecting web-logs that originated with nationally recognized publications; and nationally recognized hospitals and clinics. The web-log search was narrowed further by using the word “cancer.” The word “cancer” was a common theme when “serious medical conditions” were considered as search criteria.

I feel it important to note, that the vast number of existing web-logs, combined the vast number of new web-logs created every second, was a challenge in the selection process. In addition, because of the anonymous nature of web-log posts, demographic information regarding the subjects is limited. A common thread with the web-logs I analyzed was the interpersonal communication relationship between the doctor and the patient. Once the steps are completed, the findings will be reported and discussed in Chapter 4 of this thesis. As I examined the narratives and data contained in the web-log posts, I found several themes relating to physician/patient communication. These concepts or themes will be discussed in the following chapter.

#### **Chapter 4: Analysis and Application**

The purpose, through the use of grounded theory, was to identify common themes found in the 15 physician and the 15 patient web-logs and then apply these themes to the research questions. The doctor and patient web-logs that were used for this study were found by conducting a search on Google that included words such as “physician blogs” and “patient blogs.” Then, I narrowed my search by including words such as “communication” and “serious medical condition.” The analysis found six emergent and reoccurring themes that appeared in both doctor and patient web-logs: empathy and compassion, third-party involvement, medical schools, patient hand-offs, patient responsibility, physician honesty. The purpose of this thesis was to examine these web-logs and find themes that contributed to the implied goal of improving physician-patient communication. For example, with empathy and compassion it was discovered that empathy and compassion was needed from both the patient and the physician. With the third-party involvement theme, it was discovered that third-parties such as surrogates, nurses and extended family members can be used as a conduit for timely information exchange between patients and doctors. The discovery of the medical school theme showed that medical schools, traditionally, had not paid too much attention to teaching communication to students.

However, schools such as Harvard and Virginia Tech have recognized the need for communication education and have incorporated interpersonal communication training into their curriculum. The patient hand-off theme is virtually unknown to the public and should be the established protocol of exchanging patient information between a physician who is going home for the day and the physician who is starting a shift. Patient responsibility was another theme. This theme demonstrated the need for patients to be more responsible for their care and to not just play the role of the sick person. The last theme was that of physician honesty. And this theme addressed the need for physicians to really be honest with themselves—that there are occasions

when the doctor has done everything they can for a terminally ill patient and the doctor has to accept the fact that their patient is going to die.

I will give a brief introduction to each theme, followed by a relevant definition for that theme, ending with an example, given by a blogger, of how and why that theme is important to them.

### **Empathy and Compassion**

Empathy and compassion was a theme, not only mentioned by patients, but doctors also. *Empathy* is defined as: "the action of understanding, being aware of, being sensitive to, and vicariously experiencing the feelings, thoughts, and experience of another of either the past or present without having the feelings, thoughts, and experience fully communicated in an objectively explicit manner" (Merriam-Webster, 2005, p. 408). *Compassion* is defined as: "sympathetic consciousness of others' distress together with a desire to alleviate it" (Merriam-Webster, 2005, p. 53).

The need for empathy and compassion was a theme both physicians and patients recognized as a needed element in medical care. For a doctor, compassion may not come naturally as some may think. Doctors are trained to heal. There are times when healing does not occur and a doctor faces the grim task of delivering bad news to the patient and their family.

In the context of the empathy and compassion, the following web-log comment was posted online: "Delivering bad news is uncomfortable, and may be met with anger, disbelief, denial, etc., all of which are difficult for the physician. However, in my experience, bad news can be delivered in a kind, compassionate and transparent manner which ultimately serves the patient, family, and yes the physicians--well" (Otto, 2012, para. 1). In the context of this quote, I believe this physician is speaking to both patients and physicians. To the physician, this blogger is counseling other doctors to be kind, compassionate and forthcoming, regarding any medical situation. To the

patient, this blogger is saying if your doctor is open, honest and tactful with you, the news of a serious medical situation may be easier to bare.

According to some physicians, the use of empathy, combined with clear communication, is the beginning and the end when it comes to medical care—regardless of the medical specialty. Walker (2002), a physician who practices medicine in Scotland, wrote in a blog entry, “Good, clear communication, within a climate of rapport-building skills and empathy, underpinned by attention to beliefs and expectations is a ‘sine-qua-non’ of the effective doctor, regardless of the clinical specialty” (para. 4). It is important to note here that these physician’s identified the need for doctors to show kindness and compassion, especially when delivering bad news. And with kindness and compassion, the concept of absolute clarity is essential. Families, who have been given bad news from a physician, need options. They need to know what they can and cannot do. Families receiving bad news need to know exactly what they are up against and if the death of a loved one is inevitable, the family needs to know this, accept this and prepare.

The following summary, is a doctor’s way of using communication to show empathy and compassion. Author unknown (2013) states:

I will sit down with the relatives somewhere quite away from the patient’s bedside and after exploring the baseline understanding of the current clinical situation and explain all the treatments we have tried without success, will gently then introduce the idea that we feel their loved one is dying and that perhaps our interventions are actually causing unnecessary suffering without having a beneficial effect. Often I find people completely agree with our observations and sometimes there is an audible sigh of relief in the room. Eyes well up and tears usually start to flow, but I find that the most frequent verbalized response is ‘she wouldn’t have wanted all of this’ (para. 1).

Patient's and the relative of patient's, also recognize the need for empathy and compassion from physicians, as demonstrated by the following narrative. A grandmother shared her thoughts regarding a situation that involved her granddaughter. She states, "Empathy and compassion dwell at the core of the collective physician intention" (Rotering, 2012, para. 4).

Based on the web-log entries I have read, I have determined that when a physician shows empathy, compassion or just understanding, this empathy for others makes all the difference in the doctor/patient relationship. Empathy and compassion, exhibited by the doctor, enables both parties a degree of mutual understanding and appreciation for the overall situation.

Rotering (2012) writes the following web-log entry: "My granddaughter Zoey was nine when she was injured in a terrible accident. After hours of poking and testing, the emergency room physician began to stitch lacerations in her head when Zoey whimpered 'Ouch!'" (Rotering, 2012, para. 4). Zoey's doctor responded by stating "That couldn't hurt. I numbed it" (Rotering, 2012, para. 4). Then the doctor said "You have to lie still." Zoey was motionless as she wept. Then Zoey said: "IT HURTS!" According to Rotering (2012), the doctor *again* denied this possibility that the medicine had not numbed the injured area. The doctor said "There's no way it could! Now please lie still!" (para. 5). Rotering (2012) wrote, "Simply witnessing this exchange was unbearable. I finally asked the physician to step out of the room for a moment and said: 'I am asking you to listen to her and accept her feelings...Zoey knows what she is going through, and she is the expert on her experience.' Sadly, this competent physician lacked mindful tools to express her empathy and Zoey suffered as a result" (para. 6). Rotering (2012) wrote, "Substantial research shows that empathy enhances patient and family satisfaction, and also positively contributes to optimal clinical outcomes" (para. 7).

The need for empathy and compassion was identified as a practice in a hurried and stressful environment, such as an Emergency Department (ED). A blogger, identified as Leigh

(2013), describes how empathy and compassion could be used in this situation. Leigh (2013) explains how empathy and compassion could have been used by the ED personnel, when she brought her mother to the hospital.

Going to an ED is a very stressful experience. During my mother's time in the ED not one person directly stated an empathic response. I would have liked to hear at least one person say, 'I know it is scary being here. However we are here to help you.' This comment should often be followed by a partnership statement, such as, 'We will work together with you to find out what is going on as soon as we could...we will periodically check on you, but if you ever need anything, please feel free to let us know...we are here for you'" (para. 9).

In an unusual twist, one blogger/patient preferred to be treated in a non-emphatic, robot-like manner. Kate (2013) stated:

I adore my doctor because he is quite robotic. I find emotional tones unsettling and perhaps, unnecessarily scary. By keeping things clinical, I don't feel embarrassed about being examined, and I feel like I'm in competent hands. I don't need the TLC treatment, in fact, I back away from it (para. 1).

The Kate (2013) web-log entry is opposite the theme of empathy and compassion. This patient actually preferred being examined in a robot-like manner. However, it brings to mind the possibility that empathy and compassion could be defined by the individual. Most people (patients in this case), interpret empathy and compassion with a physician's use emotional tones or a caring demeanor. In the case of Kate (2013), she actually preferred the doctor's robotic approach—the possible reason is that with a robotic/clinical approach, the physician is viewed as a professional who is focused on medical care and not emotional care.

These findings are driven by the human desire for compassion—from both the patient and the doctor. From the web-log entries I have read, it is most beneficial if a doctor can keep in mind that his or her behavior, their position as a medical professional and their words, can have a profound effect on their patients and extended family members.

I have emphasized the need for doctors to show empathy and compassion by what they say. But does empathy and compassion include good listening skills? I propose that it does—that listening skills, as practiced by physicians is equal in importance to what is spoken by the physician and if physicians show compassion, patients are more likely to heal and not sue their doctor. From the web-logs I have read, the skill of listening appears to be important to both patients and their families. And when doctors listen to their patients, there is a better chance that the patient will receive the medical care they need. The next theme, third-party involvement, will now be discussed.

### **Third-Party Involvement**

The purpose of this thesis has been to focus on the communicative behavior of physicians and patients. However, it is evident that third parties such as extended family members and hospital administration can be utilized to enhance communication or detract from good communication. Third-parties are other individuals that are either related to, or responsible for, a patient receiving medical care. Third-parties include extended family members, hospital administrators, surrogates and social workers. In extreme cases, an impending malpractice lawsuit will involve third-parties that were not directly involved in the doctor/patient miscommunication, but were brought in to settle a dispute. Sheldon (2013) writes:

Many of the so-called ethical problems that we encounter during ethics consultations could be prevented if only a more constructive line of communication had been established from the beginning. We are dealing with patients who have more medical problems, which

often involve the risk of dying. The patient often lacks capacity and is unable to speak his or her mind about the goals of care and how far to use aggressive medical interventions.

This means that family or loved ones of the patient must speak for the patient. i.e., serve as surrogates, and communicate with the physician about care and plan goals..." (para. 1-2).

As Sheldon (2013) explained, constructive lines of communication are important. In this context, when a patient is suffering from a serious medical condition and is unable to speak for him or herself, it is essential there be a third-party spokesperson who can speak on behalf of the patient.

Jankowski (2012), who works as a hospital social worker, explains the need for empathy by hospital staff, including attending physicians, regarding the stressful role family surrogates play. Jankowski (2012) explains that the roles of family surrogates is complex, when serious health issues are concerned and that hospital personnel should be sensitive to that fact (para. 2). There are situations where patients cannot speak for themselves, therefore, a family member should be appointed to speak on behalf of the patient to make critical decisions (para. 2).

According to Jankowski (2012), family surrogates probably have strong emotional ties to the person dying and may be dealing with complex emotions that involve not only the patient, but also other extended family members (para. 3). Jankowski (2012) recommends that these surrogates should be those who can set aside their own feelings and be able to give doctors relevant medical history on the patient in question (para. 4).

This blogger recommends the addition of what she calls a "Family Support Coordinator" or (FSC) to a hospital's regular staff. This FSC could be a nurse, who would serve as a communication mediator between the family and the hospital staff. For example, the FSC would ensure that lines of communication are open between the physician and family via meetings arranged by the FSC (para. 6).

An Unknown Author (2011), who is a hospital worker, states that some family members who serve as surrogates, actually cause more problems than they solve (para. 1). This Unknown Author (2011) states:

I routinely watch extremely frail patients in their 80's and 90's receiving chemotherapy, and with all honesty, I find it troubling, and often ask myself 'why?' If a patient is of sound mind and is able to make the decisions, then perhaps that's an appropriate barometer, but I also have to wonder, how many of these decisions are in fact the result of pressure for families who are not yet ready to say goodbye to their loved one (para. 1).

In addition to family surrogates, there are others that can assist a patient's extended family. This unknown author had suggested that extended families are at times unwilling to say goodbye to their loved one. And as the following web-log comment by Nikki228 (2008) explains, there can be others that are not related to the family, who can assist when decisions about treatment options need to be made. Nikki228 (2008) writes:

There is a social worker assigned to every patient that is admitted. They will act as the mediator for your family, with the medical staff and will even intervene on your behalf and schedule a sit-down meeting. If you still do not get the satisfaction you desire, then you are not out of your realm to contact the hospital administrator" (para. 1).

Patients are not alone when it comes to their medical treatment. They have extended family members, surrogates, hospital administrators, social workers and even licensed attorneys that can play the role of advocate. These advocates or third-parties have been identified as a theme with some web-log entries. This is important to know, because some patients may feel that they are at the mercy of the hospital and their staff. And patients need to know that they do have many non-medical professionals they can count on for assistance regarding their medical treatment.

In the context of physician-patient communication, we learn that third parties such as extended family members, social workers and family support coordinators can play the role of a liaison or go-between; with the patient and his or her family on one end and the attending physician on the other. If a doctor is dealing with a patient who is on total life support and who cannot speak, the third-party/family member can play the role of patient spokesperson. In other words, the wishes of the patient and his or her family are communicated through this third-party family member. A family spokesperson is like a Godfather—someone who is respected and this Godfather can be the physicians contact person when medical issues need to be discussed. The role of Medical Schools in the context of physician communication is the subject of our next identified theme.

### **Medical Schools**

Medical schools and their role in physician/patient communication is another identified theme included in this thesis. According to the Association of American Medical Colleges (AAMC) there are 141 accredited medical schools in the United States ([www.aamc.org](http://www.aamc.org)), with many other schools waiting to be accredited. The role of the medical school has been included with this thesis, because I suspect that these schools can establish patterns of physician and patient communication that can be either effective or ineffective. du Pre (2005) identified negative patterns of communication, learned by doctors while in medical school. And as I have read the web-logs of both patients and doctors, it is clear that medical schools have a profound influence on a physician's communicative behavior. Wilkins (2012), who is acquainted with the training of doctor's wrote the following comment:

Many physicians, until recently, were never taught (in medical school) how to be good patient or person-centered communicators. Physicians employ a physician directed, paternalistic style when talking with patients. Patients, for their part are trained and are

well-socialized from childhood to assume the ‘sick role’ wherein the doctor does all the talking (para. 1-4).

There are some medical schools that have recognized the need for communication training in their curriculum. Leigh (2013), a writer for Virginia Tech Carilion states:

Virginia Tech Carilion, located in Roanoke, Virginia, is one of the newest US medical schools. The medical school has added a communication component to their admission interview process. Great grades alone will not prepare prospective students for this part of the interview process; great ‘people skills’ are needed (para. 2).

According to Leigh (2013), communication skills are more than “bedside manner” (para. 3). According to Leigh (2013), the following process is used at Virginia Tech Carilion to evaluate the communication skills of medical school candidates (para. 4). Candidates stand with their backs to doors, then a bell rings and they turn around and read a sheet of paper taped to a door. The paper will have a scenario that requires communication and teamwork skills. (The school requests that the actual scenarios be kept secret). After two minutes, the bell rings again and the candidate enters the room to discuss the ethical issue with an interviewer. The candidate has eight minutes to discuss that room’s issue. The interviewer scores each candidate with a number and sometimes a brief note. The process is then repeated several times (para. 4).

Leigh (2013) states, “The school administrators created questions that determine how well candidates think on their feet and their ability to work in teams. The interviews closely assess how well they respond when someone disagrees with them. This is a critical skill in working with teams” (para. 5). Leigh (2013) also states:

Candidates, who jump to improper conclusions, fail to listen or are overly opinionated fare poorly because such behavior undermines teams. Those who respond appropriately to the

emotional tenor of the interviewer or ask for more information do well in the new admissions process because such tendencies are helpful not only with colleagues but also with patients (para. 7).

From Leigh's (2013) comments it appears that Virginia Tech is looking for students that already have communication skills. From reading the web-log entries, I do not believe that Virginia Tech is looking for potential medical students who have mastered effective communication. The Virginia Tech example illustrates that medical students should have a basic idea on how to communicate with people, and this can serve as a foundation for further communication education.

Leigh (2013) concludes by stating, "We are trying to weed out the students who look great on paper but haven't developed the people or communication skills we think are important" (para. 8). The following web-log comment by Levin (2013) included insight regarding candidates for medical school. Levin (2013) states:

Good communication leads to more accurate diagnoses, better chance for improved compliance and more effective follow up care...the approach you described can and should be taught and are being taken more seriously now in medical education. Another way to improve communication skills is for med schools to accept more naturally empathic and skill communicators and for hospitals to hire them (para. 1).

Levin (2013) makes a valid point. The point being that medical schools are now paying more attention to the issue of physician communication. When medical schools look at potential students, they should consider those students who have some people skills. Levin (2013) is also hinting to the fact that doctors throughout their training and practice should know what empathy is and how to express empathy appropriately. In the big scheme of things, students who are good at

interpersonal communication through medical school are good communicators as practicing physicians.

Ij (2013) was a medical student and wrote the following web-log comment.

I recalled two classmates from medical school who were asked to leave, not because of poor grades (they did little else but study) but poor social skills. One of the students was planning a career in pathology, with little patient contact. Neither of them could hold a civil conversation (no joke). However, scores of student's graduate with honors or decent grades still can't hold a decent end-of-life conversation with patients and families. Grades reflect knowledge but not competency, human interaction or even common sense (para. 1-2).

Medical schools and their role in teaching communication skills to their students, has been identified as a theme of importance because many believe that medical schools have some responsibility in teaching students how to communicate. Medical school curriculum is very science-based, with little regard to the emotional element of medicine. Experienced doctors, patients and medical schools are now realizing the importance of including a "communication component" to a student's training. Both medical students and medical schools have realized that for a doctor to be effective, he or she needs to be an effective communicator.

I do not believe that if a potential medical student is awkward in people skills—they should be excluded from medical schools. Interpersonal communication skills can be learned. I believe that having some basic "people skills," combined with specific interpersonal communication training, can prevent misunderstandings and malpractice suits in the career of any future doctor.

## **Patient Hand-Offs**

Another reoccurring and prominent theme in this analysis is the concept of the patient hand-off. A hand-off occurs when a physician, nurse or other personnel “hand-off” the care of a specific patient to another physician, nurse or other authorized personnel. The reasons for hand-offs include: the end of an employee’s shift; a physician going home because of illness; a physician going on vacation or any other reason where the transfer of care is given to another.

The following web-log comments are made by nurses, physicians and others who work in the health care industry and have intimate knowledge of the patient hand-off. Based on what I have learned, the concept of the patient hand-off is virtually unknown to anyone outside the health care environment. Therefore, the following web-log comments are made exclusively from professionals in the health care industry, who are aware of the hand-off protocol. The theme of patient hand-offs was identified as information exchange between two physicians. However, the patient hand-off also includes communication between two nurses. From what I have read, patients do not know about this protocol, nurses do know about the hand-off and some hospitals have established hand-off protocols. Based on the analysis of web-log entries, hospital administrations do not support effective hand-offs. Hospitals either have established hand-off protocols, that are not supported by schedules or hospitals have no hand-off protocol at all.

Bonsall (2013) explains, “Hand-offs are known as the ‘trouble spot’ when it comes to patient safety” (para. 1). Leigh (2013) states, “An estimated 80 percent of serious medical errors involve miscommunication between caregivers when patients are transferred or handed-off” (para. 3). Mishkind (2011), states that miscommunication amongst physicians is evident during an important, yet common and practical element of the patient’s hospital stay: The hand-off. According to Mishkind (2011) a hand-off occurs when an attending physician, who is responsible for a specific patient, hands-off or transfers the responsibility of the patient to a nurse or another

doctor (para. 3-4). Mishkind (2011) also states, “Medical errors are more likely to occur during a shift change or when one doctor signs off to another doctor” (para. 1). Mishkind (2011) states that there have been cases where a patient hand-off was executed poorly and the result was serious injury or death of a patient (para. 2). Mishkind (2011) states the reason for hand-offs include: A physician gets sick and needs to leave, the physicians shift has ended or the physician get pulled off the case to attend to something more pressing (para. 2).

It should be noted, that the hand-off or transfer of responsibility of a patient includes both written and verbal communication from the physician leaving, to the physician taking over. Communication during the hand-off can be incomplete or simply does not happen. (Mishkind, 2011, para. 5). In some cases (during a hand-off) the patient is placed in jeopardy because the patient’s information was incomplete or not communicated at all (Mishkind, 2011, para. 5-6).

Mishkind (2011) gives an example of a poor hand-off. A patient needed a special CT (Computer Axial Tomography or CAT) scan and the scan could have been completed in 15 minutes. Instead of doing the test, the doctor handed the patient off to another doctor. The first doctor wanted to go home. The hand-off was “done poorly” and the CT was never done. The patient went undiagnosed for eight hours and the patient died. This hospital had no established hand-off protocol (para. 6). To address the hand-off problem, Mishkind (2011) suggests that hospitals should have a 15 minute buffer zone, embedded in physician schedules, to ensure adequate time for hand-offs (para. 7). It should be noted that the Mishkind (2011) reference originated from a law firm that specializes in medical malpractice. The Mishkind (2011) reference adds validity to the original search criteria, because Mishkind (2011) adds a non-medically related voice to the patient hand-off theme. Basically, an outsider has not only recognized that patient hand-offs are important, but Mishkind (2011) took the time to share the experience with the online community. Leigh (2013) illustrated hand-offs with the following narrative:

When my brother and I arrived at the ED, we went to my mother's room and the nurse told us that their tests did not find atrial fibrillation and that my mother was going to be discharged now. I asked about the issue with mom's leg. They said, "What issue?" In spite of the fact that the clinical trial physician clearly stated the leg needs to be evaluated for a possible DVT. That information never made it to the ED records. After discussing the leg issue, my mother was scheduled for an ultrasound. (As an FYI, the ultrasound revealed no clots). To avoid these botched communication episodes that could seriously harm patients, professionals should engage in 'repeat-back.' After the information is shared the receiver must 'repeat back' the information to verify accuracy.

Leigh (2013) suggested the practice of "repeat-back" as a solution to faulty hand-offs. Repeat-backs have been identified as a sub-theme to patient hand-offs. According to Frellick (2011) study after study has shown that human beings don't communicate very well, not just during a hand-off, but in everyday life (para. 1). Frellick (2011) states that at the University of California, San Francisco, they estimate that at their 550-bed medical center, 4,000 hand-offs take place every day (para. 1).

Frellick (2011) mentions the challenges to communication when hand-offs are done poorly. "There are great data showing that speakers systematically overestimate how well their message [sic] are understood by listeners...we use vague language and assume people know what we're talking about" (para. 4). Frellick (2011) said, "Unfortunately, the most important piece of information was not communicated 60% of the time" (para. 6). Frellick (2011) added, "We really are not good with uncertainty," and "We will rewrite the story in our mind and pretend like we knew what the answer was. This actually goes on a lot in handoffs..." (para. 8). This researcher as states, "To fully participate, receivers need to use active listening behaviors, which include note-taking, asking questions and using repeat-back" (para. 10). He says that if you were to use a

drive-thru for Chinese take-out, Frellick (2011) guarantees that the person taking the order is going to practice “repeat-back,” where the person taking the order repeats the order as it was given by the customer. He also states, “That is because the restaurant had an incentive to get it right” (para.11). Frellick (2011) believes that if repeat-back is practiced in fast-food transactions, then repeat-back should be practiced by licensed physicians during a patient hand-off.

Frellick (2011), like other bloggers, has noticed that *interruptions* are a problem in hand-offs and suggests a protocol to deal with the problem. Physicians, who arrive late for hand-offs and then have to rush through them, are another problem (para. 14). He then states, “You need 15 minutes of overlap built into the schedule so people know that hand-offs are still part of their job” (para. 13-14).

Patient hand-offs are identified as a reoccurring theme as I have read through the doctor and patient web-logs. Patient hand-offs are in essence, a transfer of information about a patient; from one doctor or nurse, to another doctor or nurse. If the hand-off does not occur the patient should take some responsibility for their own health care and inform the physician. The issue with the hand-off is that some hospitals have a protocol for hand-offs and others do not. It also seems that patient hand-offs are not a priority unless there is a death as the result of a poor hand-off. There was one blogger that suggested the following long acronym to assist with the hand-off procedure.

For example, Bonsall (2013) suggested the use of the following acronym, among others, that can be used in the patient hand-off to insure complete information exchange. The acronym is: “**I PASS the BATON**” which stands for **I**ntroduction; **P**atient; **A**ssessment; **S**ituation; **S**afety concerns; the; **B**ackground; **A**ctions; **T**iming; **O**wnership and **N**ext. Patient hand-offs or the lack of effective patient hand-offs, caused problems that involved risk to patients. According to bloggers, the remedy to poor patient hand-offs is the incorporation for 15 minute window for

doctors to perform an effective transfer of physician responsibilities. The **“I PASS the BATON”** acronym was given by a nurse and may not be known and/or used currently by doctors.

Patient hand-offs need to be incorporated into the schedules of attending physicians. Hand-offs should include “repeat-back.” Doctors should have at least 15 minutes to speak with the nurses and doctor’s who will, from then on, be responsible for a patients care. Hand-offs are important because they function as a vehicle to transfer important information regarding a patients care. If a hand-off does not occur, a patient’s life could be at risk. Hospitals and clinics need to have established hand-off protocols in place and create schedules that support this vital communicative practice. The lack of the patient hand-off is a problem. I believe the patient hand-off it is not considered a serious problem by the health care industry as a whole. Nowhere in the published material, did I see listed the issue of patient hand-offs. Patient hand-offs appear to be an issue with bloggers, and not with the health care industry. The solution, regarding patient hand-offs is to convince hospital administrators that patient hand-offs need to happen. Hospital administrators should be shown statistical and/or narrative examples what happens when hand-offs are and are not performed.

### **Patient Responsibility**

The patient as a responsible participant was a theme identified in the analysis. Patient responsibility is the role, assumed by a patient, to take an active role in his or her medical care. Web-log writers have made comments regarding patient responsibility. Wen (2013) suggests six tips patients can use to be more responsible in their medical treatment.

First, patients should answer the doctors pressing questions first. The statement, “I took an aspirin...didn’t help,” is an example of answering a pressing question first (para. 4). Second, patients can attach a narrative response at the end of these close-ended questions. An example of a narrative end is: “It’s in the middle of my chest and it started after I really pushed myself in

swimming tonight” (para. 5). The third tip is to ask your own questions (Wen, 2013, para. 5). The fourth tip is interrupt when interrupted (Wen, 2013, para. 6). Wen (2013) suggests a patient should pretend to have a conversation with the physician, even if the patient is not having a conversation with the doctor (para. 6). The fifth tip is to focus on your concerns. An example of “focus on your concerns” would be: “Excuse me doctor, I have tried to answer all your questions...” (para.7). The sixth tip is to make sure you are courteous and respectful to your doctor (Wen, 2013, para. 9).

Miscommunication and dishonesty are not just a challenge for doctors. Patients also share the responsibility for being honest. Pirates life for me (2012) states, the “Problem is that patients lie to doctors all the time, and they have to decipher the truth to find out what’s going one. It happens out of pride, embarrassment and any number of reasons--patients are reluctant to give the truth” (para. 1). According to Black (2013), patients should play an active role when it comes to their health (para. 4). Black (2013) suggests that patients talk to their doctors and explain their symptoms clearly (para. 4). Black (2013) states, “Ask questions when you’re unsure about something...” (para. 4). Corbett (2012) states that doctors are trying to do the right thing, but patients have to speak up about their individual needs and values (para. 4).

According to Corbett (2012), if a patient does not speak up, physicians will make assumptions based on their own experiences and perceptions of what the patient’s needs really are, and this approach may not be the best for the patient (para. 4). Corbett (2012) suggests five tips that will assist patients in being more honest with their doctors. First, *tell the doctor what you want*. Don’t assume the physician knows what you want. Tell your doctor you want him or her to be totally open and honest with you and that you should play an active role in the decisions made regarding your medical care (para. 5). The second tip, according to Corbett (2012) is that patient’s should educate themselves. In other words, patients should review information about treatment

options *before* their appointment (para. 6). Third, Corbett (2012) suggests patients have a *face-to-face-meeting* with their doctor. Corbin (2012) states, “It’s easier to know if someone is being open and honest with you if you can look into their eyes [sic].” (para. 7). The fourth tip for patients is to *jot down questions beforehand*. Corbett (2012) suggests that patients prepare questions in writing, and writing questions will prevent the questions from being forgotten (para. 8). The fifth tip is: *Don’t be shy about speaking up*. If a patient doesn’t understand something or if what the doctor said something that may not sound right, a person needs to ask the doctor “point-blank,” and be specific. The doctor may be tired and may have misunderstood what the patient has said. Corbett (2012) states, “Doctors are human” (para. 9).

Part of patient responsibility is for a patient to be honest to him or herself. This honesty with one-self is especially applicable when the patient is suffering from a terminal illness (cancer for example) and has little time left.

Handzo (2012) is a chaplain, who has worked with cancer patients for over 20 years. Handzo (2012) addresses the need for patient responsibility and honesty. According to Handzo (2012) the vast majority of patients come to the “truth” when they are ready for it and it may mean that doctors need to be alert for signals from the patient that they are ready to hear the prognosis (para. 1).

Patient responsibility has been identified as a theme in this analysis. This theme is important because communication (in the context of patient responsibility) has been described as a “two-way street.” Patients are responsible to perform some research regarding their ailment, be prepared to ask questions and then be honest with their doctor, so that the best options can be considered. I started my communication based research with the physician in mind. However, as I have analyzed web-logs, I have realized that effective communication is the responsibility of both the doctor *and* the patient. In the context of patient responsibility, questions from the patient

need to be asked. Patients also need to follow the directions from their doctor. And patients need to make sure that their doctor understands the problem.

I would suggest, that health care organizations be willing to educate patients on what to expect from their doctor during that first initial visit to the doctor's office and during the course of any given treatment.

### **Physician Honesty**

The use of honesty by physicians was a theme found in the web-logs and as expected, the use of honesty by doctors produced positive results. The practice of dishonesty, by physicians, had predictably negative consequences. *Honesty* is defined as: "Fairness and straightforwardness of conduct" or "...a refusal to lie, steal, or deceive in any way" (Merriam-Webster, 2005, p. 596). Patients naturally expected their doctors to be honest with them and in turn, that doctors be honest with themselves. Adele (2012), who is a radiology technician, witnessed first-hand the pain that patients suffer, when doctors are not honest with themselves. Adele (2012) writes:

I believe doctors need to be honest with their patients and themselves...why put a patient thru endless tests, when the course of treatment will not change the outcome...the patient is suffering, yet let's do more painful radiology exams. All because the physician can't allow himself to say that the end is near, and allow the family to make the decision that they can say 'No more testing' (para. 1).

The following narrative is an example of what honesty can do. According to Porter (2013), a two and a half year old girl was brought into a doctor's office. Both the mother and the daughter were sick with a respiratory infection. The three physicians at the clinic were swamped with patients and the office was very busy. After a while, the mother and daughter were called back to see one of the attending physicians. After being looked at by the doctor, the mother and the daughter were both given prescriptions of cough syrup and codeine. The mother had the

prescriptions filled and followed the directions of the physician precisely. The mother started feeling better, but the daughter's health became worse and the daughter became lethargic. The mother called the doctor's office, and explained the situation with her daughter. The doctor's office told the mother to bring the daughter and the medication back to the doctor's office (para. 1). As the mother carried her daughter into the clinic, she was approached by the same doctor whom they had seen two days earlier. The doctor noticed the daughter was still very sick—but not from the respiratory infection, but from the prescribed cough syrup. The doctor had written the prescription for the daughter as an adult dose and the daughter was suffering from a codeine overdose. The daughter was immediately treated for the over-dose and recovered completely (para. 2, emphasis in the original). Porter (2013) states the following:

The physician ADMITTED his error and APOLOGIZED to me! He told me that he completely understood if I wanted to NEVER see him again after what he had done. I told him I was THANKFUL that he was able to admit the error and help me correct it before any permanent damage was done. That man remained my daughter's doctor until we moved away several years later. I have more respect for that physician than any that I have encountered that try to hide the mistakes they make. The courage it took for him to say he was sorry was enough. We are all human (para. 3, emphasis in original).

This narrative, given by a concerned mother, demonstrates what a little honesty can do. In this case, not only was the doctor-patient relationship saved, but the relationship endured for many years to come, because the doctor chose to be honest. The web-logs where the theme of physician honesty was discovered were written by patients and the extended families of patients. These bloggers emphasized two sides of physician honesty. First, a doctor needs to be honest with himself or herself. If a physician is treating a terminally ill patient and when everything medically has been done for the patient, the doctor needs to make an objective assessment of the situation,

counsel with peers and other medical professionals and then accept the fact that the patient is going to die and there not much more that can be done. Secondly, a physician should be honest with his or her patients.

The narrative given by Porter (2013) regarding the cough syrup is an excellent example of why a doctor should be honest. In the Porter (2013) case, the doctor made a mistake, had the humility and courage to admit that mistake and the end result was admiration of the patients mother. Physician honesty is important. As I conducted my research, it was apparent that many injuries and deaths occurred because of a mistake or an accident. When this happens, some doctors have tried to down-play or outright lie to cover up a mistake. Based on what I have learned, the victims of a medical mistake just want some accountability, for someone to apologize and then given assurances that the mistake will not happen again to someone else.

This chapter has focused on six themes that emerged from the analyzed data of thirty patient and physician web-logs. The themes identified were: empathy and compassion, third-party involvement, medical schools, patient hand-offs, patient responsibility and physician honesty. Through the use of grounded theory, these six themes were identified. By comparing the 15 physician and 15 patient web-logs, patterns of human behavior or themes started to emerge. These themes were evident as patterns started to repeat themselves with web-logs that were written by different individuals who were not related to each other nor did these bloggers know each other. And these themes were produced by bloggers who shared their common interest of communicating their experiences with others via the Internet. The significance of these themes and how they apply to the research questions will be discussed in the following chapter.

## Chapter 5: Conclusion

The purpose of this study was to analyze the web-logs of physicians and patients, identify themes and if possible, sub-themes that contribute to our knowledge of the communication problems between physicians and patients. Therefore, the target for original research was 15 physician and 15 patient web-logs. This chapter will discuss how the themes shed light on physician and patient communication. It should be noted that as the communication behaviors between physicians and patients were analyzed, this allowed a look at the relationships between doctors and patients in the context of medical treatment. In addition, the limitations of this study, suggestions for future research, and final thoughts regarding this study, will also be addressed.

There were six themes discovered during the analysis, they were: empathy and compassion, third-party involvement, the role of medical schools, patient hand-offs, patient responsibility and physician honesty. Empathy and compassion was the first theme. Empathy and compassion were character traits that physicians were expected to have. The ability of a doctor to possess these traits hinged on the examples and teachings from others. Web-log writers stressed the need of physician empathy and compassion, in the following two situations. First, patients desired that doctors showed compassion and empathy during a physician's day-to-day patient care. Second, patients (and their families) expected empathy, compassion and even tact when discussing life-and-death issues involving a loved one.

Why is empathy and compassion so important and why is there such a high expectation for doctors to be compassionate with patients? Physicians are treating patients who are sick or injured; who are away home, away from family and these patients should be treated, at the very least with dignity and respect and at the very most, with empathy and compassion. Treating a patient with empathy and compassion will reduce the possibility of a malpractice suit. More importantly, the use of compassion and empathy is good communication. Empathy and

compassion demonstrated a physician's concern for the person and not just the disease. Empathy and compassion promote healing, understanding and honesty. When a physician shows concern for a patient, that patient is more likely to trust the doctor and follow the counsel given. And if empathy and compassion can be demonstrated through appropriate physician disclosure, patients will not feel so alone in their situation. In the following narrative, a patient had injured his knee and needed surgery. The patient describes his interaction with the orthopedic surgeon and his feelings before and after, his surgery was performed.

Will (2010) states, "Before the surgery and during the post-op visits, the guy was dismissive and arrogant and even sometimes, downright hostile. It's like the doctor had no ability to understand how stressful it was for me to go under the knife, or how to be empathetic, or how even the smallest kind word or reassurance would have meant the world to me and my family. His lack of courtesy would have left me with zero hesitation to sue, had I been harmed because of him. There was no connection at all" (para. 1).

Some physicians believed that communication was worthy of their attention and were willing to learn how to communicate better. When doctors used web-logs to communicate their experiences and their stories, they were communicating to others. And when doctors used web-logs, they were sharing their stories, their experiences and their feelings, from their point-of-view regarding issues surrounding doctor/patient information exchange. I believe that some physicians are serious about how they communicate. Information, that has been entered previously in this thesis shows that a little more than 50% of the medically-related web-logs are written by physicians, nurses and other health care professionals. Medical schools, who employ physicians as teachers, have realized that communication is important. Medical schools, such as the one at Harvard, have recognized the need for communication training and have incorporated

communication basics into their required curriculum. And physicians have demonstrated a desire to learn good interpersonal communication by starting and contributing commentary to web-logs.

According to du Pre (2005) medical students can actually be desensitized to the feelings of patients, due to the fact that during a medical students training they work with cadavers as part of their course work. du Pre (2005) argues that medical students do not have to be compassionate or empathic with a dead person and when students graduate and start their own practices this non-compassionate and non-empathic behavior could be transferred to living people. du Pre (2005) argues that the behavior of medical students can differ—based on the condition of the patient. Cadavers have no feelings, they don't think, they don't move, and they do not speak. Cadavers do not feel pain and if the medical student makes an error, while using the cadaver, the cadaver will not file a law suit against the student. With all of these factors considered, I can understand how some of these cadaver-based behaviors can be transferred to living patients, once a medical student has graduated.

The influence of medical schools was an identified theme in the analysis. Medical students are learning medicine in a highly competitive and stressful environment—where grades are everything. Teachers and fellow students can be abusive and as was mentioned earlier, the years spent in medical school has been referred to as the longest rite of passage existing in the western world. And a blogger/medical student observed that some medical students exhibit some anti-social behavior, which may affect the way they treat patients in the future.

Fortunately, medical schools are beginning to realize the importance of including an interpersonal communication element into their programs. Harvard Medical School has done so with their three-year “humanistic approach” program that teaches medical students effective communication. In addition to the efforts at Harvard, the Warren Alpert Medical School at Brown

University has established a nine step competency based curriculum, and is called *The Nine Abilities*. The first of these nine abilities is Effective Communication.

The next theme discovered in the analysis was third-party involvement. In the context of patient care, it is not just the attending physician that is included in the patient's information circle. Other people such as social workers, hospital administrators, family surrogates, family spokespersons and the Family Support Coordinator or (FSC) as suggested by Janowski (2012) can also be included as partners in the communication process. However, even the role of the family spokesperson or surrogate can have negative consequences. The downside to being a family surrogate or spokesperson was their responsibility to not only speak for the family, but also make life-and-death decisions for the family.

There were arguments presented by bloggers suggesting that family surrogates or spokespersons can do more help than harm. In these situations, extended family members and their chosen spokesperson would ask doctors to do everything medically to extend the life of their loved one, even at the overall detriment of the patient. Therefore, the "Family Support Coordinator" was suggested by a blogger as a third-party advocate. The Family Support Coordinator or (FSC) should be a person that is employed by the hospital or clinic; who is not related to the family and can serve as a liaison between the health care institution and the family. The reasoning behind the FSC was that this person would not have emotional ties to the family and could act objectively, for and in behalf of a patient. The FSC is needed and families need to be offered the services of such a person.

The theme of patient honesty, which also was found during the analysis, is connected to third-party involvement. The analysis suggests that family members had a difficult time being honest with themselves. Some families had a difficult time accepting the fact that their loved one was dying. Patients and their extended family need to seriously consider the counsel given by

doctors, in the event that a patient or loved one is soon to die. The issue is that family members will rely on science to prolong the life of their patient/loved one, when in reality the death of the patient/loved one may only be days or weeks away. Extended families may know and realize this—that their loved one will die soon. However, to avoid a guilty conscience, the extended family will use science to prolong life. Family members need to be honest with each other, in order to avoid necessary and costly medical procedures. And by the same token, physicians are equally responsible to be honest with him or herself with the impending death of a patient.

The next theme discovered was patient responsibility. I found the theme of patient responsibility, as physicians and other medical professionals vented their frustration via web-log comments how patients lacked good listening skills, would not follow-through with reasonable requested form their physician and would outright lie to their doctor.

This theme was connected to the use of web-logs. Doctors expressed in their web-log comments that patients should take responsibility for their own medical care. Patients could take responsibility by logging on to the internet, finding web-logs that were accurate and credible to their medical concerns and find information they could use. It should be mentioned at this point that although web-log technology has the potential to inform people and save lives, not every person can benefit from web-log technology. There are countries in the world that do restrict Internet access. There are places in the world that are have not adapted to the Information Age and simply do not have the infrastructure to facilitate access to the Internet. There are people who have access to the Internet, but may be intimidated by the technology. Those individuals who have used the web for information must keep in mind that not all web-logs are created equal and many web-logs may not be that accurate when considering the source of web-log information. There are also a vast number of medically related web-logs. Many of the web-logs chosen by bloggers originated with health care organizations, hospitals, clinics and by other reputable

organizations that appeared to have a vested interest in web-log narratives. Patients can exercise more responsibility by becoming more educated. When using the Internet/web-logs, patients can enter specific words in their search engine that will yield the best results.

There are imposed guidelines by professional organizations that help regulate web-log content. Miller and Pole (2010) states “Professional organizations such as the American Public Health Association and the American Medical Association have developed guidelines regarding the quality and nature of health and medical information posted on the Internet” (p. 1518). Included in patient responsibility, was the asking of good, pertinent questions during the first doctor/patient interview. And it was evident that both doctors and patients stressed the usefulness of web-logs to become better informed.

The discovery of the patient responsibility theme was unexpected, but made sense given that communication is in reality—a two way street. A sub-theme of patient responsibility is connected with not only patients, but doctors also. That sub-theme was the socialization of both doctors and patients. According to previous research findings and the web-logs, doctors are socialized to act in a patriarchal or authoritarian role. Patients unfortunately, are socialized to play the ‘sick role’ of a patient. This “sick role” was described by Wilkins (2012) as the following, “...patients for their part are trained and are well-socialized from childhood to assume the ‘sick role’ where the doctor does all the talking” (para. 1-4). The “sick role,” as demonstrated by patients, has a negative effect on the doctor/patient relationship. When a patient plays the “sick role” they removed themselves from being an active participant in the healing process. This socialization of both doctors and patients had a negative impact on interpersonal communication. This socialization has a negative impact on both the doctor and patient because the interaction between the doctor and patient can be one-sided—with only the patient or the doctor doing all the work.

According to web-log comments, a more proactive approach is needed. Patients need to do their own research and be prepared with specific questions for their doctors, so that they can receive specific answers to concerns they may have. Both the patient and the doctor should be good listeners and based on previous research studies, physicians should not interrupt their patient's explanation of what is afflicting them. I would suggest, that a health care organization that operates hospitals and/or clinics, be willing to educate patients on what to expect from their doctor during that first initial visit to the doctor's office and during the course of any given treatment. How to educate patients effectively is yet to be found. Physicians could go so far as to ask for verbal commitments from patients to ensure that patients follow medical advice as given by their licensed doctors. Asking for commitments and holding patients responsible for their treatment could avoid enabling tendencies.

Physician honesty was yet another theme. Some web-log narratives suggested that doctors were expected to be honest, not only patients but with themselves as well. Web-log writers did mention physicians who cannot accept that their patient is beyond hope and is going to die. Web-log writers suggested that physicians, who are not honest with themselves, will use all of the medical technology at their disposal in an attempt to save the life of a patient they know will die soon. For a doctor to save and extend life is the fulfilling of their medical duties and obligations. However, there are times when the death of a patient cannot be avoided. In the context of the imminent death of a patient, some doctors would do everything they could to save a patient for two reasons. First, a doctor can have a difficult time being honest with himself or herself and second, doctors felt that if a patient died while under their care, it was a failure on the physician's part. Clear communication can be achieved if the doctor is honest with the family. And second, being honest with families includes being honest with oneself when the death of a patient is the reality.

The role of medical schools was also an identified theme in the analysis. There is evidence that medical schools such as Virginia Tech Carilion and Brown University have taken the concept of communication seriously. Virginia Tech Carilion implemented a screening process; testing the communications skills of potential candidates and when medical students are admitted, interpersonal communication skills were taught by both Virginia Tech Carilion and Brown University, in conjunction with sciences related to medicine.

The next theme discovered was the patient hand-off. With all the themes analyzed for this thesis, the theme of the patient hand-off was the most frequently mentioned. Not only was the patient hand-off recognized as an industry-wide problem, but there were solutions, suggested by medical professionals, that could solve the problem. For example, Bonsall (2013) suggested the use of the following acronym, among others, that can be used in the patient hand-off to insure complete information exchange. The acronym is: “**I PASS the BATON**” which stands for **I**ntroduction; **P**atient; **A**ssessment; **S**ituation; **S**afety concerns; **t**he; **B**ackground; **A**ctions; **T**iming; **O**wnership and **N**ext. Patient hand-offs or the lack of effective patient hand-offs, caused problems that involved risk to patients. According to bloggers, the remedy to poor patient hand-offs is the incorporation for 15 minute window for doctors to perform an effective transfer of physician responsibilities. The “**I PASS the BATON**” acronym was given by a nurse and may not be known and/or used currently by doctors. I do acknowledge that the “**I PASS the BATON**” is a long acronym, but it is a start.

During the web-log analysis, there was one issue that surfaced that did not have enough evidence to be classified as a theme, but is worth mentioning. This issue was that of non-medical related factors that had a negative effect on physician communication. Many doctors work for hospitals which belong to massive Health Maintenance Organizations (HMO's). Many doctors manage their own clinics; hiring their own staff, ordering their own medical supplies and

basically, running their own business. It is clear that financial issues can play a role in doctor/patient communication, especially when those issues involve a small, physician managed clinic. The pirates life for me (2012) asked his physician about how much money the doctor earns, or doesn't earn. This blogger stated:

My doc told me he gets the princely sum of \$85 or so a MONTH per patient. It costs him \$58 per patient to cover administrative costs. They come in once a month, he does OK, they come twice, he's in the hole--cost wise. Three times, he's losing big time....trust me, the average doc isn't making much of a profit after they pay staff, office rent and malpractice insurance (para. 1).

I recognize that fact that many clinical physicians are actually running a business and for a business to survive, a reasonable profit margin needs to be maintained. It can also be concluded, that if a doctor is trying to make a profit, he or she will try to see as many patients as possible. This in turn leaves less time for communication and understanding. I believe that if patients have an understanding that a doctor's time is precious, these patients can arrive to their doctor appointment with good questions and a more cooperative attitude.

Miscommunication as a theme, which was mentioned extensively in published material, was mentioned briefly in the web-log entries. For example, Donahue (2013) states, "Nothing erodes confidence as much as when I speak to physician 'A' about the findings of physician 'B' and he has no clue about what I am speaking to" (para. 1). Another example of miscommunication between doctors is given by Kagalwala (2013) who states, "If the lines of communication fail, it can be disastrous for the doctor too, as the attending doctor may carry out a procedure or test that may have been contraindicated for some reason" (para.1). The following narrative written by a physician, describes what can happen when doctors and surgeons don't communicate. Reznick (2013) relates the following story:

I had a 92 year old patient with a history of paroxysmal atrial fibrillation who fell and broke her hip...the patient went down to the OR at 7 am and family went to the surgical waiting room...the anesthesiologist cancelled the case as being too high risk...the surgeon forgot to go to the surgical waiting area and tell the family that the case was cancelled. The patient had been taken to a hospital room and was there for several hours until the family found out that the surgery had been cancelled (para. 1).

When there is miscommunication between doctors and other support personnel, the odds increase that mistakes can be made and deaths may occur. Patients are definitely interested in communication, especially interpersonal communication with their doctors. Many patients do recognize the need to take responsibility for their communication behaviors, whereas others wanted or assumed the role of the sick person, and left all the communication to their physician.

To help train patients to be better communicators and thus change patient behavior, Dr. Donald Celgala at the University of Ohio developed the **PACE** framework. The **PACE** framework consists of the following. **Presenting:** Detailed information about how the patient is feeling is presented to the doctor. **Asking:** Questions are to be asked by the patient, if the desired information is not provided. **Checking:** Information is to be checked, by the patient, to ensure that the information given is understood. **Expressing:** Concerns, if any, are to be expressed about the recommended treatment.

The already established and increasing number of medically related web-logs has demonstrated that communication is important to patients. Patients are starting to realize the need to take on some responsibility for their health care. Patients are aware of physician behavior that may be considered anti-social and have openly expressed their concerns with web-log comments. Patients appear to be more vocal about treatment concerns when the treatment involves a loved one, like a family member.

Bridges of communication were and are being built by patients and physicians, through the use of web-logs. Web-logs have become an extremely popular and continuously growing, form of communication. Web-log commenters can be completely honest about what they have learned and what they are experiencing. Patients can read the web-log entries of doctors and vice-versa, at their convenience and then grow to appreciate the roles that each have to play. The patient and physician web-logs are building bridges of understanding. This bridge of understanding is built as comments are made on web-logs, and readers of those web-logs make comments of their own. Web-logs allow both the doctor and the patient to express their opinion in a medium that allows complete honesty and anonymity. I wish to point out that Osborne and Ulrich (2008) stated that 69% of doctors interrupted their patients before patients could complete their opening statements. When a person is writing a web-log comment, the possibility of being interrupted by someone in cyberspace is remote. Web-logs are used as a tool of understanding because they allow both physicians and patients to gather their thoughts and articulate concerns, without the influence of outside distractions.

### **Limitations**

The sample size, when the search criterion was entered on Google search box, ended up with results that were in the 7 million range. There were 15 physician and 15 patient web-logs selected for the research data. As Miller and Pole (2010) demonstrated, web-logs that focus on health care issues are unknown. Miller and Pole (2010) also have stated that virtually everything written about web-logs to date has consisted of anecdotes and descriptions of individual web-logs. There really has not been much empirical research performed on web-logs. Miller and Pole (2010) also discovered that most bloggers were younger, well-educated and female. Therefore, I may not have the opinions of those people who are older, less-educated and male.

The purpose of this study was to examine the narratives of physicians and patients through grounded theory method, discover emergent themes and with those themes, attempt to fill in gaps of knowledge regarding physician/patient communication. While this thesis has provided evidence of several themes and other supporting subthemes, there were limitations to this study that must be considered, and those limitations are addressed in this section.

As a researcher, I also acknowledge the limitations of the analysis. One problem is the use of stories or narratives. Some of the narratives that were written by bloggers are written based on the opinion of just one person, sharing only one side of the story. However, there were bloggers, both patients and doctors who tried to walk in the shoes of each other and actually complemented each other when effective communication was used and that resulted in a successful outcome. I am acknowledging that there are two sides to every story and I needed to read between the lines to come to a conclusion. In addition to the narratives, I recognize the limitations I bring into the study. I have not experienced any serious medical issues and have not been the victim of a serious injury. Therefore, my experience with physicians is quite limited. As a researcher I have to admit my own bias concerning doctors based on the experiences of my spouse, who has had numerous health issues and numerous interactions with family doctors, chiropractors, thyroid specialists and surgeons.

In August of 2008, my spouse went into cardiac arrest, and a Code Blue was called, which was a result of a drug overdose in preparation of an impending gall bladder surgery. Lack of effective communication between doctors, nurses and technicians, in my opinion, was a contributing factor. Thus, the motivating theme behind this thesis “Physician and Patient Communication,” became the driving force behind my research. As a researcher, I too share some characteristics with the blogger’s, whose comments I have read. I share a quest for knowledge and a sense of validation, as I can share my narratives and opinions with others.

## **Future Research**

In conducting future research, it is recommended that web-logs or blogs be used as a primary source of raw data for analysis. Web-logs are an excellent source of information. Web-logs can be written anonymously, at the convenience of the web-log writer and if possible, in the privacy of the bloggers home. Web-logs are indispensable because identities are kept confidential and this allows web-log writers to be completely honest in what is written online. Web-logs can remain unedited and can be accessed by anyone with a personal computer.

While this study did produce six prominent themes, there were several other themes that were identified, but lacked sufficient support information. Some of these lesser supported themes were: Medical errors and apologies, relationships and communication, ineffective communication and non-medically related factors. In years past, research was done with interviews and surveys. The use of interviews and surveys for this thesis would have been adequate, but when compared to the vast number of rich and vibrant blogs, surveys and interviews would not have provided the quantity and quality of raw data that web-logs contained.

## **Conclusion**

The purpose of this thesis was to research physician and patient web-logs or blogs. Using grounded theory as a lens to view narratives, the analysis discovered six themes, they were: empathy and compassion, third-party involvement, the role of medical schools, patient hand-offs, physician honesty and patient responsibility. As grounded theory was used, this theory could be likened to the use of filters. In the use of grounded theory, web-logs were selected by imputing specific search criteria that brought up a certain amount of web-logs that were related to patients, doctors and communication. As the web-logs were examined, there were patterns of human behavior or themes that emerged. These themes would be identified and selected, if the theme

reoccurred in some of the selected web-logs. As all of the selected web-logs were examined, it was clear that six patterns or themes kept repeating as the analysis progressed.

The ultimate goal of this research was to find and analyze web-log entries then discover themes that may not be found in published material on the subject. Web-logs were used as opposed to in-person interviews because of the volume and variety of information contained in the narratives that were written on these web-logs. Web-logs were selected based on their originating author or organization. Many of the web-logs used by bloggers had originated from reputable health care organizations, such as hospitals, clinics and law firms.

The analysis showed that interpersonal communication is a two-way street and it is the responsibility of both parties (the doctor and the patient) to be both effective transmitters and receivers. I believe that when it comes to the doctor/patient relationship, this relationship represents a partnership and that as patients; we need to be responsible for our medical treatment. I also believe that physicians need to be better trained in interpersonal communication skills. But until these things happen, we may need to change our expectations.

What I have found is that there is a link to my findings and the findings of earlier web-log researchers. Web-logs are becoming a dominant method of doctor/patient communication research. I believe that there is information contained in web-log entries that cannot be found anywhere else. The evidence suggests that more empirical research is needed to understand medically related web-logs. This thesis could be used as a start for further research that examines whether or not these themes are present across a larger sample of web-logs.

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## Appendix A

### Hippocratic Oath: Classical Version

I swear by Apollo Physician and Asclepius and Hygieia and Panacea and all the gods and goddesses, making them my witnesses, that I will fulfill according to my ability and judgment this oath and this covenant.

To hold him who has taught me this art as equal to my parents and to live my life in partnership with him, and if he is in need of money to give him a share of mine, and to regard his offspring as equal to my brothers in male lineage and to teach them this art—if they desire to learn it—without fee and covenant; to give a share of precepts and oral instruction and all the other learning to my sons and to the sons of him who has instructed me and to pupils who have signed the covenant and have taken an oath according to the medical law, but no one else.

I will apply dietetic measures for the benefit of the sick according to my ability and judgment; I will keep them from harm and injustice.

I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect. Similarly I will not give a woman an abortive remedy. In purity and holiness I will guard my life and my art.

I will not use the knife, not even on sufferers from stone, but will withdraw in favor of such men as are engaged in this work.

Whatever houses I may visit, I will come for the benefit of the sick, remaining free of all intentional injustice, of all mischief and in particular of sexual relations with both female and male persons, be they free or slaves.

What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of men, which on no account one must spread abroad, I will keep to myself, holding such things shameful to be spoken about.

If I fulfill this oath and do not violate it, may it be granted to me to enjoy life and art, being honored with fame among all men for all time to come; if I transgress it and swear falsely, may the opposite of all this be my lot.

## **Appendix B**

### **Hippocratic Oath: Modern Version**

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

I will apply, for the benefit of the sick, all measures [that] are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug.

I will not be ashamed to say "I know not." Nor will I fail to call in my colleagues when the skills of another are needed for a patient's recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my own frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person's family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to reserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help.