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ABSTRACT

Despite the emphasis on improving physician-consumer communication, patients, families and friends of patients, and other consumers still report frustrations during communication interactions with physicians. Some of those problems could be alleviated by more physician training in effective communication. Others could be alleviated by reducing the pressures physicians encounter from managed care insurers to increase patient loads and decrease appointment times. These solutions, although feasible, require major institutional and systemic changes. This project proposes that scholars in health communication develop and implement community education programs that address consumer concerns about health communication. Based on a review of literature, it suggests the broad objectives and logistical issues that should be considered during the planning stages of such programs. Based on a case study, it describes the benefits the programs hold for members of the community and scholars in health communication. (Contains 12 references.) (Author/NKA)

Positioning the Practice of Health Communication in Community Education Programs

by

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Abstract

Despite the emphasis on improving physician-consumer communication, patients, families and friends of patients, and other consumers still report frustrations during communication interactions with physicians. Some of those problems could be alleviated by more physician training in effective communication. Others could be alleviated by reducing the pressures physicians encounter from managed care insurers to increase patient loads and decrease appointment times. These solutions, although feasible, require major institutional and systemic changes. This project proposes that scholars in health communication develop and implement community education programs that address consumer concerns about health communication. Based on a review of literature, it suggests the broad objectives and logistical issues that should be considered during the planning stages of such programs. Based on a case study, it describes the benefits the programs hold for members of the community and scholars in health communication.

Positioning the Practice of Health Communication

in Community Education Programs

A recent survey found that 33 per cent of the unsupportive experiences encountered by parents of children with chronic illnesses or disabilities occurred during communication transactions with health care providers, primarily physicians (Gilbert, 1997 Dec. 28). The survey, completed by 182 families in Seattle and Minneapolis, was part of a study on social support co-authored by Robert W. Blum, an obstetrician with the University of Minnesota's School of Medicine. When asked to comment on the results, he said they reflect the difficulty physicians experience when they have to relay distressing news. Blum noted that physicians, like other people, "'often don't know what to say'"(Gilbert, p. C-6).

Survey responses suggested that parents did not know how to respond when physicians dismissed their concerns. The parents stated that physicians ignored their questions about diagnoses and prognoses, made insensitive comments, or seemed too hurried to talk (Gilbert). According to Blum, the failure of physicians to provide supportive communication stems from the failure of medical schools to offer classes in effective physician-patient communication.

Blum's explanation is supported by a recent Harris poll in which 61 per cent of 230 primary care physicians stated medical education programs did not provide adequate training in effective communication (Gilbert). During an interview, C. Everett Kook, who commissioned the poll, told Gilbert that he concurred with the survey's findings. The former surgeon general stated that he plans to discuss the results with members of the Take Time to Talk Advisory Council, a group he organized in an effort to improve the quality of physician-consumer communication.

Although the council may succeed in solving a "longstanding problem"(Gilbert, p. C-6), the implementation of that solution will require changes in institutional priorities and professional practices. The slow evolution of such shifts will not alleviate immediate consumer concerns about health communication.

This project proposes that health communication scholars develop and implement community education programs to address those concerns. Based on a review of literature, it suggests the broad objectives and logistical issues that should be considered during the planning stages of such programs. Based on a case study, it describes the benefits the programs hold for members of the community and scholars in health communication.

Amplifying the Voice of the People

Although business, educational, and political campaigns often claim to represent the voice of "the people," (Barrett, 1974), scholars in rhetorical criticism have often dismissed the significance of the text intended for members of the general public (McKerrow, 1989). According to McKerrow, scholars who adopt his framework of a critical rhetoric can restore the voice of the people by constructing a text comprised of messages about a particular issue that reach a general or mass audience. He advocated that scholars enact twin critiques of domination and freedom based on their analyses of the constructed text. The critique of domination, which identifies oppressive elements of the status quo, is complemented by the critique of freedom, which addresses possibilities for change.

In health communication, scholars have applied McKerrow's philosophy in studies of physician communication with patients, families and friends of patients, and other consumers. They have constructed and analyzed texts of consumers who represent "the people" within the

context of health communication. From McKerrow's perspective, they have advanced critiques of domination and freedom based on their findings. For instance, Geist & Gates (1996) pointed out that studies about health communication in organizational settings often focus on managerial strategy and ignore the consumer's story. According to the authors, these studies fail to acknowledge the significance of the context, the domain of interpersonal communication, and the voice of the people.

Kreps (1988) has amplified the voice of consumers through his model of relational health communication. Witte, et al. (1996) have also strengthened that voice by placing people at the center of a health communication model based on chaos theory. Although Kreps and Witte, et al. hold different theoretical perspectives, they support the same conception of the patient or consumer as a co-participant in health communication transactions.

Ballard-Reish (1990), Geist & Gates (1996), and Rimal, Ratean, Arnston & Freimuth (1997) have also stressed the importance of communicative behaviors that demonstrate equal regard for the voices of the consumer and the physician. Their studies, like Kreps' model, illustrate how verbal expressions, nonverbal communication, and listening behaviors can invite or deny compliance and build or destroy relationships. As Kreps noted, consumers and physicians who attend to the process of communication by acknowledging each other's credibility, listening with empathy, and engaging in other supportive communication behaviors enhance interpersonal satisfaction and therapeutic outcomes.

Although it is beyond the scope of this project to discuss all of the studies that have suggested means of amplifying the patient's voice, they represent solutions to the "longstanding problem" (Gilbert, p. 6). Consistent with McKerrow's philosophy, they have communicated their research results within and beyond the Academy in efforts to engender

"change through critique" (McKerrow, 1991, p. 75). Yet, as Black (1997) pointed out, most medical educators and practicing physicians have failed to acknowledge their findings.

Positioning the Practice of Health Communication

Health communication scholars share the frustrations of Blum, Kook, and other physicians who have undertaken efforts to amplify the patient's voice. Although their findings hold the promise of improving the quality of physician-patient communication, realizing that potential requires a long-term commitment to change on the part of individuals and institutions. Their efforts to share and apply health communication scholarship in physician training and health care delivery systems will not address the immediate concerns of the patient in a physician's office. As Kook and Lammers & Geist (1997) observed, those concerns will multiply with the growth of insurance systems that emphasize population health at the expense of individual well being.

Geist and Lammers proposed that health communication scholars respond to these concerns by showing patients how assertive communication skills could help them manage their interactions with managed-care insurers. They also noted that scholars could help patients understand the need to employ clear and concise language when communicating with doctors who are pressured to increase the number of patients they see and decrease the amount of time they spend with each one. Their suggestions could be incorporated into community education programs on health communication. Such programs could amplify the voice of the patient and position the practice of health communication. Their success would not be hampered by institutional forces, professional practices, or the traditional lack of communication between academe and industry. Based on my experiences in organizing a program on health communication, they also generate an enthusiastic response from

community members. I decided to begin my practice of health communication during a conversation with three friends who belonged to a local senior citizens group. They complained about the confusion and frustration they experienced when they tried to obtain information or clarification from physicians about health problems, prescriptions, and other topics. They also stated that their doctors ignored their complaints. One of them remarked that his physician "never seems to have time to talk."

When I asked them if they would be interested in organizing a discussion group to address their concerns, the response was an enthusiastic "yes." During the next three months, my friends helped me recruit participants, select a discussion topic, and reserve a room at the local senior citizens' center. As a result of our efforts, 12 other members of the senior citizens' group agreed to share in a discussion of an article titled "Rx for Better Patient-Doctor Communication." The article, which appeared in a recent edition of New Woman, referenced the work of two physicians, Debra Rotter and Christine Laine. Rotter is a professor at Johns Hopkins School of Public Health and Laine is a professor at Jefferson Medical College in Philadelphia. Two weeks before the meeting date, my friends personally delivered copies of the article and asked the participants to be prepared to discuss it.

The 10 a.m. meeting began with a roundtable review and discussion of the article's main points. Then, I assigned the participants to four groups and asked them to develop and perform skits to illustrate scenarios suggested by the article. The skits, which were instructive and entertaining, ended at noon. The discussion continued during a lunch prepared by volunteers at the center. Before adjourning our meeting in the early afternoon, I asked the participants to try to follow at least one of the article's suggestions.

They agreed and wanted to meet again to discuss their experiences. We agreed to meet for lunch three to four months later, with one of my friends volunteering to make the arrangements. Several weeks later, twelve of us met a local restaurant. Their follow-up reports convinced me that our program succeeded in addressing the concerns of consumers and surprising a few local doctors.

We also decided to hold another discussion on a different health communication topic. We agreed to meet sometime during the last two weeks of May and to share the planning responsibilities. They will select the topic, reserve a room in the senior center, and recruit additional participants. I will provide ideas and materials and moderate the discussion.

As of this writing, I believe that our discussions will continue. I will continue my limited practice of health communication as long as the demand for my services exists. The demands on my time will be lessened by the willingness of the participants to handle all logistical matters. The rewards for my efforts lie in the knowledge that scholars in health communication can apply their findings to help consumers amplify their voices.

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