THE STORY OF MEDICINE: FROM PATERNALISM TO PARTNERSHIP

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ABSTRACT

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Physicians were interviewed and asked about their perspectives on communicating with patients, media, and the ways in which the biomedical and biopsychosocial models function in the practice of medicine. Fisher's Narrative Paradigm was the primary critical method applied to themes that emerged from the interviews. Those emergent themes included the importance of a team approach to patient care; perspectives on physicians as bad communicators; and successful communication strategies when talking to patients.

Physicians rely on nurses and other support staff, but the most important partnership is that between the physician and patient. Narrative fidelity and probability are satisfied by strategies physicians use in communicating with patients: using understandable language when talking to patients; engaging in nonverbal tactics of sitting down with patients, making eye contact with patients, and making appropriate physical contact with them in the form of a handshake or a light touch on the arm.

Physicians are frustrated by media's reporting of preliminary study results that omit details as well as media's fostering of expectations for quick diagnostic processes and magical cures within the public. Furthermore, physicians see the biomedical and biopsychosocial models becoming increasingly interdependent in the practice of medicine, which carries the story of contemporary medicine further into the realm of partnership, revealing its humanity as well as its fading paternalism.

Kristina Horn Sheeler, Ph.D., Chair

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ABBREVIATIONS & DEFINITIONS

Angina: Chest pain.

Angioplasty: Involves temporarily inserting and blowing up a tiny balloon where an artery is clogged to help widen the artery (Mayo Clinic).

Cardiologist: Physician who specializes in treating the heart/cardiovascular system.

Cellulitis: "Common, potentially serious bacterial skin infection. Cellulitis appears as a swollen, red area of skin that feels hot and tender, and it may spread rapidly" (Mayo Clinic).

Defibrillator: Device used to shock the heart back into a normal rhythm [may be internal, i.e., implantable cardioverter device (ICD) or external, i.e., shock paddles].

Ejection Fraction (EF): "A measurement of how well your heart is pumping" (May Clinic).

Electrophysiologist: Cardiologist with special training in treating heart rhythm disturbances.

Familial Hypercholesterolemia: Extremely high total cholesterol level that is hereditary in nature.

Hyperlipidemia: High level of fats in the blood.

Hypertriglyceridemia: A high level of triglycerides, or specific type of fat, in the blood. Hypertriglyceridemia is a type of hyperlipidemia.

Low-Density Lipoprotein (LDL): "Bad" cholesterol.

Myocardial Infarction (MI): A.K.A., Heart attack—"Occurs when a blood clot blocks the flow of blood through a coronary artery — a blood vessel that feeds blood to a part of the heart muscle." (Mayo Clinic)

Nephrologist: Physician who specializes in treating the kidneys.

NPO: Literally, "nothing per oral"- when patients cannot eat or drink anything prior to a test or procedure, they are considered to be of 'NPO' status.

Patent Foramen Ovale (PFO): "While a baby grows in the womb, there is a normal opening between the left and right atria (upper chambers) of the heart. If this opening fails to close naturally soon after the baby is born, the hole is called patent foramen ovale (PFO)." (U.S. National Library of Medicine)

Pulmonologist: Physician who specializes in treating the lungs/respiratory system.

Stable Angina: Chronic chest pain that responds to medications like sublingual nitroglycerin or ranexa.

Stent: "A small mesh tube that's used to treat narrowed or weakened arteries in the body" (National Heart, Lung, & Blood Institute).

Unstable Angina: Chest pain that is no longer responsive to medication (like sublingual nitroglycerin or ranexa) and could indicate a life-threatening condition (heart attack).

INTRODUCTION

Many forms of media, particularly film, depict physicians as cold, uncaring scientists who are incapable of recognizing a patient as anything more than an incubator for disease. Goals such as discovering new cancer treatments with the hope of finding a cure, in addition to the very act of saving lives, are portrayed as selfish and arrogant. The cinematic patient is a victim—not of terminal illness—but of experimental treatments and hasty, hollow, purely obligatory niceties of doctors.

I became acutely aware of this phenomenon during a graduate level medical humanities course, "Perspectives on Film in Medicine," in which I was introduced to films that presented physicians in this way. For instance, while *The Doctor* (1991) had its positive portrayals, it also had its negatives. Dr. Jack McKee was diagnosed with laryngeal cancer (cancer of the voice box) by an ENT with a severely lacking bedside manner. She did not participate in small-talk and made it clear to him that she was in charge—her schedule mattered more than his. *Wit* (2001) also centered on cancer diagnosis and treatment overseen by non-empathic, non-sympathetic physicians (www.imdb.com). This film is discussed further below. Having worked with physicians, including oncologists, on a daily basis for a number of years, I knew that these presentations were not telling the whole story. The potential for audience members to perceive these portrayals as true and representative of actual doctors became readily apparent.

This led to an IRB-approved research project in which I interviewed undergraduate communication students in conjunction with showing them the film *Wit*. Emma Thompson stars as a Professor of 17th Century Poetry who is diagnosed with Stage

IV Ovarian Cancer. She is treated at the University Hospital affiliated with the institution at which she has taught for many years. Her oncologists are portrayed as the above paragraphs described. Furthermore, although fictitious, *Wit* was filmed as if it were a documentary.

Since documentaries are largely believed to be factual, it seemed reasonable to believe that the audience would be affected more deeply than they otherwise would have been had Emma Thompson's character not been talking directly into the camera—"telling her story." With that framework in place, I interviewed IUPUI undergraduate students about their experiences and comfort/discomfort with family and specialty physicians; their general feelings about physicians; as well as their primary means of acquiring information about physicians (i.e. via appointments, work in healthcare, or via media). I then watched *Wit* with them and asked follow-up questions to gauge any change in or confirmation of students' perceptions of doctors.

Interview transcripts were analyzed for emergent themes according to Vladimir Propp's concept of *Dramatis Personae*. Propp was a Russian scholar of narrative structure who initially studied folktales and broke down the narratives into their most basic parts, called "narratemes." When put together, these narratemes represent a formulaic narrative structure, particularly in regard to plot and character, which most storylines still fit today (www.isfp.co.uk; www.changingminds.org).

Along with identifying the 31 narratemes, Propp also identified eight character types usually featured in narrative structure. These are known collectively as Propp's *Dramatis Personae*. When applied to the *Wit* research project, four character types emerged throughout the participants' responses to the interview questions: patient as

"hero"; nurse as "helper"; physician as "false hero"—not quite a "villain" but a necessary evil; and biomedicine/biomedical model as "villain."

As can be seen, the film *Wit* confirmed pre-existing negative notions about doctors. None of the students were surprised to see how the physicians had treated the patient as a person (not medically but socially). Fisher (1984), who proposed the idea of a Narrative Paradigm (to be further explained in the Methodology Section), would say that the students' notions of narrative fidelity had been confirmed, meaning that the patient's experience with physicians rang true to the students' own personal experiences (p. 8).

The experience I had speaking to students about their general perceptions of physicians before and after viewing *Wit* helped me begin to realize that their perceptions were very similar to patients' perceptions that had been discussed in many of the academic articles that I had consulted throughout multiple semesters of study. At that point, I looked more closely at the existing doctor-patient communication literature and found that a much larger volume has been dedicated to the patient's experience—not only with illness but with physicians. While the significance of the patient's point of view is great, the physician's voice is present in a much smaller volume of the literature.

My main goal in making the physician's voice a bit louder within health communication research is to unveil the presence of humanity in biomedicine. Films that showcase the physician's poor bedside manner as *The Doctor* did and those that highlight the physician's drive to achieve fame as an expert in his/her specialty field to the point of sacrificing acknowledgement of human suffering as *Wit* did oppose any notion of a caring physician. The students I spoke with seemed to agree with that opposition.

Having worked with physicians for five and a half years, I knew the stories, touted by these films, were not the only stories to be told. Rather than add to the existing large volume of patients' perceptions about experiences with physicians, I want to add to the comparatively small volume of physicians' perceptions about experiences with patients. With that in mind, I really want to make the idea of communicating with physicians tangible for others and to give physicians the opportunity to respond to others' perceptions of their occupation. However, the word 'occupation,' seems inappropriate after working with them as I have because the role of physician seems to be more of an identity than an occupation. In any event, I thought it only fair to give physicians the academic space in which to tell their stories.

Throughout this proposal, I will explain why this particular research on the physician's voice is important. I will also further discuss the health communication literature that has led me to this point, defining terms and concepts as necessary. Afterward, I will reveal the questions that still remain and explain the methodology, Narrative Analysis (Fisher), to be utilized in answering them.

RATIONALE

In general, scholarly articles focusing on narrative medicine, or physician-patient relationships, either chronicle a disease/illness experience, showcase how/why patients feel as they do about doctors, or present the perspective(s) of third party analysts. These matters are important, but *very few* academic articles present the physicians' points of view. I would like to contribute to, and expand, that particular set of viewpoints.

A foundational element to the absence of the voice of the physician is the framing of biomedicine, or the biomedical model. The participants from my most recent research project involving the film *Wit* drew stark contrasts between the biopsychosocial model (which they associated with nurses) and the model of biomedicine (which they associated with physicians). The biopsychosocial model is one that addresses the physical, emotional, and familial/friendship dynamics of patients' conditions (Smith, 2002). The biomedical model, on the other hand, is one that only focuses on the physical condition to the exclusion of the other dynamics—as is discussed throughout this proposal.

The students' linking of doctors to an all-biological-business demeanor emerged from my interviews and indicates a perceived chasm between physicians and patients, suggesting there is lack of a rapport between them. I consider the perspective of students to be equivalent to the perspective of patients since they are neither physicians nor publishing scholars (as of yet); further the students in my study identified with the patient's role. Since I had asked the students about their experiences with physicians—as patients—this parallel is fitting. Therefore, what is represented by the student-as-patient population is yet another collection of viewpoints that does not include that of doctors. Again, it was my hope to give doctors the opportunity to address the primary claims

made about their ability to communicate (or, lack thereof, according to my previous research with the students) as well as the main claims made about the traditional approach to their life's work. My project sought to make the physician's representative voice a bit louder in the literature by interviewing physicians about their experiences with the following:

- Treating disease/illness
- Treating patients
- Successful and unsuccessful communication with patients
- How contemporary media impact their practice
- Their perceptions of the ways in which contemporary media portray them
- Whether patients ask more or fewer questions than they did in previous generations
- Their perceptions of the biomedical model and reactions to physicians being labeled as "bad communicators."

Questioning doctors from the angles of interpersonal and mediated communication was important because both are prevalent in medicine. Additionally, their perceptions on each of these topics culminated in resultant viewpoints which will inevitably affect future interactions with patients and, possibly, with fellow physicians.

The biomedical model, with its roots in molecular biology, has been perpetuated through the years as a "reductionistic" perspective—one that quarantines the body from the mind and proceeds only to focus on the body (Engel, 1977, p. 130). Reading Engel's article in particular leads one to believe a stigma against science was born in the 1970s. Biomedicine has been labeled an institution that does not care to concern itself with

emotions or social circumstances. As long as biological function is restored, the goal is met, and the job is done. The doctor cares about no more than that.

Frames or frameworks according to Entman (1993) are lenses through which we explain and understand phenomena (p. 52). For instance, the film *Wit* portrayed academic physicians as cold, uncaring scientists. In doing so, the film framed the image profile of doctors as cold and uncaring. The lack of surprise expressed by students who saw this image profile displayed in the film indicated that this is the type of physician they expect to meet in the exam room. Additionally, the fact that these students associate who they perceive to be cold, distant physicians with the biomedical model, ties the story of biomedicine to the existing negative framework. It is for this reason that Fisher (1984) would see this framework as affirming the perceived narrative fidelity of biomedicine. These perceptions are stronger for viewers who can identify with the central character's experiences with physician encounters (pp. 8-9).

To continue Entman's notion of framing, the model of biomedicine has been *framed* as detached, uncaring, and emotionless. This framework is also discussed in additional literature and is presented as a problem; however, the only proposed solution is to minimize the biomedical model in favor of a "humane medicine" model (Marcum, 2008, p. 393). Along the same lines, there have been efforts by media as of late to reframe the physician as more caring and concerned with the relational aspects of patient-care in order to advance the physical health of the body.

For example, "The Dr. Oz Show" (13-WTHR, 2 pm, M-F) features Dr. Mehmet Oz, a cardiovascular surgeon, who shares information about preventing heart as well as general health problems. He is quite interactive with audience members, often inviting

them onstage for health-related demonstrations and discussions (www.doctoroz.com). WISH-TV 8 offers "The Doctors" at 4 pm Monday – Friday. This program showcases a panel which includes Dr. Travis Stork (ER Physician); Dr. Lisa Masterson (OB/GYN); Dr. Andrew Ordon (Plastic/Reconstructive Surgeon); and Dr. James Sears (Pediatrician). These doctors discuss contemporary health issues which many of today's viewers are facing and answer questions received via email on the air (www.thedoctorstv.com). "Deliver Me" (OWN, 7 am, M-F) chronicles Drs. Alane Park, Yvonne Bohn, and Allison Hill. They are OB/GYNs in an LA office who went to school together and are now working together. This show portrays their work and home lives; it tells their stories as they live as physicians and as women (http://health.discovery.com/tv/deliver-me). Finally, "Mystery Diagnosis" (OWN, 4 & 5 am, F) showcases real-life patients and physicians reflecting on stories of rare diagnoses as actors re-enact events that occurred throughout the diagnostic process for the doctor as well as the illness experience for the patient (www.oprah.com). Recent programs such as these are in line with a reframing of the biomedical model to reveal the humanity within it. How physicians view communication further impacts this framework.

Biomedicine is a language—a discourse. As a scholar who views the world through communication-oriented lenses, I am driven to investigate the communication strategies of biomedicine and trace its roots to the extent possible. It has been the goal of this research project to reveal the psychosocial behaviors of patients that physicians acknowledge in addition to the biological phenomena, bringing to light the physicians' understanding of the types of issues they encounter on a daily basis on the front lines of medicine.

LITERATURE REVIEW

As stated above, many scholars have framed the biomedical model as "reductionistic." Callahan & Pincus (1997) are no exception, although they did highlight the areas in which this model has been successful, namely in acute (emergent) medical situations wherein the patient has little knowledge and is dependent upon the expertise of physicians to address the problem(s). However, these authors also criticized the biomedical model, calling it insufficient to treat chronic illness and accusing it of only recognizing "single causes and cures for diseases" (p. 283).

Additionally, Callahan & Pincus (1997) associated unhealthy behaviors with low socioeconomic status (pp. 284–285), but to what extent do unhealthy behaviors exist across financial brackets? This piece of knowledge is important to physician-patient interactions and, particularly, to patients' behavioral choices and compliance issues.

Continuing with the notion of physician-patient interaction, de Haes & Bensing (2009) observed that while studies have been consistent in identifying and explaining goals of the clinical encounter, specific communication components *within* that clinical encounter need to be elucidated. Particularly those components which are deemed successful and unsuccessful need to be highlighted (p. 288).

In 1962, Hanley & Grunberg noted that the physician-patient relationship was not part of the medical school curriculum (p. 1022), which suggests that communication was absent as well. According to the Indiana University School of Medicine's (IUSM) website, effective communication is one of the nine core competencies medical students must demonstrate prior to graduating. Although the year that this was put into effect could not be ascertained, I asked the physicians I interviewed if they took a

communication course in medical school, whether it was required or elective, as well as the course's main focus. In any event, the considerably late entrance of communication into the [required] list of medical education courses, which undoubtedly occurred in different schools at different times, has aided in perpetuating the current framing of biomedicine.

Laidlaw, Kaufman, Sargeant, MacLeod, Blake, & Simpson (2007) discussed the ways in which differences in physicians' personalities affect communication with patients. These authors did focus on physicians' assessments of their own videotaped simulated clinical encounters with patient-actors. Unfortunately, the physicians who were said to "focus on biomedical information" were deemed part of the "Least Exemplary Communicators" group (p. 157). The authors drew a distinction between "patient's perspective" and biomedicine.

Moving forward, Morris (2008) focused on narrative medicine as viewed by Drs. Mehl-Madrona & Charon (2007 & 2001). Here, narratives are not seen to encompass numerical data recorded about patients, such as blood pressure and heart rate (Morris, p. 89). To what extent do clinical data represent *part* of that narrative, though? Furthermore, to what extent does biological medicine tell a story which influences the type of conversation that takes place between the physician and patient?

Eggly (2002) acknowledged biomedicine's narrative component when she referenced Mishler's (1984) "voice of medicine" and "voice of the lifeworld," (p. 343). The first encompasses the medical details of disease and illness; the second encompasses the way these details were subjectively experienced by patients. Eggly's description, or framing, of these two voices as "conflicting rhetorical agendas" (pp. 342-343) implies

that these two voices are at odds with one another. Mishler's (1984) account introduced this conflict when he framed the medical interview as a session in which the patient's story "interrupts" the physician's "voice of medicine" with the "voice of the lifeworld" (p. 97). These two voices are academically positioned in a competitive dynamic between physician and patient.

Oderwald (1994) took the unique position of explaining some of the ways in which metaphors and storytelling are foundations of biomedicine. To exemplify metaphor, he discussed physicians using the concepts of "demons and monsters…to explain bacteria and viruses to the general public." Patients understand biomedicine in simplified terms (p. 86). To exemplify the storytelling aspect, Oderwald described a study, conducted in Southampton, which split 200 patients with vague symptoms into two equal groups. One group was told no story could explain their symptoms while the other group was "given a fake biological explanation." One half of each of the groups (50 from the "no story" group and 50 from the "story" group) was given a placebo. The remaining group members were not given pills but told their symptoms would likely go away soon. Patients returned to see the doctor after two weeks. While there was no difference in the "frequency of healing" between the placebo groups, there was a remarkable difference in this frequency between the "no story" and "story" groups: 38% and 68%, respectively (p. 86). This study demonstrated that storytelling, and therefore, narrative analysis *matters*.

As mentioned earlier, the media's portrayal of physicians can have a significant impact on viewers. Brodie, Foehr, Rideout, Baer, Miller, Flournoy, & Altman (2001) noted that people have begun addressing health concerns with their physicians after having seen the same concerns addressed on popular television shows, such as *ER* (p.

192). This exemplifies a possible positive effect of medical shows. They are capable of prompting viewers to be proactive and initiate dialogue with their physicians about particular preventive health issues. However, a negative portrayal of a physician in the context of such a conversation, fictional as the scenario may be, could deter those viewers from seeking dialogue with their physicians, in reality. This notion is quite plausible when one considers Gerbner's Cultivation Theory, which suggests that the more viewers are exposed to a message(s) on television, or in a film, the more these viewers will expect their reality to align with those mediated messages/events (Brodie, et al., 2001).

Unfortunately, negative portrayals of physicians in cinema seem to be increasing. Flores (2004) marked the 1960s as the dawn of the unkind and uncaring physician in film, especially. Lupton & McLean (1998) noted that actual physicians are worried about the negative images that the media are often projecting. They feel as if their "entire profession is being judged by the excesses of a few doctors" (p. 947).

Of additional significance is the repeated presentation of research physicians who cannot seem to acknowledge their patients as people. They are only focused on the diseases they are attempting to cure (Flores, 2004). These doctors are often portrayed as inhumane beings looking for nothing more than the chance to make journal headlines in their respective fields. The suffering humans, within whom these diseases are wreaking havoc, are invisible to the research doctors. This scenario is yet another tied to an aged, shortsighted vision of the biomedical model.

Fearing (1947) was also interested in the impact films can have on subsequent attitudes and behaviors of the audience. He noted that several studies had been conducted on films' effects and stated that they offered "unequivocal evidence that

motion pictures *do* affect human attitudes" (p. 72). Furthermore, he mentioned several additional academic inquisitions, all of which demonstrated "that films have measurable effects on attitudes and that the effect is in the direction indicated by the film" (p. 74). When physicians are portrayed as symbols of insincerity, viewers may be less likely to seek [or follow] their input which can be a danger to their personal health.

In the same vein, Chory-Assad & Tamborini (2003) discussed the potential for media's negative depictions of physicians to become a detriment to public health in general, by decreasing the viewing public's trust in physicians. They found that repeated exposure to fictional prime-time medical shows correlated with negative public perceptions of physicians (p. 209). In light of that, they consider the possibility to be very real that media's seeming affinity for projecting adverse characteristics and behaviors of doctors may cause people to avoid seeing physicians when needed. The consistent depiction of doctors as self-interested and unkind has a strong probability of cultivating expectations for similar experiences in real life (p. 211).

Finally, as previously mentioned, the sheer number of studies looking at physician-patient communication from the vantage point of the patient is much larger than the number looking at the same phenomenon from the vantage point of the physician. Step, Siminoff, & Rose (2009); Albrecht, Penner, Cline, Eggly, & Ruckdeschel (2009); Liang, Kasman, Wang, Yuan, & Mandelblatt (2006); Hajek, Villagran, & Wittenberg-Lyles (2007); Bogart (2001); McComas, Yang, Gay, Leonard, Dannenberg, & Dillon (2010); and Conroy, Teehan, Siriwardena, Smyth, McGee, & Fernandes (2002) have all studied some aspect of physician-patient communication from the perspective of patients.

Physician-patient communication has also been looked at by third-party analysts in the form of meta-analyses. For instance, Duggan (2006) discussed a shift in health communication research over the last decade. Rather than making a specimen out of the doctor-patient encounter, researchers have broadened the scope to focus on the physician-patient relationship at large as well as the relational communication that contributes to it.

Frankel (2001), on the other hand, named the information exchanged during the clinical encounter as the "unit of analysis" when studying relational control (p. 107). Relational control has been applied to many types of dyadic communication in the past (p. 106). Applying it to the physician-patient encounter, however, implies that one person will always be in control of the conversation. Communication is not expected to be balanced.

Rimal (2001) has called for a clearer conceptualization of communication from researchers. He did so after reviewing six research studies on physician-patient communication and reading conflicting results. For example, one study found that "physician talk" was only patient-centered part of the time while another found "the opposite." Rimal would like to see more of a standard definition of such concepts (pp. 90-91; p. 98).

Moving along to a focus on physicians' perspectives, Harris took interest in medical students' viewpoints in 1981. Manchester medical students were mailed the first questionnaire of a longitudinal study one week before beginning medical school in 1971. This questionnaire intended to gauge students' perceptions of personality traits of the following: surgeons, physicians [medical rather than surgical], psychiatrists, and GPs [General Practitioners]. These same students again answered this questionnaire before

their final exams in 1976. Harris was struck by the similarities in both sets of answers from different points in time (pp. 1676-1677).

Cegala, McClure, Marinelli, & Post (2000) focused on both physicians' and patients' points of view. They found that "information exchange" is extremely important in physician-patient communication models which encourage "joint participation and decision making." They additionally noted that in order to engage in such participation, patients need to have a basic knowledge of their diagnosis (p. 219).

RESEARCH QUESTIONS

As I have attempted to demonstrate, the volume of literature devoted to health communication from the perspective of physicians is miniscule compared to the volume devoted to the perspective of patients. Therefore, my research questions were as follows.

RQ 1: Which themes are present across physicians' stories about communicating with patients?

RQ 2: What do physicians perceive as the overarching story of the biomedical model? How is it similar to and/or different from that perceived by the media, general public, and academia?

RQ 3: What are the conversational/storytelling elements required to begin to shift the dominant frame of the biomedical model? What new characters, themes, plotlines, and dramatistic arguments need to be born?

METHODOLOGY

I approached physicians I had come to know through working with them at various IU Health facilities. I approached them one of two ways: face-to-face or via email and explained that I was working on my thesis for graduate school. I also explained that I was interviewing physicians, asking for their opinions about portrayal of physicians by media as well as communicating with patients. I, then, asked them if they would be willing to sit down with me for 20 or 30 minutes to do an audio-taped, semi-structured interview. When they agreed, I inquired as to the best way to get that scheduled—whether it was to be directly with them or through a secretary.

Overall, I approached 19 physicians. Eighteen of them agreed to help me. One never responded to an email request, and I was not aware of an alternative email address for him outside of the general organizational email address. Six of the physicians, who had agreed to—and wanted to—help me, were simply far too busy. In the end, I was able to conduct conversational interviews with 12 physicians.

Three physicians were Interventional Cardiologists—meaning they treat heart attacks in the Cardiac Catheterization Laboratory by opening up blocked vessels in the heart. Three physicians were Cardiothoracic Surgeons. Three physicians were Heart Failure Specialists who treat patients with heart failure as inpatients and outpatients. I also spoke with one Electrophysiologist—a cardiologist who further specializes in treating rhythm abnormalities in the heart by placing permanent pacemakers (PPMs) or automatic implantable cardioverter devices (AICDs). Additionally, I interviewed one medical oncologist (one who prescribes and manages chemotherapy for cancer) as well as

one Emergency Medicine/Critical Care Medicine Specialist who treats patients in the emergency room and follows them in the intensive or critical care unit.

In order to answer the three research questions I posed, I asked physicians the following specific questions.

- How do you feel that physicians are portrayed by the media? [*Will results from Lupton & McLean's study from 1998 be confirmed in 2011?*]
    - Is this a fair/accurate portrayal and why/not?
    - How would you change this portrayal if you could? [*This question was not asked of everyone due to the evolution of the different conversations.*]
- How do you feel that the pervasiveness of contemporary media impacts your practice? Does it help or hinder? Or, is there no noticeable effect?
- With increased Internet access, have you noticed that patients are more inquisitive about their health than in previous generations—just because more information is now available to ask about?
    - OR, have you noticed that patients ask fewer questions than they used to?
    - If so, do you feel that patients are more trusting of the Internet/media than they are of their doctors?
- How do you respond when you hear that [the majority of] the public regards physicians as "bad communicators"?
- When do you feel that your communication with patients is successful (what are the successful components of that conversation/series of conversations)? [*This addressed what de Haes & Benson noted as a literature deficit in 2009.*]

- By the same token, when do you feel that your communication with patients is unsuccessful? Is there something specific?
- Were there specific courses in med school that dealt with doctor-patient communication?
    - Were they required or elective?
    - What was the nature/focus; how was the class/material structured?
- Do you feel the way in which biomedicine is framed (by the media, the public, even academia as detached, emotionless, and uncaring) is accurate? Why/why not? If not, how would you change it?

After all 12 interviews were conducted and recorded, I transcribed and analyzed them informed by Walter Fisher's Narrative Paradigm. Fisher first proposed his rationale for a Narrative Paradigm in 1984. He viewed human beings as storytellers who understand and articulate experiences through the telling of stories. Sense is made of these stories by assessing narrative fidelity and narrative probability/coherence, which, according to Fisher, we all have the natural capacity to do (1984, p. 9). Narrative fidelity is the believability of a story—the degree to which a story can be identified with and labeled as true. Fidelity is established when the characters and members of the viewing/listening/reading audience share the same values. It is also present when these various audience members can see themselves taking the same action or behaving in the same manner as the characters in question should they find themselves in the same or a similar situation (Fisher, 1985, pp. 349-350). Narrative probability/coherence, then, refers to a story's consistency, or coherent flow (Fisher, 1984, p. 10). It is present when the plotline and character histories are free of contradictions and fallacies. The analytical

tools of narrative fidelity and narrative coherence come together to form the quality of narrative rationality. Stories, deemed to be reliably good by the aforementioned tools, will exhibit this quality (Fisher, 1985, p. 349). Though Fisher has been my main academic informant throughout the analytic process, I did find that the principles in Aristotle's *Rhetoric* were also quite useful in analyzing emergent themes from the physicians' viewpoints.

Once physicians shared their stories with me during interviews, I evaluated them, looking for shared themes to emerge and create an overarching story which can explain how physicians view their communication with patients. Additionally, I looked for each physician's notion of narrative fidelity and probability to manifest in their stories of successful and unsuccessful communication with patients since the presence of these two elements indicates good listening and integration skills. The overall narrative structure present in each of the physicians' stories provided the larger frame through which to assess the explanations they give to their patients when explaining diagnoses and accompanying treatment options. It also helped to construct the framework of biomedicine as applied to the daily practice of specialty physicians.

ANALYSIS

As Walter Fisher insightfully stated in 1984, human beings are "storytellers" (pp. 1 & 6). We learn about and come to understand ourselves and each other through sharing our respective life-stories. Some of the most important stories shared throughout that time are those regarding illness and healing. The main voices participating in the construction and assessment of these stories belong to physicians, physicians' assistants (PAs), various levels of nurses and allied health staff, patients, and their family members. This particular analysis focuses on the voice of physicians as they navigate human interactions in both inpatient as well as outpatient settings.

RQ 1: "Which themes are present across physicians' stories about communicating with patients?"

Two major themes came to the forefront when analyzing the interviews I conducted with physicians: 1) teamwork consisting of important partnerships in healthcare and 2) successful physician-patient communication. Both of these themes are addressed in the following response to my first research question.

TEAMWORK

The importance of a teamwork approach to patient care—including communication with patients—emerged from each of my interviews with doctors. Physicians view their physicians' assistants (PAs), nurse practitioners (NPs), and medical assistants (MAs) as extensions of themselves. This allows different healthcare professionals on the same team [i.e., heart failure team] to continue the same conversation with patients that physicians initially begin. Doctors realize that patients—particularly in the hospital—are, likely, afraid and overwhelmed. This is especially true

if their stay is a consequence of an unexpected emergency or if they have recently received a grave diagnosis, such as cancer.

Fisher (1985) would suggest that the importance physicians place on the value of teamwork illustrates the value of trust they have in their fellow healthcare providers (p. 350). Additionally, their reliance on teamwork devalues arrogance on a larger scale. This is because medicine is no longer a story of which the physician is the sole author. He/she is the *primary* author, but doctors now have co-authors in the forms of physicians' assistants (PAs) and nurse practitioners (NPs). I feel it is pertinent to note that I have used the phrase 'primary author' because the physician is legally responsible for treatment decisions made by NPs and PAs, especially (Indiana Physician Assistant Committee, 2011, p. 5). However, the fact that physicians are legally required to supervise these roles (to varying degrees according to state law), does not detract from the notion of working together as a team, as made evident by the content of interviews I conducted.

Contemporary medicine tells a story of partnership: partnership between the physician and patient, between the physician and other members of the healthcare team including other physicians, as well as between other members of the healthcare team and the patient. Dr. K referred to it as "a circle" of communication that "the physician directs" (See Appendix K, p. 251). The analogy of a circle is put into effect when a patient calls his/her physician's office with a question. This question is usually posed to a nurse, who then speaks with that patient's personal physician and returns the patient's phone call to relay the physician's response.

Fisher would identify the presence of narrative fidelity in medicine's story of partnership. Assessing narrative fidelity involves looking at the values that inform the story (1985, p. 350) as well as the values found in characters throughout the story. In the context of a patient care team, fidelity is established through the values of community and goodwill toward other human beings. The entire healthcare team comes together, in the spirit of community within the healthcare institution, with the goal of restoring patients to good health (Fisher, 1985, pp. 358-359).

> Dr. D made this apparent when he stated, "Especially on the inpatient scene, I think a lot plays out behind the scenes that patients don't realize—where there's a pulmonologist, a nephrologist, and a cardiologist all involved in the care of a patient. They get together, at various times during the day when they see each other, and say, 'Hey, patient x—what do you think about the kidney function? I'm really worried that there is a little bit of heart failure present, but the kidneys are getting worse. Do you think there is a need to look toward dialysis? Is this person a candidate for dialysis?' You know, I think there is a lot that goes on behind the scenes. The doctors don't go in the patient's room and talk about the patient. They talk amongst themselves, make decisions, and try to figure out what's best for the patient. Is this person really going to thrive on dialysis? Is that a bad option? Are they, ultimately, going to succumb to infection? Are they just not going to tolerate dialysis? Should we look at another option here? I think a lot of that goes on, and I think that is part of the humanity, or compassion. We're trying to figure out what's best for somebody from a medical standpoint, and thinking about them down the road. Ethically, is it right to subject them to this treatment? And, the patients don't see that" (See Appendix D, pp. 138-139).

Dr. D's comment illuminates the presence of narrative fidelity in the contemporary story of medicine. Specifically, his mention of communicating with physicians from other specialties in an effort to make the best decision to discuss with patients—not only from a medical perspective but from an ethical perspective—

exemplifies the values of community and goodwill. These shared values support the existence of narrative fidelity.

The team approach in healthcare also provides a greater consistency during communication with patients. Dr. C explained, "That's where I think physician extenders are very helpful—having a PA that works with me. A lot of times, I'll have a discussion with the family. Then, I'll leave and let the PA sit there and spend more time with them and clarify some of the things that were said" (See Appendix C, p. 117). Dr. E echoed those sentiments when he stated, "I know my PA is really good...having a good *team* is really important" (See Appendix E, p. 148).

When various healthcare professionals maintain consistency of the messages communicated to patients, it works further to establish ethos of the entire healthcare team, which, ultimately, leads to a greater sense of credibility within the physician-patient relationship. For instance, Aristotle expressed, "A statement is persuasive and credible either because it is directly self-evident or because it appears to be proved from other statements that are so" (Book 1, Part 2, p. 9).

Therefore, each time a PA, NP, bedside nurse, physical therapist, occupational therapist, cardiac rehabilitation specialist, dietician, etc., speaks to a patient about his/her condition, the content of those messages will supplement/confirm the message that was originally communicated to that patient by his/her physician. When this type of consistency occurs, credibility of the entire healthcare team is supported because various staff members have contributed to the patient's story in such a way as to reinforce the original core message about the patient's condition. Because that core message was initiated by the physician, credibility is extended to the physician-patient relationship.

This makes sense from the standpoint that the physician retains primary authorship of the story of medicine and holds the primary relationship with the patients he/she treats.

As exemplified above, every time a Physician's Assistant (PA) or Nurse Practitioner (NP) reinforces patient education, initially provided by the physician, not only are the reinforcements proving the credibility of statements originally made by that physician, they are also further establishing credibility of the entire healthcare team's relationship with the patient. These statements of reinforcement also represent overlapping stories as they concurrently merge to create yet another story. This happens each time a conversation takes place. Two stories converge to create a new, or sustain an ongoing, story shared by those two individuals.

Dr. J commented about the narrative element that exists within his patient encounters. "I don't start the conversation with the patient by saying, 'Tell me about your lung cancer,' or, 'Tell me about your aortic valve problem.' I usually say, 'Well, what brought you here to see me today?' So, what I do is I let the patient communicate to me, and it's very interesting how the answers come. 'I've got this valve problem; I've got this spot on my lung; I don't know—Dr. So-and-So said to come see you; well, it started three months ago.' They can tell you a story" (See Appendix J, pp. 220-221).

The story one of Dr. J's patients tells him about his/her own personal health history converges with the story Dr. J shares with that patient about the surgical options available to treat his/her [patient's] problem. In that time period, the patient's illness story is sustained through conversations until the surgery is done and the recovery period begins. At that point, a new story detailing the patient's return to health can begin to be told through a series of conversations.

These conversations will not only take place between the patient and Dr. J. They will take place between the patient and other members of the healthcare team in addition to taking place between Dr. J and those same members of the healthcare team. Therefore, the converging of stories is not merely applicable to a conversation between two individuals. It is also applicable at the team level. On this level, though, many more stories are overlapping and merging to create a narrative network.

PHYSICIAN-PATIENT PARTNERSHIP

While a team approach to managing patient care and the communication it entails is a dominant theme across all physicians' stories, the most important partnership within the realm of teamwork is that between physician and patient. In fact, physicians appreciate when patients partner with them. Dr. B championed the idea of partnering with patients and their family members. Patients with chronic illnesses, as well as family members of these patients, can become "very sensitive" to being told what to do (See Appendix B). She, instead, advocates creating "…a partnership of sort where you really have to make sure that they feel like a partner of a discussion rather than—you have to avoid creating a stereotypical environment for them" (See Appendix B, p. 109).

In fact, each physician I spoke with mentioned appreciating those patients who are engaged and active participants in their own healthcare. For instance, Dr. A stated, "I'm okay with patients reading on the Internet. I'm okay with patients being engaged with their healthcare. They should—*absolutely*, they should [but] I also want them to read the right thing. I don't want them reading some garbage blog that someone wrote about something. I'm okay with them reading and being engaged. They're perfectly welcome to look stuff up. I just want to make sure that they're reading the right websites.

I, a lot of times, will direct people to certain websites. If you want to read about this, go to *this* website because I know it's credible and not just garbage that someone put up there" (See Appendix A, pp. 92-93).

Dr. I shared a similar perspective. "Patients need to be very much a partner in their healthcare. So, I encourage people to read stuff, but I try to guide them to things that are relevant for them. That way, they don't just go and type something in a search engine because, a lot of times, they're not going to find exactly what it is they need to read about. The stuff they need to be reading, they're not interested in—losing weight, controlling the salt in their diet, and that kind of stuff" (See Appendix I, p. 197).

Furthermore, Dr. F feels that patients who take an active role in planning their own care are more likely to stick with the plan. "I think, sometimes, someone who has a better understanding and is more interested in what's going on, and in themselves, they're more likely to be compliant and follow through with instructions as opposed to someone who says, "Do whatever you think, Doc"" (See Appendix F, p. 159).

Physician-patient partnership is also a storyline supported by Fisher's notion of narrative probability. Three components are used to test for the presence of narrative probability when assessing a story: material coherence, structural coherence, and characterological coherence. First of all, Fisher describes material coherence as a story's ability to stand up against similar "stories told in other relevant discourses" and still be regarded as true (1994, p. 24). The idea is fact-checking and cross-referencing to ensure that different stories told about similar subject matter contain the same foundational information.

This is especially germane to stories told in the healthcare setting. When different healthcare professionals explain the same phenomenon to patients, from their area's perspective (i.e., cardiac rehab, nutrition, pain management, etc.), the core information needs to match across these stories. For instance, the staff member from cardiac rehabilitation should describe exercise's effect on the heart in a way that confirms the physician's description. That represents the heart of material coherence and acknowledges the interconnected nature of all stories (1987, p. 15). In this context, material coherence is the metaphorical glue that binds each of the partnerships within the healthcare team. Once again, it helps to foster credibility and trust between the patient and each of the team's representatives.

Recall that Fisher describes material coherence as the ability of a story to still be considered true when compared to stories told by others (1994, p. 24). Therefore, it stands to reason that when other members of the healthcare team supplement the physician's initial message, and the core information matches as the staff members' stories are compared to the physician's story, credibility and trust are fostered between the patient and each of those staff/healthcare team members (Aristotle, Book 2, p. 9).

Drawing upon the interconnected nature of stories, it can also be observed that interactions with various members of the healthcare team may be considered as simply part of *one* patient's cumulative health/illness story over time. However, chapters in the professional stories of healthcare personnel, including physicians, are being written alongside chapters in the illness stories of patients. To an extent, the stories for both are a co-construction. Part of the physician's story is constructed by the patient, especially when the physician has been caring for that patient for many years.

Dr. I shared these thoughts on the matter. "You know, we were always told that it would be absolutely unprofessional to cry in front of a patient or their family. Yet, when you go and talk to families, and the patient's not doing well, or the patient has died, it's hard to keep from crying with them. I've learned, over the years, that I think they appreciate if the tears are true. They are touched by the fact that you're touched by the death of their loved one in some fashion" (See Appendix I, p. 213).

This comment demonstrates that physicians' stories are partially constructed by their patients—through their [patients'] presence as well as their absence. Fisher would agree that an individual's story forever changed once it converges with another individual's story. Furthermore, Fisher illustrated that the presence of just one character can profoundly impact, even alter, the story of another character. Once that impact, or alteration, has been made, the absence of the "impact-or" will "shatter the world" of the character left behind (1984, pp. 17-18).

Due to the nature of the partnership, one may expect the physician to represent the character who most profoundly impacts the other characters with whom he/she comes into contact. It is likely true that the absence of a particular physician character will affect the lives a greater number of patient characters. However, Dr. I's shared sentiments of crying with family members of deceased patients is evidence that some patients are capable of impacting their physicians' stories to a degree that evokes sadness.

Just as part of the physician's story is constructed by the patient, part of the patient's story is also constructed by the physician. Additionally, there are portions of the patient's story that are *jointly* written by the physician and patient together—the quintessential example of partnership. In fact, Dr. I specifically stated that, "You get out

of it [partnership with patients] what you put in," referring to her long-time patients as "sort of like family" (See Appendix I, p. 214).

Furthermore, Dr. A shared his approach to partnering with patients. "My approach has been I always give them the options of something. I say, 'Okay, we've got this option, this option, and this option.' Then, they say, 'What would you do?' Then, I voice my opinion, but I don't ever want them to be swayed by my opinion. I'm just not that type of person" (See Appendix A, p. 95).

In the same way that the interactions a patient has with various healthcare team members can be considered his/her own collective, or cumulative, personal health/illness story, the cumulative interactions a patient has with his/her physician can be compared in an effort to assess material coherence. In this context, the patient assesses the messages communicated by the physician. If the core information matches across time, material coherence will be confirmed and trust established within that relationship. As applied to the notion of the physician-patient partnership, each time Dr. A presents the treatment options to his patients and allows them to choose the one with which they are most comfortable, material coherence of the physician-patient partnership storyline is substantiated.

Keeping with the notion of one cumulative health/illness story, I envision the concept of material coherence having a broader application than Fisher initially indicated. For instance, while material coherence is generally applied to different stories regarding similar subject matter, I argue that it can also be applied to a singular conversation within a story in an attempt to discern discrepancies between words and non-verbal cues. Dr. F provided a story to exemplify this in which he spent 20 minutes explaining the risks and

benefits of a procedure to a patient and the patient's son. After the explanation, the patient was nodding his head in agreement. However, when the patient's son asked him what he thought about proceeding, the patient responded that he was unsure because he could not hear anything that had been said (See Appendix F). In this situation, the patient's non-verbal communication did not align with his verbal communication. It led to a lack of material coherence in the patient's story for the physician—the material, in this case, being the patient's non-verbal cues. If such a lack should continue, it has the potential to threaten long-term success of the physician-patient partnership. Without the success of this partnership, the success of the entire healthcare team is put at stake.

As imperative as material coherence is, it is only one component of narrative probability. The remaining two components are structural coherence and characterological coherence. From Fisher's point of view, for a story to have structural coherence, its central argument needs to be of sound reason and make sense (1987, p. 15). In the healthcare setting, this refers to the ways in which physicians explain conditions, procedures, treatments, and results to patients.

For instance, Dr. A avoids "medical jargon" and employs analogies to aid his patients in understanding what has happened to the surrounding vessels of their heart as a result of having a blockage. "You know, I've used car examples to describe the heart for mechanics. They get that. They can relate to those kinds of things. So, you've got to kind of bring those things down. When I talk about a blockage with post-stenotic dilatation, I'll be like, "Okay, imagine you have a garden hose with a blockage. What happens when you have a garden hose with a blockage? It gets big after that. That's what's happened inside your artery"" (See Appendix A, pp. 93-94).

Relaying complicated medical processes in common terms serves to bridge the knowledge gap between physicians and their patients. Additionally, it creates structural coherence for patients because simple language allows the physician's central argument—which in the clinical setting is equivalent to the explanation of a new diagnosis or the explanation of a new facet of a chronic condition—to be understood by their patients.

Dr. D also utilizes analogies but finds that they are more helpful for those of his patients who are better educated as he stated, "My less educated patients—I feel like I could be in there all day explaining myself, and it wouldn't do any good. I can't get them to understand. Even if I try to make analogies, it's not sinking in. They just don't get it. They have no insight to their own disease," (See Appendix D, p. 131).

Dr. D's comment exhibits his attempt to create structural coherence for his patients because he is breaking complex topics into mentally digestible pieces. However, his comment also lends itself to the realization that there are individuals for whom understanding of their condition is not going to come easily, if at all. Unfortunately, there are people who have not had as many educational opportunities as others. Therefore, they lack that "insight" Dr. D described.

Still, the need for using less complicated verbiage when circumstances allow is recognized. Dr. J, for example, likes "to talk in common terms" (See Appendix J). Dr. K also vocalized the need to "use simplicity in language" (See Appendix K). Similarly, Dr. F discussed drawing pictures for his patients prior to performing any procedure. Due to the nature of his specialty (electrophysiology), he cannot *completely* avoid the use of medical terminology since he implants devices in the heart (See Appendix F).

To the extent possible, however, using everyday terminology creates structural coherence for patients who are not familiar with medical terminology and helps them to comprehend the plot twist in their personal health/illness stories. Fisher would agree that physicians' efforts to create structural coherence for patients prove beneficial for both parties. When patients understand their condition, made possible by a structurally coherent explanation of their current illness storyline, they are better able to provide physicians with relevant information, in the future, regarding issues that may arise between appointments or hospitalizations. This understanding also aids in creating comfort and trust within the physician-patient partnership.

The third component of narrative probability is characterological coherence. It refers to the consistency of a character's behavior—including communicative behavior—over time. Quality of character, or personality, is reflected in a person's words, decisions, and actions. It is the quality of character that others will use to draw positive or negative conclusions about a person (Fisher, 1987, p. 16; Fisher, 1994, p. 24).

I would argue that a lack of material or structural coherence in a story/set of stories leads to a negative character profile assessment. This is further elaborated upon in the next few paragraphs. Human nature suggests that physicians and patients will form conclusions and make character judgments about one another over the course of interactions during appointments and/or hospitalizations. These conclusions and judgments stand to affect the physician-patient partnership. However, as I explain next, physicians do employ certain rhetorical strategies to prevent any negative character assessments of patients from putting a strain on the partnership. One of these strategies

involves keeping in mind that they are only capable of advising their patients—not controlling their behaviors.

As I just alluded to, the development of patients' characterological coherence, in the eyes of physicians, is affected by their rates of compliance with medical regimens. Dr. B provided insight into the so-called "non-compliance" of heart failure patients to their low-sodium/low-fat diet, medications, maintenance of an appropriate exercise routine, etc. She stated that heart failure patients have been proven to "have memory disturbance" (See Appendix B). The professional reflex is to call a heart failure patient's lack of following instructions non-compliant regardless of what the root cause may be. In certain cases, immediately attaching a negative characterological assessment to the forgetful patient's profile may be premature, according to Dr. B.

Additionally, Dr. I relayed similar sentiments regarding non-compliance. She explained the need to speak very plainly to patients—which aligns with Dr. A's philosophy to avoid "medical jargon" (See Appendix A). Specifically, Dr. I discussed the importance of delivering the bottom line to patients. Saying the words, "You must quit smoking; you must lose weight; you must exercise; you must take your medications," leaves no room for patients to doubt what it is the physician wants them to do for their own good (See Appendix I, p. 203).

Continuing the same train of thought, the next task is to offer them help in achieving these goals whether it be in the form of a class, a support group, or a referral of some sort. Dr. I also stated that once she has completed these actions for a patient, she repeats them. After two thorough attempts, she leaves the responsibility to take action with the patient and simply lets him/her know she is available to help in those areas if

needed (See Appendix I). From Dr. I's perspective, it is the continual scolding of the patient for not stopping a detrimental behavior that leads to the negative characterological coherence of the patient's story. "To continue beating ourselves up because we can't get people to stop bad behaviors just puts us in a tizzy. Then, we get in a confrontational relationship with the patients, and I think that's bad. I don't want to take care of you anymore because you don't listen to what I say, and it's hard not to feel that way sometimes; *but* we're not doing either one of us any good. Maybe, with some time and continued talking about smoking cessation—or, if they have to have another angioplasty, or something—maybe, the light will come on, and they'll be willing to do it" (See Appendix I, p. 205). Such an antagonistic dynamic defies, damages, and may lead to the dissolution of the physician-patient partnership as well as the partnerships between the patient and remaining healthcare team.

Earlier, I briefly mentioned some of the negative, or non-compliant, behaviors in which patients engage (i.e., smoking, being reluctant to exercise, not taking prescribed medications). I will now discuss the classification of patients' negative behaviors in a bit more detail. Smoking status and diet are considered lifestyle factors (Carpenter, 2010, p. 4; McKinley, 2009, p. 2) that are generally more social in nature, but Drs. I and A deem these areas to *be part of* medical therapy. In fact, Dr. A discussed what he defines as "optimal medical therapy" in his cardiology practice. It includes "smoking cessation" and "dietary control" *in addition* to medications necessary in the cardiovascular setting (See Appendix A).

The fact that physicians consider social behaviors to be part of medical therapy further exemplifies the interdependent nature of the biomedical and biopsychosocial

models in the clinical practice setting. Moreover, when physicians address lifestyle changes with their patients, it represents another attempt to create structural coherence for these patients regarding their health/illness story. It provides physicians with the opportunity to establish correlations between behaviors, like smoking, and adverse health outcomes. If a patient has recently experienced an adverse health event, he/she may be more likely to deem the physician's advocating abandonment of detrimental behaviors as logical.

Dr. B had this to share on the matter. "How successful are people lowering cholesterol by changing diet, or lowering body weight by changing diet, or increasing people's exercise by educating them? Success rate of this is pretty slim. I don't think the success rate with heart failure patients is any different when you tell them to change their life completely. Right? It kind of follows the trajectory of our overall habits. However, let's go back to that education. If you're able to successfully demonstrate that you're going to make them feel better and make them understand *why*, suddenly, they are salt sensitive. Then, the success rate is much higher. It may not be persistent success rate, but at least short-term success rate is much higher" (See Appendix B, p. 106).

From Dr. B's point of view, providing education about lifestyle changes creates structural coherence for the patients regarding their condition. Furthermore, when this structural coherence is truly established, it is capable of improving the patients' quality of life.

RETURN TO THEME OF TEAMWORK AT LARGE

Thus far, I have discussed the importance of teamwork in the healthcare setting and highlighted the physician-patient partnership as the most significant relationship

within the healthcare team. I have also explained the constituent parts of Fisher's concept of narrative probability: material coherence, structural coherence, and characterological coherence. These components were applicable to specific issues and events that are capable of affecting the physician-patient partnership in both positive and negative ways. At this point, I need to direct attention from the physician-patient partnership back to the healthcare team at large.

In regard to the overall team, I would be remiss if I did not point out that the main reason behind the team-oriented approach to patient care and communication is nurses and various assistants have more time to spend at the patient's bedside. They are a greater physical presence at the bedside, learning about psychosocial issues that will thicken the plot of the illness experience. According to Dr. A, "The thing about nurses and the biopsychosocial model is the nurses are at the bedside a…lot more than I am. They're learning who these people are. They're learning about their families. They're learning about the fact that they were in jail for 5 years. They're learning all these things that I'm not even cognizant of" (See Appendix A, p. 99).

> Dr. D explained it this way. "I think the perception is, 'The nurse cares about us. They're taking care of us. The doc was here for 15 minutes, and all I got from him was a bill.' I think that has a lot to do with it. Let's face it. The nurse's job is *very* important. It's probably underappreciated, and they get frustrated, too. They're there with the patient—changing the bedpan, dressing them, giving them a shower—really taking care of the patients' daily needs; helping them eat if they need help eating. We're in there, examine quickly, make some decisions as to what we want to do with their therapy, and we're out the door. We may let them know how they're doing, or how we perceive that they're doing, and we may let them know what our plans are. Other than that, we're not in there very long. That's where that perception comes from" (See Appendix D, p. 136).

Additionally, a nurse working on one of the hospital's cardiovascular units may have a total of two or three patients for whom to provide care during an 8–12 hour time span. Dr. K made the distinction between the roles of physician and nurse which serves as further support for a teamwork approach to patient care. "…the roles are very different. For nurses, during a 12-hour shift, will have their own 3–4 patients. That's all they do—answer the phones, bring them food and a smiley face, probably give them a sponge bath, or feed them, so on, so forth. They sit down with the patient. That's what the roles are" (See Appendix K, p. 249).

On the other hand, according to Dr. D, "Our role is to round on 30 patients" (See Appendix D, p. 136). This is in addition to seeing patients in the office and/or performing scheduled procedures during the day. When the story of patient care is viewed through this lens, it becomes readily apparent that physician and nursing roles serve two separate functions for the same team. Again, the values of trust, community, and goodwill are illuminated. Moreover, the work ethic of physicians is highlighted which further underscores the fidelity of contemporary medicine's story of partnership—in this case, among members of the healthcare team.

At this point, I would like to elaborate on the values referenced in the previous paragraph. First of all, the value of community is illuminated by the team spirit among physicians and nurses who work together to deliver quality patient care. Secondly, the value of goodwill is highlighted in the healing that takes place in the story of medicine. Finally, trust is implied in the sense that physicians clearly rely on nurses to tend to their patients, who are hospitalized, during the times in which the physicians cannot physically

be present to do so. The circle Dr. K referred to in the outpatient setting can be extrapolated and applied to the inpatient setting as well (See Appendix K).

For instance, if a patient begins asking questions that a nurse cannot answer—such as when he/she might be released from the hospital—the nurse will contact that patient's physician. The nurse will then relay that message back to the patient. When the messages are backed by actions, trust is secured between the patient and nurse, the patient and physician, as well as the physician and nurse. Once again, the presence of material coherence within the contemporary story of medicine is confirmed by the consistency of messages inside the circle of communication by the healthcare team.

Diagrammatically, the team interactions can be represented as a wheel. The medical and psychosocial spokes come together around the patient who is at the center, or hub, of every decision made. All avenues of care unite around the same patient with the same goal of helping that patient return to living the healthiest life possible. This includes helping him/her to access resources needed in order to manage a chronic illness.

> Dr. H shared his views on the matter. "We have our social workers, our psychologists. We try and be psychotherapists, sometimes, and try to address these problems in the scant time that we have. At the same time, do patients want us to be taking over that much? Maybe, some of it is just recognizing those things, trying to do what we can. I don't think we'll ever totally be—we're not going to be addressing all of the psychosocial needs that our patients have 100% of the time, but, certainly, I think it's worth making that an important part of the treatment plan. I think we recognize more and more it's pivotal. At the end of the day, our goal is to have people at home, having a reasonable quality of life and doing the things that they want to do with the rest of their life. So, to the extent that we can do that, I think we recognize more and more that it's an important part of the picture" (See Appendix H, pp. 191-192).

As I hope to have made evident, physicians see other members of the healthcare team such as beside nurses, NPs, and PAs as extensions of themselves. This is important

because each physician is only one person and has, as Dr. D mentioned, 30 inpatients to see on rounds in a given day. Recall that number is in addition to seeing patients in the office and doing procedures. If the healthcare team was not in place, the daily practice of medicine would cease to be operational. The team approach makes it possible for individual, meaningful physician-patient partnerships to exist.

Another salient point that I hope to have made equally as evident is the blended nature of the biomedical and biopsychosocial models. These models are communicated about as if they are dichotomous [which I will discuss in more depth later], but one of my goals is to reveal that the representatives from both of these models rely on one another to function appropriately.

PHYSICIAN – PATIENT COMMUNICATION

Although teamwork is a recurring theme throughout my physician interviews, it is not the only theme. Physician-patient communication was partially alluded to in my discussion of the healthcare team, and physician-patient partnership will be connected to my discussion of physician-patient communication. However, I will now transfer my main focus to the theme of communication. First of all, the most surprising element to emerge from my interviews was the fact that nearly all of the doctors I talked to agreed with the public and academic assessment of physicians as bad communicators. The number one factor that yields this perception is the lack of time the patient gets to spend with his/her physician.

"I also think the public has this perception because doctors are always in a hurry. Whenever I see patients, personally, I always try and sit down so that they know that their time is important" (See Appendix A, p. 94). Dr. B also mentioned physicians are "all

quite hurried" (See Appendix B, p. 104). Dr. C shared similar sentiments. "Quite frankly, at the end of the day, that's why a lot of people perceive physicians as poor communicators because they're so busy, trying to get on to the next thing" (See Appendix C, p. 117).

Along the same lines, Dr. K acknowledged, "A physician has about 100 patients. He comes in the morning, discuss for about 10–15 minutes with them, and he's gone. So, their [patients'] time with them [physicians] is limited, but these roles are what they are" (See Appendix K, p. 249).

It is this area of timing in which the team approach to patient care is critically important. In fact, Dr. E never leaves a patient's hospital room for the first time without providing the patient with his cell phone number. He does this to make the patient feel empowered because he knows all of the questions are going to surface after he leaves the room. He does not want patients "to feel like they weren't fulfilled in terms of their interaction…" (See Appendix E, p. 148). This exemplifies physician-patient partnership.

Despite the hurried nature of the physician's role, there are nonverbal, as well as verbal, communication strategies they utilize in order to alter the patient's perception of time in a positive way. Dr. A had this to share. "I'm never reaching for the door. I look them in the face and try to have a conversation *with* them as opposed to *at* them. I try to engage them in the decision-making, too, which I think most patients appreciate. I try not to be paternalistic, and I think that's very successful with patients" (See Appendix A, pp. 94-95).

Furthermore, sitting down—as already mentioned—in the exam room or in the patient's hospital room, smiling at the patient, and making eye contact with him/her is

vital (See Appendix A). These actions, although small, have a significant impact on the patient's perception of how much time was spent with the physician.

Dr. J also confirmed this. "If you *sit down* to talk to the patient, they'll think you've been there *all* day. If you're standing by the door, and you never put your hand on the door handle, and you always walk completely into the room. For example, here at Methodist, what I'll do when I walk in, if they're sitting in the chair, I'll sit on the edge of the bed and talk to them. Or, I'll sit in the chair across from them, but always, if I'm going to have a conversation, it's going to be the more time spent with them—what I call the communication time—I sit down. It's amazing the response you get from that" (See Appendix J, p. 232). Drs. A and J, in particular, believe that when they sit down with a patient, it lets that patient know his/her time is considered important and is respected.

Additionally, Drs. A and I indicated that human beings like physical contact. A handshake at the beginning or end of a visit, a pat on the back, or a light touch on the arm serves to create a much-needed connection between the physician and patient as fellow human beings. Dr. I further verified that "Patients do well with touching—even patients on ventilators. You can go in the room and talk to them softly and say, "It's Dr. [I]. You're doing fine." If you stand there long enough, you can even watch the heart rate go down. So, you know they're hearing you, or at least, there is some recognition that you're there, and they're responding to it" (See Appendix I, pp. 214-215).

Nonverbal communication bridges the time gap patients would otherwise sense and underscores the feeling of receiving genuine care. A smile, a handshake, or a pat on the arm has the potential to be seen as going the extra mile in today's hurried world. Narrative fidelity is honored in the way that physicians clearly communicate that they

respect the patient as a person. It lends toward creating a comfort zone for the patient within his/her partnership with the physician. Nonverbal communication has the ability to make or break partnerships because it heavily influences patients' perceptions.

Across the physicians' stories about communicating with patients, Fisher would acknowledge the shared values of friendship, empowerment, comfort, healing, and respect (1985, p. 359). These values, to which partnership aspires, establish narrative fidelity for the collective story that is representative of medicine today. Evidence of narrative probability (Fisher, 1987, pp. 16-17), then, is present in terms of structural and characterological coherence.

The criterion of structural coherence is satisfied based on the previously accepted premise in the field of Communication Studies that the majority of human communication is nonverbal. The argument implied by physicians' positive nonverbal communication tactics—namely, that they lead to positive patient perceptions and, therefore, strengthen the feeling of partnership—is logically sound. Characterological coherence is manifest over the course of the physician-patient relationship. When the physician consistently utilizes positive nonverbal communication techniques with patients, the values of friendship, empowerment, comfort, healing, and respect are illuminated which create security and trust. In the clinical setting, especially, a physician's consistently positive character yields comfort for patients.

In regard to verbal communication strategies mentioned earlier, the physicians I spoke with feel it is important to include patients in the conversations about their health status. Talking *with* them, as Dr. A (See Appendix A) suggests, allows and encourages them to take an active role in helping to shape their own healthcare plans. The technique

of having an inclusive conversation *with* patients makes a significant impact when physicians are educating patients about a condition. Encouraging patients to ask questions and participate in the communication process is key to helping them understand their illness in addition to how and why certain actions the physician asks them to take will help them to feel better. Recall that the education process seeks to establish structural coherence for patients because sense is made of the physician's central argument during the explanation of the patient's condition. Questions that patients ask further solidify their notion of structural coherence.

Along these lines, Dr. J shared his approach to ensuring that patients, who like to do Internet research before appointments, feel comfortable in their knowledge level and included in decisions. "Sometimes, it *makes* them a little bit nervous because if they've read one thing and are expecting one thing, and you tell them something completely different based on the clinical findings in their exam, it confuses them a little bit. I'd rather be able to explain those things to them and have them feel like they're *a part* of the decision process" (See Appendix J, p. 218).

Fortunately, according to each physician I interviewed, patients are definitely asking more questions now than they did in previous generations. Physicians appreciate this for a few reasons. First of all, when patients ask questions, it demonstrates that they are engaged with their healthcare. To exemplify, Dr. B stated, "I think that successful communication is when patient is able to actively engage and ask questions" (See Appendix B, p. 105).

Secondly, even if a patient asks a medical question that is not relevant to his/her illness, it represents a place from which to begin the conversation. Dr. B explained,

"Those questions can be appropriate, or not appropriate, but still, they at least initiate discussion. Even if the question is not there, connected with the current issues, it is a conversation-starter. You can always offer something more to a patient who, actually, is asking questions because the fact that they are asking questions sort of exposes their knowledge base" (See Appendix B, p. 101).

Regarding patients asking questions, Dr. F further stated, "I think, ultimately, it's a good thing because, obviously, they're trying to understand things" (See Appendix F, p. 159). Dr. E also expressed positive feelings about patients asking questions. "…it's a good thing" (See Appendix E, p. 145).

In fact, Dr. J considers it a red flag when patients are not asking questions. "The one I get concerned about is when, after I've completed my discussion with the patient, they either have no questions, or they give me this nonverbal communication like they don't understand. Or, there is not an affirmation from them" (See Appendix J, pp. 223-224).

Physicians get nervous when patients do not ask questions because they are not sure whether patients actually understand or are simply too overwhelmed to think of any questions. In cases like these, narrative fidelity and coherence are pending for the patient as well as the physician. However, when patients ask questions, the types of questions predict narrative fidelity in the sense that patients are exhibiting their values by asking about the things that are most important to them. When patients ask the same question a dozen times, it demonstrates their perceived lack of narrative coherence as their illness story does not make sense to them.

In situations like these, Dr. C advocated starting from scratch during the explanation process. "It seems like communication is the most important thing in terms of avoiding future conflict, which is what I don't like. What I do is shortly after you have done what it was that you had talked to them about doing, if it's immediately obvious that they don't understand it, or are asking questions about it, you've got to regroup and start all over again" (See Appendix C, p. 118). This indicates that physicians want to provide patients the understanding and reassurances that chronic/critical illness demands.

As can be seen, physicians do make efforts to maximize the time that they do have to spend with their patients. They utilize both nonverbal and verbal communication tactics to do so. Over time, as physicians continue to make those efforts and their positive characterological coherence is cemented, it is hoped that patients will not hold such negative perceptions about their doctors' communication styles.

Drs. I and K pointed out two additional reasons that patients may consider physicians to be bad communicators: physicians sometimes need to communicate "bad news" in terms of a grave diagnosis, and physicians remain detached while communicating bad news. These two physicians, in particular, explained the rationale behind emotional detachment. For instance, Dr. K discussed the need for an emotional barrier in the physician's mind when he/she is communicating serious information to patients or their family members. If physicians take on the emotional burden of every patient they treat, they will not be able to function in their role from patient to patient. Nor will they be able to have a normal life with their own family once they leave the hospital/office.

"…let's take example of oncologist. *Every* day, he is going to see a person who is dying, or who has a bad cancer. *Every* day, that's what he's going to treat. Now, if he carries that emotional burden home, he'll be a personal wreck. So, somewhere, he has to put a barrier where this doesn't penetrate. That is what they are doing. So, yeah, you would like your doctor to hold your hand and cry with you when he delivers the news that somebody has a cancer somewhere; but the problem is, he cannot. So, he is going to be as impartial, detached as possible, and he's going to deliver the news and say the scientific rationale behind how he's going to treat it. You cannot hold that against him. Now, if they are *rude,* and they come out as not caring, that is a different story" (See Appendix K, p. 242).

Medicine is comprised of some moments that demand stoicism and others that allow sharing emotions of the human experience. Physicians' stories entail tending to an entire cast of patients whose own stories need mending. It is a cast that continues to grow—for specialists, in particular. Going from one patient's room to the next requires checking prior negative experiences at the door.

While it may seem or sound inhumane to be detached, it saves lives so that stories may continue. In this light, it is the foundation of humanity. For example, if someone encounters a health crisis and requires emergent care, it is in the best interest of that patient's life story for the physician not to be emotionally overwhelmed by the sheer nature of the emergency. The patient's story can come to an abrupt end in the time it would take for the physician to gain composure.

Dr. K explained it this way. "If I am too emotionally connected, or too emotionally attached, because I know them [patients] 6 – 10 years, in my office, I won't

be able to perform as efficiently as I would [otherwise]. That's why you don't see many doctors do procedures on their own family members. They usually give it to their colleagues or somebody else, because when they're attached, there are several things that might influence what they're trying to do. If something goes wrong, they'll never forgive themselves. They're trying to remain above this so that they can do this in a detached fashion, objectively, understanding that they are humans, and there is small percentage of chance that bad things might happen despite *best* efforts. They don't get too much emotionally caught up with that which can, actually, destroy their personal career" (See Appendix K, p. 241).

Having the ability to mentally step outside the river of human emotion when emergencies necessitate it is a true testament to narrative fidelity in the sense that the physician is trying to maintain the very essence of the patient's story—life, itself. The ability to be a psychological chameleon is also at the heart of narrative coherence in the urgent situations of medicine. Aristotle would agree that the avoidance of extreme emotion allows for greater clarity of thought and action.

"There has to be an emotional detachment from a lot of things. When you're coding a patient or when you're doing procedures to a patient. If you stand there and think, 'Oh my gosh, this poor person. I'm going to hurt them if I do this,' you'll never get it done. So, there has to be some detachment…compartmentalization…I don't know what it is so that you're not continually paralyzed by the feelings that could overcome you about what you're doing" (See Appendix I, p. 213).

As mentioned earlier by Dr. I, when modern medicine loses the battle, family members "appreciate" tears from physicians in those initial grieving moments. Getting

emotionally attached to *every* patient, however, is exhausting "because it takes a piece of you every time one of them dies, especially if you've taken care of them for a while" (See Appendix I, p. 213).

There is a difference between being overcome with emotion and feeling/demonstrating compassion for someone. Physicians feel connected and closer to some patients than others. As human beings, we bond on a deeper level with people whose value systems align with our own. In other words, we feel more connected to people with whom we feel a strong sense of identification—whose stories foster our deepest sense of narrative fidelity. That is the essence of Fisher's Narrative Paradigm (1984). We understand our own lives in terms of a story. It is only natural that we understand others in the same way and form connections on that basis.

From this perspective, it is appropriate to exhibit emotions in the face of a patient's death. The physician is no longer that patient's physician. He/she is a friend of the deceased, particularly if the cause of death was a chronic illness that the friend had been managing in the role of physician for many years. Allow me to explicate this notion a bit. While the term, "friend," was not used synonymously with the term, "patient," in my interviews with physicians, it seemed to be an appropriate word in light of the description shared with me about grieving with the family of a deceased patient who was well-known to the physician(s) for a number of years. In that context—in that specific, grief-stricken moment—it is described in the same manner one might describe losing a friend. Therefore, that is the word I chose.

Bearing this in mind, I believe Fisher would agree that the former-physician-still-friend sharing emotions with the surviving loved ones speaks to narrative fidelity as it is a

show of respect for the story that has just concluded. The very act of a doctor allowing himself/herself to be human with their deceased patient's family members also preserves narrative probability. Structural coherence is maintained because it makes sense to feel sad when a friend passes. Material coherence is satisfied because it is compatible with other stories of grief. Characterological coherence is established based on the physician's exhibition of his/her own humanity.

This exhibition also creates a permanent bond between the physician and surviving family members because it is not only a display of pathos. It is also the ultimate establishment of ethos. In that context, a doctor will have broken social protocol to showcase his/her own broken heart for the fallen patient.

Since it is a delicate situation, and everyone has different emotional thresholds, Dr. I stated that all medical students need to engage in the balancing act of determining "how much of a human being to be" (See Appendix I). She also acknowledged that it is more rewarding to allow oneself to become an important, integral part of his/her patient's life. That represents the ultimate physician-patient partnership—the ultimate clinical communication success story.

Recall that the primary successful communication strategies physicians shared with me were positive nonverbal tactics such as sitting down in patients' exam/hospital rooms, making eye contact with patients, and making appropriate physical contact with patients. Primary successful verbal tactics include talking *with* patients, including patients in decision-making processes, and encouraging patients to ask questions. Now, I will discuss additional successful communication strategies physicians mentioned to me during interviews.

The importance of physicians listening to patients was mentioned more than once. In reality, Dr. A's (See Appendix A) tactic of talking *with* patients implies the importance of listening to them. Whereas, talking *at* patients would not require any knowledge of what they were trying to say. An individual who is talking *at* another person typically needs only to be concerned with the words coming out of his/her own mouth.

Similarly, Dr. E voiced the import of listening when discussing his view of successful communication with patients. "I think just good rapport, spending time with them, listening to them. I think if you try to understand them, first, before you make sure they understand you, that usually works pretty well" (See Appendix E, p. 147). Doctors need to listen to patients in order to understand the nature of their problem(s). It, therefore, stands to reason that listening is the foundation of developing a good rapport with patients. A good rapport is another sign of the physician's successful communication.

Drs. A, I, and J shared the tip that patients will essentially tell doctors what their diagnosis is during the History & Physical (H & P) if doctors are listening for it. Dr. A relayed his belief that "…you'll probably get your diagnosis if you just shut-up and listen [to the patients]" (See Appendix A, p. 96). Dr. I concurred, "We have to have the time to sit and listen to what they [patients] say because, most of the time, they'll tell you what's wrong" (See Appendix I, p. 199). Dr. J further echoed this notion when he stated, "Listen to your patients, and they will tell you 85% of what's going on with them. The rest of it, you'll pick up with an exam or with a diagnostic study" (See Appendix J, p. 226).

Listening is one of the most important duties a physician has. It reveals the character of the patient as well as the character of the illness/disease process plaguing that patient. The fact that physicians are aware of the need to listen to their patients also reveals the character of physicians themselves. This character is one of dependability and trustworthiness. Such is the composition of narrative probability in the form of characterological coherence. Narrative fidelity is simultaneously satisfied in the sense that character constitution aligns with the values someone holds dear (Fisher, 1987, p. 16).

Let me now turn the focus toward medical education and communication. Most of the physicians I spoke with had some communication exposure in their Introduction to Clinical Medicine course. Some participated in conducting H & Ps with mock patients who would then comment about the student's performance. It was protocol in the classes a few physicians took to videotape these sessions to review and learn from later.

According to Dr. B, the Indiana University School of Medicine has incorporated communication into its "competency-based curriculum" (See Appendix B). Dr. B is an Associate Professor of Medicine with Krannert Institute of Cardiology. As such, she is in a position to see first-hand that residents and students are emotionally invested in the care they provide to patients. "As a teacher to residents and students, I am greatly appreciating how emotionally invested they are into care. They are invested in care. So, we have great material. This is not a group of people who are uncaring" (See Appendix B, p. 110).

Dr. B did note something that is lacking in the medical education process, however, and that is some type of formal debriefing session for new physicians after

negative patient encounters. Without encouragement, physicians can become toughened and guarded in future encounters. Negative communication encounters, especially if consistent, may lead to the appearance of good intentions transforming into apathy.

While this type of course could certainly prove to be very beneficial, the majority of physicians I interviewed believe that a bedside manner cannot be taught in a classroom. More than one physician referred to communication as "the art of medicine" (See Appendix B, Appendix D, & Appendix H). Theoretical teaching of the fundamentals of a bedside manner would be as effective as theoretical teaching of the fundamentals of baseball. It is far more sensical to teach through demonstration or lead by example. Communication is an applied skill that needs to be honed.

"I don't believe you can teach someone to have a bedside manner. People either have a bedside manner, or they don't. My bedside manner is just my personality…The way I talk to patients is the way I would talk to my friends or anybody else" (See Appendix A, p. 97). Similarly, Dr. B believes "…you really cannot provide patient education from courses. I don't think so, at least… There are different doctor personalities. Something, which works for me, will not work for a young male doctor, right, because he is a different substrate" (See Appendix B, p. 107).

Dr. D further echoed these sentiments with his comment. "You know, you can't teach empathy. It's the same thing when I would teach some of the medical students. You can't teach someone to look at somebody and tell if they're sick. Now, they can look at their labs, and they can look at their x-rays and tell you what's wrong them. Some people just can't look at another person and say, 'Gee, that patient is sick. We need to do something soon, or they're going to crump.' There are things you can't teach.

You either know it, or you don't. You either have empathy, or you don't have empathy. It's not a teachable trait, I don't think" (See Appendix D, pp. 126-127).

Along the same lines, Dr. G stated, "Some physicians are better communicators than others… Definitely, it's not something that can necessarily be taught. Although, modern day medical education is sort of trying to" (See Appendix G, p. 174).

However, communication within the realm of medicine is referred to as "bedside manner" which most of the physicians I spoke with believe cannot be developed by reading a book about it. Medicine's story has opened up within the last decade to recognize and embrace the idea of teaching its students formal communication techniques and strategies to apply during the patient encounter: "addressing" and affirming patients' feelings. When people's feelings are acknowledged, it dissolves tension and paves the way for a more positive interaction.

At this point, I have described and explained, from the perspective of Fisher's Narrative Analysis, the main themes which emerged from the stories physicians shared with me about communicating with patients. The dominant theme that stood out was the absolute necessity of a teamwork approach to patient care along with the importance of the physician-patient partnership to that team. A second theme to become clear was the sharing of successful physician – patient communication strategies across my interviews with physicians. They are acutely aware of the significant impact of nonverbal communication tactics as well as the profound importance of listening to patients.

Additionally, more than one physician broached the subject of caring for patients in a 'detached' manner. Their openness about the topic gave me the opportunity to help it make sense for other people who may read this, again from Fisher's perspective of

Narrative Analysis. Their openness also allowed me to reveal that there is an extent to which the idea is founded in humanitarian sentiment. Recall that I thoroughly explained this notion when discussing the emotional balance for which physicians continually strive. Now that I have presented the most relevant themes pertaining to physicians' successful communication with patients, I will present physicians' personal perceptions of biomedicine as well as the ways in which those perceptions differ from the perceptions of others.

RQ 2: "What do physicians perceive as the overarching story of the biomedical model? How is it similar to and/or different from that of the media, general public, and academia?

PHYSICIANS' PERSPECTIVE ON BIOMEDICINE

Just as teamwork emerged as the dominant theme throughout each of my physician interviews, it likewise emerged as the overarching story of the biomedical model. Again, one nurse takes care of three or four patients a day while one physician takes care of 10 times that many a day. Therefore, the main storyline across all 12 interviews is that physicians need nurses and other support staff (i.e., social work, nutrition, chaplaincy, physical/occupational therapy, etc.) just as nurses and other support staff need physicians in order to maintain continuity of medicine's story. One cannot tell the story alone.

This storyline represents a narrative shift in medicine. The physician-patient relationship has often been viewed from a lens parallel to the Transmission Model of Communication, i.e., doctor says; patient does. In other words, the communication taking place in this particular dyad has long been perceived as one in which the physician

says something, expecting the patient will interpret it as intended, and moves along to the next topic. It is not as often highlighted, but the patient is capable of the same act. In this context, information is being transmitted, but no attention is paid to its reception. From this point of view, once a message is transmitted, the sender's job is complete. The receiver's job is to retrieve and understand that message appropriately—as the sender intended (Craig, 2007, p. 103).

With this narrative shift in medicine, however, Fisher would agree that a greater number of physicians are continuing to abandon the Transmission Model style of communication and opting for more of a Dialogic Model style of communication with patients. Physicians want patients to be involved in their care to the extent possible, assuming they are not in the hospital, sedated. This further drives home the notion that medicine's contemporary story is an inclusive one—a team-centered one. Patients and their families are part of that team, contributing to/(dis)agreeing with the decisions being made about their care. The story is not exclusive or univocal; it is multi-vocal which is the essence of the Dialogic Model (Baxter, 2007, pp. 118-119).

Media and academia seem hard-pressed to realize the multi-vocal nature of this story. Physicians had much more to share about media in my interviews with them. So, I will begin with their perspective on academia.

According to Dr. L, in the 1970s and 1980s, medicine was specifically a scientifically-driven field.

> "There was a generation of physicians trained, in the 70s and 80s, that were very scientifically-oriented. These people were very intelligent, but as you know, very intelligent people in any social circle sometimes aren't the best socializers. They, often, are introverted, sometimes outcasted. These individuals made their way into mainstream medicine, and got into clinical medicine, with

> very little social skills. In my own experience, interacting with physicians as I came through the high school ranks, and what not, you find kind of a change. So, the new focus, really, is on communication. For a long time, the focus was on science and being the best scientist/physician—not realizing that medicine is more than just diagnosing, understanding, and being a scientist" (See Appendix L, p. 262).

Physician recruitment for hospitals was focused on hiring the best scientist. Naturally, the medical education system sought to train physicians heavily in the natural sciences to give their graduating students the best chance of having a successful career. Medical schools neglected the social sciences 30 – 40 years ago.

Dr. L additionally stated, "For years, that's the way it was taught. The
> physicians were geared toward the biomedical aspects. Whereas, nurses were geared toward the 'meeting the patients' needs/communicative model.' So, the product of the schism was driven by the educational structure. That's sort of the division of labor, if you will, when it came to healthcare. The nurses were at the bedside with the patients. They [nurses] were dealing with those social issues. The physicians really weren't. I mean, they were segregated from that. 'This is what you've got. This is what you take to get better.' They walked away from the emotion of the interaction. Now, the consumer wants somebody that is better versed to walk the path between the two" (See Appendix L, p. 273).

However, Dr. L also believes that education is changing for both physicians and nurses. Physicians are learning more about communication, and nurses are learning more about science. Both roles are receiving education necessary to bring biomedical and biopsychosocial areas of medicine toward a middle ground. "I think it has to do with education and how those two models are now being met on an education level, such that trainees are being taught components of both. It's the same thing for nursing. It's not just communication. You're there to be an investigator. You're there to understand the situation and be able to uncover those things. You need to understand the science more

and bridge the gap between those things. So, both sides of the aisle have sort of moved toward the midline" (See Appendix L, p. 273).

Dr. G echoed those sentiments and added that there is no longer a sole focus on science. "In the past, recruitment for physicians was focused more on people with a basic science background. Increasingly, more physicians with a humanistic background are being recruited, and that's being valued, especially in the areas of clinical practice. I do think that a lot more people are putting an emphasis into that. Even if you look at our clinical trials, quality of life assessments are being used more often. So, it's not a question of 'how long did somebody live?' but 'how well did they live?' I do think that is something that is progressively getting integrated into medical practice (See Appendix G, pp. 178-179).

Contemporary physicians are not just thinking about saving the life at all costs. They are thinking about how much of the patient's life will be restored (See Appendix D, Appendix G, & Appendix H). From a chronic illness perspective, the story has the potential to become focused on comfort measures (palliative care). The communication challenge in that scenario is likely going to be a family member. Narrative probability for the physician and patient is realized when they both come to terms with the fact that the treatment is not working. The condition is worsening in spite of best efforts on both the physician's and patient's sides. Narrative probability is fully realized with acceptance of that sad reality. Narrative fidelity is established, then, by the physician giving the metastatic cancer patient a morphine pump and honoring their desires/values of peace and dignity.

As can be seen, healthcare's modern perspective is not solely focused on medicine. For instance, Dr. L also discussed the growing focus on patients' perceptions of quality during their hospital stay. That not only includes quality of medical care but also quality of interactions with physicians and staff. Personal income is increasingly tied to patient satisfaction in these areas. "You know, they [patients] got a curative surgery that saved their life, but they walk away from the encounter with a negative vision because of some poor interaction in the middle of the night. You're like, 'Hmm, that's not good.' Unfortunately, the bottom line is going to be tied to that opinion" (See Appendix L, p. 274).

In the same vein, Drs. C and L made comments to the effect that the best, brightest physician can be perceived as the worst if he/she has poor communication skills. Dr. C commented, "At the end of the day, you can have the worst doctor in the world that doesn't know his…uh…you know…doesn't know anything. Because he has such an excellent bedside manner, he is going to be perceived like he is the most wonderful doctor in the world. Whereas, you can have the doctor who is the smartest, most competent, and well trained individual but can't communicate. So, he's perceived as an idiot" (See Appendix C, p. 120).

Dr. L additionally stated, "You can be the best physician and have patients who absolutely think the care is horrible because of the way that you communicated with them" (See Appendix L, p. 274). In fact, Dr. L firmly believes that those remaining physicians who are poor communicators will not have a job in the next decade. "I think the future in a lot of healthcare is going to be professional communicators" (See Appendix L, p. 276).

Fisher would starkly contrast medicine's old story with its contemporary one. The old story was fragmented, without a healthcare team in place. Doctors treated diseases only, instructed nurses what to do for patients, and spoke very little with nurses or patients about anything beyond the order of business. It was merely a chain of command that was mostly aligned with the Transmission Model of communication.

In fact, Dr. F discussed how the physician-patient relationship is "evolving." It used to be "authoritarian" in nature but is now more of a "working relationship"—a partnership. He also noted that continuing to frame the physician-patient relationship as a tyrannical dynamic will only perpetuate the image that is falling by the wayside in the clinical setting (See Appendix F). Social protocols practiced by physicians of previous generations are acknowledged and criticized by today's physicians. In fact, Dr. I stated, "I think the paternalism we fostered, as a medical community, that, 'Oh, don't you worry about anything. I'll tell you what you need to know.' I think it's very outdated, and it was very wrong to treat the patients that way. Patients need to be very much a partner in their healthcare" (See Appendix I, p. 197).

Dr. L also shared thoughts regarding modern medical education components compared to those of the past. It is the modern components that will affect physician-patient relationships of the future. "Now, it is completely different in that communication is a component of the educational model. We, actually, are tested on communication style. Students have to, actually, go in and speak with people… So, communication has become a big component of it when we start talking about core elements. Communication and socialization skills are a big point of that check mark. Not only is it knowledge-based, but interpersonal skills are one of the things that we

evaluate, training physicians and medical students with regard to it. So, I think it probably did suffer for a long time. We, unfortunately, are repairing the repercussions of that narrow-mindedness" (See Appendix L, pp. 262-263).

Continuing with a modern perspective, technology and greater media access has allowed patients to research their own conditions and medications. In the old days, if someone had an interest in a medical topic, that person had to find a medical book at the library and try to understand its terminology (See Appendix F). In that time period—putting rhetoric in the context of its time—the physician's treatment was the means to narrative probability for patients who did not understand the nuances of a given disease. The physician of those days prescribed a medication or performed a procedure which alleviated or minimized symptoms of the disease. That was typically the end of it.

Medicine's story for the patient used to be "I'm sick or injured. The doctor makes me better." Therein lied the narrative coherence. The doctor's office was the only place where sense was made of the story insofar as healing occurred. Doctors did not share details with patients in those days. Narrative fidelity, then, was established via the nobility of the healing profession. It was considered a show of good work. That is why physicians never advertise(d) their own practice. It was [and still is] frowned upon to create business for oneself.

Dr. K elaborated by saying, "…for a long time, physicians never were in the media for any reason, mainly, because it was considered to be a noble profession—not a business. So, physicians never were allowed to advertise themselves. Physicians never were allowed to portray themselves as the best, so on, so forth. So, for decades,

physicians never were involved, directly, with any advertisement or media… I don't think we'll ever go in that direction" (See Appendix K, pp. 236-238).

That being said, contemporary times have created endless choices for patients along the information highway. Competing physician stories exist on the Internet especially in the form of (auto)biographical profiles on office websites. After a few visits, or possibly a single visit—if patients are not in a health crisis—they will choose to go elsewhere if they do not like the table of contents offered by the initial encounter(s) with that physician.

Dr. F had this to say regarding the paternalistic remnants that may still be present in today's story of medicine. "…people just go elsewhere because there *are* choices, and there *are* people who don't do it that way. I think if you don't evolve and change your ways, or change that approach, I think people will seek other choices" (See Appendix F, p. 159).

It became clear after just a few interviews that the way in which academia frames contemporary biomedicine—as lacking compassion and focusing only on science—is not supported by contemporary physicians. They endorsed empathic communication with patients. For instance, Dr. A believes, "The people [physicians] who are good are good at reading people," (See Appendix A, p. 97). It stands to reason that having the ability to read others paves the way for empathy.

Furthermore, Dr. J shared a particularly poignant insight into compassionate communication. "The part I like to do is I like to go that extra step and realize they are people with feelings. If you take them away from their disease process, you can delve into so much more about them, and they will open up to you. If you're just a spot on the

lung, or a valve problem, it's one-dimensional; but if you say, 'How did you get to come see me today? What brings you here? How are you doing?' You know, one of the things is if you let them communicate to you, the process is so much better" (See Appendix J, p. 221). Labeling a patient as his/her disease process reduces that patient to his/her disease, alone, without recognizing the multidimensional person who deals with the lung cancer or heart valve problem on a daily basis.

Showing an interest in patients' stories—as human beings apart from their disease processes—establishes narrative fidelity of the physician-patient partnership through the shared values of open communication, bonding, trust facilitation, and respect. If patients can explain their health problem, it restores to them a sense of control and initiates a sense of narrative probability regarding their personal health story. Putting ideas into words teaches the listener and speaker simultaneously.

Physicians facilitate patients' stories of understanding and acceptance of the new chapters in their lives. Dr. G had this to share regarding oncology. "Well, we know that the way that people feel, or the way that they interact with others, makes their course of disease change, or at least, how they perceive the course of their disease. I don't believe that if you're happier, you do better with chemotherapy, but you may have a better outlook. So, you may not live longer, but at least, you'll have a better outlook on things and, maybe, enjoy the life that you have. I do think those are things that we try to address with our patients" (See Appendix G, p. 179).

Once acceptance is achieved, the road to managing/curing the disease can then be traveled. Acceptance does not typically happen in a single conversation. It often takes a series of conversations (See Appendix J).

Depending upon the course of the disease itself the patient's denial can steer him/her off the road to recovery. When patients begin feeling better, they often gradually slip back into old habits without thinking about the ramifications. In an emergent setting, patients usually do not hesitate to say that they will never smoke again or to vow against further dietary indiscretions. In subsequent chapters, however, the more time and distance that amasses between patients and their health crisis, the more likely they may be to take a detour off the straight and narrow. Unfortunately for patients who have a chronic illness, feeling good can actually lead to a setback in the story.

Dr. B shared her experience with patients' perceptions over time. "When you're asking for what patient perceives, it's too much, and it's unsuccessful. The patient's perception of, 'You want me to stop eating?' type of thing, but it's *perception*. If you're really not successful in communicating, then something is necessary. If patient is kind of in denial, sometimes, you can tell them what's happening; but they just say, 'But, I really don't feel that bad.' When, in fact, they are sitting in front of you with swollen legs or having trouble going to the bathroom" (See Appendix B, p. 107).

Returning to Dr. J's notion of labeling patients, labeling them *as* their disease minimizes the patient's story as well as the physician's participation in that story. Awareness of this represents further evidence that paternalism is continuously fading from the practice of medicine. Today, fewer physicians consider patients to be the equivalent of tasks to be accomplished and worthy of no more than cursory communication. While this road has not reached its end, I would like to acknowledge that evolution is taking place. Physicians are not merely reading the cliff notes about their patients and calling it a day. They are delving deeper into the heart of their patients'

stories and learning who they are in spite of their illnesses. As Dr. I shared, "…that's part of the thing I've always thought has made it worthwhile is when you did become an important part of that patient's life, or their family, and to be able to know that they've got kids and grandkids, or to know that they like this or that" (See Appendix I, pp. 213-214).

This reality—a small sample though it might be—contradicts the story, masquerading as reality, which was portrayed by the film *Wit*. Furthermore, the real-life stories that were shared with me laud the value of humanity. This works to preserve fidelity of their [physicians'] own story of partnering with their patients to help them live the healthiest lives possible.

Getting to know their patients allows physicians to know which resources to provide for them so that they are *able* to make the healthier choices more easily. Dr. I offers her patients supplemental programs. "Who can help you with this? Do you need to go to a cigarette, or tobacco, cessation thing? Will you go to this? Will you try that? Will you try a medicine?" (See Appendix I, p. 204). Thus, narrative probability is satisfied via all three types of coherence (Fisher, 1987, pp. 15-17).

Structural coherence lies in the fact that physicians and patients truly getting to know each other is a logically sound premise. After all, they do form a partnership. Material coherence is established in the compatibility of this story of partnering individuals knowing one another with other stories of partnership. It fosters mutual trust, respect, and healthy expectations. Characterological coherence is given the best chance to yield positive outcomes in these circumstances.

The physicians' overarching story of teamwork—which includes physicians, nurses, other support staff, patients, families—serves as evidence that they are not responsible for placing the biomedical and biopsychosocial areas of medicine at odds with one another. The physicians I interviewed clearly see the two as integral parts of one another working in unity rather than polarized entities working alone. Science has to be part of the story. If the body is not functioning properly, the patient's story, itself, is endangered. That story depends on science for restoration. Let us not forget that Fisher (1984) considers science to tell its own story.

Along these lines, Dr. E believes that some areas of medicine may have provided some physicians with greater opportunities to develop communication skills than other areas. "I also think the spectrum of family medicine, internal medicine, OB/GYN probably have developed the psychosocial model a little bit better than, for instance, surgeons because a lot of our interaction with the patient is when they're asleep. During a lot of our one-on-one time, they're asleep, and we're doing surgery on them—something mechanical. We have to be really good at that because that's the key part of the teamwork that we provide. So, we haven't had as much time to develop the psychosocial skills, probably, than people who are doing it all day, everyday" (See Appendix E, pp. 152-153). However, Dr. E also recognized the necessity to further develop this set of skills. "We've got to work to learn stuff from the nurses about how to better serve that part of patient care need" (See Appendix E).

During my interviews with physicians, I realized that while science may be the reason behind the initial physician-patient encounter (i.e., sick people visit their doctors), the foundation for the physician-patient partnership is communication. Since I have

already shared insights of the physicians I spoke with in that regard, I would like to direct attention to their perceptions of media and the ways in which various forms impact the story of contemporary medicine.

PHYSICIANS' PERSPECTIVES ON MEDIA

For the most part, physicians I spoke with expressed a love-hate relationship with media, depending on the topic and the way in which it is presented. Though this portion of the story is fraught with mixed feelings at times, it seems to largely be one of antagonism between physicians and the media. Physicians would like synergy but do not feel it fits with the agenda-setting functions of the media. For instance, when media glorify physicians to an extreme, it sets up patients and families to expect all fatalities to be averted by their own physicians—a point I had not considered. I have long been a proponent of telling positive stories if one is going to be about telling them.

Dr. D shed some light on this matter. "I think that in the mainstream media entertainment, at least, physicians are glorified a little bit, and rarity is the norm. Like, people that have terminal illnesses—I think when it comes to end of life issues, families will want everything done when we know that the inevitable outcome is going to be death. They're thinking, 'What if there is a chance?' because they see it happen that way on TV. There is a little bit of glorification in Hollywood that sets up for misinterpretation" (See Appendix D, pp. 123-124).

Dr. A shared a personal example to demonstrate patient/viewer expectations. "I didn't know if they were joking—I think, partially, they were joking. I remember I saw a patient when I was a resident. I went in, and the patient was transferred to IU Hospital from an outlying hospital, and I came in with the CT scans [reports] and was looking at

them. I said, "We've got to figure out what's going on with you." The husband of the patient said, "Boy, man, this would be a great time for Dr. House to be here." I mean… I think there is this perception. It doesn't work like that. You don't sit at a table like that, and it doesn't come like that [snapping fingers]. It just doesn't" (See Appendix A, p. 88).

Virtual experience, however, has led patients to believe there is little or nothing that doctors cannot fix or cure. Media have established narrative fidelity of this notion for patients through countless stories of triumph over death, leading to the valued belief in American society that "death is optional" (See Appendix B). Entertainment media perpetuate the medicine-as-magic mantra. A life saved = doctor is seen as hero; death = doctor is seen as the villain for letting the true villain (disease) win. Since physicians are in the business of restoring lives to the best of their abilities, Fisher would agree that patients perceive physicians to share the belief that "death is optional."

When reality deals the death card, it is a violation of narrative fidelity as well as narrative probability. Direct-to-consumer ads from pharmaceutical companies tell the story that a pill exists for everything. Dr. A spoke about these particular types of advertisements. "So, it's the way they [media] spin it—without giving all the full information. Therein lies the problem. You know, I think it's even worse now because the pharmaceutical companies advertise, and, 'Oh, ask your doctor about being on Plavix.' You're just sitting there, thinking, these are the wrong patients. Patients come in and just say, 'Oh, I want to be on Plavix because I saw it on a commercial.' That makes our job incredibly, incredibly difficult. It's frustrating that the media lead people down the wrong way" (See Appendix A, pp. 91-92).

Dr. I echoed these sentiments. "Everybody thinks there's a fast and easy cure for whatever it is that you have. 'Go ask your doctor…' It's, 'Ask for it by Name'" (See Appendix I, p. 196). From this perspective, when patients die, it does not make sense to families and therefore violates narrative probability on the grounds of lacking material coherence. According to other stories family members have been exposed to, there must be a pill to fix the problem. Family members are not likely to blame media when a patient dies in the hospital. They are more likely to blame the physician in the immediate thick of grief for not living up to the glorified image portrayed by the media.

Let us now move to the end of the spectrum opposite glorification. Physicians, who are portrayed as unfeeling robots with no compassion, tell a story which also suggests "death is optional." In these presentations, life will be maintained by any means necessary with no regard to quality of life. These stories create antagonism for entertainment's sake, but the antagonism transcends when people are put into real situations similar to those dramatized. They expect the same outcome they were exposed to in a movie or on a TV show. All of the physicians I spoke with testified to the fact that patients *do* have these expectations. The physician, then, has to quell that antagonism.

"So, in some ways, media has provided more information to people in the public. However, sometimes, that information is not always very accurate or can be misinterpreted. So, sometimes, it makes the job harder. Patients come with expectations, or wants, that you can't meet. They don't jive with what their diagnosis is or what their needs might be" (See Appendix L, p. 257).

Dr. G verified that patients expect the miracle cure that always seems to happen for soap opera cancer patients, for example. However, he also discussed the fact that if

someone keeps thinking a cure is coming, it "doesn't allow him/her to prepare for what's eventually going to happen." In an oncology practice, doctors do not discount hope itself but they are aware of the Internet sites that charge people money in exchange for *false* hope. In the thick of a battle with cancer, patients will typically try mostly anything in the name of hope (See Appendix G).

Teas and vitamins are not going to cure their cancer, but it is a delicate story to navigate. It violates the physician's sense of narrative probability when patients believe that special teas and vitamins are going to cure them (See Appendix G). At the same time, the physician cannot violate the patient's sense of narrative fidelity by making the patient feel as if the physician does not share the same goals and values of healing and remission.

Entertainment media portrayals should incorporate death of characters who are suffering from chronic conditions like cancer into their storylines. In doing so, I argue that they also need to depict the involved physicians showing compassion to these patients in end-of-life scenarios. Telling the occasional sad story may make the reality of such situations easier to fathom for viewers who are forced to navigate the same type of plot twist in the stories of their own lives. It may allow them to do so without resenting the real-life physician for being unable to save the life of a relative who may have succumbed to the same type of cancer that many fictional characters have been able to survive.

Physicians' frustrations do not end with entertainment media, however. According to Dr. G, "…I think the biggest thing is that it creates false expectations, especially in what I do which is oncology. Every day, there is a news article about a new

treatment that cures cancer, and it's not necessarily true" (See Appendix G, p. 173). Physicians feel that the sense of urgency with which news media want to be the first to report a story in today's competitive market create false hopes as well as false fears for the public. Dr. A provided a couple of examples in which media reports elicited false fears within his patient population.

The first example involved reports taken out of context regarding results of the COURAGE Trial in 2007. This trial randomized patients who had chronic, stable heart disease to either optimal medical therapy (including heart medications, smoking cessation, dietary control) or optimal medical therapy plus intervention (placing a stent in the patient's artery). Results showed essentially the same outcomes between these two groups. Ultimately, placing a stent in a patient who is not experiencing a life-threatening emergency does not increase or decrease the likelihood of death. Life is not prolonged by placing a stent electively. Dr. A further stated, "Well, the media took this and ran with it…I had patients calling up the office. I was a fellow at the time, but they wanted their stents out because they didn't think they needed them!" (See Appendix A, pp. 89-90). Via earlier conversations with Dr. A, I know that stent placement is permanent.

The second example involved media reporting results of a study which showed the cholesterol-lowering medication Vytorin was not effective. Dr. A explained that the patient population the researchers used was one in which patients had "familial hypercholesterolemia" (See Appendix A). This is a hereditary condition in which people have extremely high levels of 'bad' cholesterol. The patient population that this study spoke of does not include Dr. A's patients. So, the only take-home message his patients

received from that report was that Vytorin does not work. That message was only *part* of the story, however.

"The media will go on and say, "Oh, there was a study published that said, "Vytorin is not good for patients—blah, blah, blah, whatever." Whoa, wait a minute. Talk about the patients you used. You used the patients with familial hypercholesterolemia—not *my* patients that *I* take care of. Most of my patients don't have cholesterols like those patients had. Those are patients with total cholesterols of like 300, 330, and 350. Mine don't have *that*. They just have a little bit of hyperlipidemia" (See Appendix A, p. 91).

In cases like this, media do not provide necessary context and details to the public. These partial stories incite the perception of misaligned values between physicians and patients as well as fear and mistrust toward physicians. This was a point of contention with nearly all of the physicians I interviewed. It appears that Lupton & McLean's findings from 1998 are confirmed in 2011. Physicians, to an extent, felt that their "entire profession is being judged by excesses of a few doctors" (p. 947).

Dr. I discussed situations in which media ask physicians for comments on studies. Physicians want to ensure that the study methodology was sound, look at the patient population that was targeted (See Appendix A), and ensure that the study results are accurate. Media may interpret physicians' hesitancy to make comments as silence based on a desire to be uncooperative.

> Dr. I elaborated, "We've never had 24-hour a day news. Now, we've got 24-hour a day weather. I mean everybody is looking for something fresh and new to put on the air, or on the TV. I think the problem with that is that they'll take information, that is very preliminary, and make huge leaps as to its applicability. For years, we wondered how did the media know that the New England Journal article for

> this coming week says, 'this.' They wanted you to make a comment on it, and we didn't have a copy of it. Then, we learned that they were on the early mailing list—or early communication list—to receive those articles before we did. Then, they'd want to know our opinion about them, and we'd have to scrounge around, or have that media person send it to us because our subscription didn't come as early as theirs did… They're getting the information first and wanting us to comment on it when we haven't even had time to read it or even contemplate on it—was this a good study; analyze whether the study was any good, or the study set-up was any good; or the questions they were asking. Is that exactly what the results say? So, really analyzing the study, and how it was written, is very important. You can't do that in 10 minutes to come up with an answer for the media" (See Appendix I, pp. 193-194).

As can be seen, media take *preliminary* study results and broadcast them as true without waiting for final results to be analyzed and preliminary notions to be confirmed. Media thrive on sound bites and headlines. When doctors need time to dissect a study, media often fill in the gaps by airing 5 to 10 second clips of a physician speaking in vague terms and presenting that commentary in the way that will lead to the interpretation they [media] support (Entman, 2007, p. 166). Berliner & Cohen (2011, p. 53) would suggest that they do this via continuity editing (Zimmerman, 1988, p. 36). It is hard to violate narrative probability of reported medical stories among the majority of viewers. Studies have shown that most of the public believes that if something is presented on the news, it must be true (Hwang & Southwell, 2009, pp. 726-727).

News shows are not the only ones to utilize the tool of continuity editing, however. Dr. L alluded to this when discussing some of the "reality medical shows," particularly those that follow emergency room physicians since that is also Dr. L's specialty. His concern with these types of shows is that the diagnostic process is shown to be an extremely short one. "So, if it takes three days to occur, they'll try to snap it into what may seem like 60 minutes…So, the expectation is, well, this should happen in an

hour. I should get all this done. It's not how it is. This does unfold over many, many hours—days, sometimes" (See Appendix L, p. 259).

Continuity editing—which is a functional necessity for television/film and is considered one in a "set of standard practices" (Berliner & Cohen, 2011, pp. 45-46)—does have a role in creating expectations for patients. First of all, viewers watching reality television are likely to equate it with reality, especially if the action is taking place in a hospital (Papacharissi & Mendelson, 2007, pp. 356, 357, & 366; Hammermeister, et. al., 2005, pp. 254-255). This setting establishes ethos. These are true stories. When viewers become patients and need to visit the emergency room, their senses of narrative probability are going to be violated when it takes many hours or days for them to receive a diagnosis. Narrative fidelity will be violated as well because they may feel that the physician is not valuing their time or illness stories.

Even though much frustration exists between physicians and the media, one physician in particular shared his unique perspective regarding the subject. Dr. K expressed the opinion that physicians underutilize certain avenues of media. He feels that physicians should place a professional video profile on YouTube. In this scenario, patients would have the opportunity to learn about the physician's story up-front and decide whether they feel that story is compatible with his/her own. It would allow potential patients to put a face, name, and voice together. The physician would then be able to speak to these potential patients in his/her own words. Physicians could include their YouTube link on their business cards. Dr. K developed this idea because of the nature of his practice.

"My feeling is, for example, a patient needs to know who the physician is. Many times, you don't know your physician, okay? You probably can pull up his picture to see how he looks, or you have word of mouth. You never seen him, or heard his voice, or anything like that. So, I came up with an idea to tell people, how about if we have a 30 second introduction by the physician about himself and put it on YouTube for a patient to go and look at. It becomes part of their business card—just like your office address, phone number, email. Then, you have this YouTube site address" (See Appendix K, p. 236).

As an Interventional Cardiologist, Dr. K has encountered situations in which he has had to delay his arrival to patients' clinic appointments because of the need to finish up an emergent procedure on a different patient. If he has never seen the clinic patient before, that patient may not understand the nature of his role and may form negative opinions about him based on this first impression. Therefore, Dr. K thought it might be helpful for patients like these to have a website to visit where they will hear the doctor's story *from the doctor* rather than being left to draw conclusions based on mitigating circumstances.

While Dr. K may have an entrepreneurial spirit in regard to media, he also shared some of the same concerns his colleagues had expressed. He also agreed that patients do believe news stories they read regarding various study results. If patients find a story about statins (cholesterol-lowering medications) being harmful in some way, they generally will not want to take statins in spite of the physician explaining why statins are beneficial.

"So, I have people who have strong beliefs that statins are harmful, and they come in and say, 'I read about this, here. I don't want to take a statin.' You know, statins are cholesterol medications. They have a proven beneficial effect. At the same time, they [patients] won't take this; but if you look at the medical list, they'll be taking about 15 herbal medications, or vitamins, or ancillary medications, which have not been shown to have any value. If any, they might have a negative effect, but they [patients] are more comfortable taking those pills. They don't want to take a statin" (See Appendix K, pp. 231-232).

Patients feel more comfortable taking herbal pills because they can find little-to-no harmful information about them without realizing the reason for that is because little-to-no research has been done on them (See Appendix D & Appendix K). These patients subscribe to the "no news is good news" adage. As long as they feel well, their story maintains fidelity and probability in their own eyes.

Dr. D has also encountered the issue of certain patients not wanting to take western medicines in general, statin drugs in particular. They will, however, take Red Yeast. He tells these patients, "Okay. That's fine. I just need you to understand that Red Yeast is an unregulated statin. In fact it's the derivative of Lovastatin. So, you are basically taking a statin where one day, you might get 2 milligrams. The next day, you might get 10 milligrams, depending on which sample you buy because it's unregulated. Because it can have partial contaminants in it, being unregulated, it may cause kidney failure. So, if you're okay with all those things, keep that Red Yeast" (See Appendix D, pp. 128-129).

Even with an explanation like this one, patients are not deterred from this behavior. Dr. D stated that he would rather they take Red Yeast than nothing at all due to the need for some type of treatment in the face of coronary disease. Again, I believe Fisher would recognize that as long as patients are feeling well, their own narrative fidelity and probability are preserved. Unless a patient's story becomes fractured by a health emergency, he/she typically will not question his/her own behaviors or perspectives.

Physicians I spoke with pointed out that sometimes not even a fractured story will cause a patient to question his/her own ways. Doctors deal with every imaginable personality. Even in the most trying situations, though, they believe that compassion has to be part of the equation when communicating with patients.

Dr. F shared a thought that speaks to this, "Something I was always taught is that you can tell somebody, "You have cancer." After that, you could be in the room for an hour talking to them about the type of cancer and how to do the staging, treatment options, and so forth. Most people, as soon as they hear that, they're going to be thinking about their entire life—their family, their friends, what's going to happen to them, and the voice of the physician, or whoever is communicating to them, is going to be in the background" (See Appendix F, p. 163). Recognizing this phenomenon suggests a compassionate, empathic communication method.

Recall that successful communication with patients relies, in part, on successful teamwork in the healthcare environment. Teamwork also represents the overarching story of the biomedical model according to the physicians with whom I spoke. In addition, it helps to maintain the continuity of each patient's health/illness story. Now

that I have established that there are some physicians who view teamwork as the overarching story of biomedicine, let us now consider what new conversational directions we need to take in order to shift the dominant frame of biomedicine.

RQ 3: What are the conversational/story elements required to begin to shift the dominant frame of the biomedical model? What new characters, themes, plotlines, and dramatistic arguments need to be born?

CONVERSATIONAL/STORY ELEMENTS

Fortunately, there is an extent to which the story elements are already in place. Many of the physicians spoke of IU School of Medicine's initiative to bring awareness to the necessity for physicians to have positive communication skills. Dr. L in particular discussed how today's medical education system is exposing more medical students/residents to the art of communication while at the same time exposing more nursing students to science. This indicates a bridging in the stories of biomedical and biopsychosocial medicine (See Appendix L).

The conversational piece is still missing on a larger scale, however. The dominant frame of biomedicine will be unable to change if we do not begin to communicate about it differently. I believe this project takes a small step toward demonstrating that there is humanity in the story of contemporary medicine. It is not a story merely about the cold, hard facts. Today's physicians are enlightened of the need to provide patient-centered care—not simply disease-centered care.

As I stated in response to my second research question, physicians do not share academia's view about biomedicine. By academia, I am not only referring to health communication studies but to studies done in the collective social sciences. Academia

has had a role in segregating the biomedical and biopsychosocial models which are quite dependent on each other in practice and are increasingly becoming more integrated in nature. I argue that this conversation needs to be taken in a new direction: one that highlights integration rather than segregation.

Additionally, as physicians acknowledged across my interviews, there are doctors who are arrogant, and there are doctors who are poor communicators. However, after speaking with the physicians I have, I believe those types of practitioners are dwindling in number. It became clear to me, throughout the interview process, that when one is in a high-status position, there is a tendency to overlook the fact that the person occupying that high-status position is still human. Complaints abound that physicians demean the fact that patients are human, but I think patients sometimes forget that physicians are human as well.

Furthermore, Dr. D discussed 'comment boxes' offered by many organizations, and the fact that few people take the time to put positive thoughts on paper. Usually, if someone takes the time to put their feelings on paper, it is because he/she is upset about something. "Anything that is sensational gets told. You don't hear the good outcomes. There is always a complaint box. No one ever writes, "I had great service!" It's always if you're angry enough to write something down, it's because you had a bad experience" (See Appendix D, p. 126).

During various interviews, physicians noted that it is human nature to remember the bad times. I, therefore, argue that a new theme needs to be born—one of positivity. Good changes in physicians' communication styles have taken place over the years, and

more are on the horizon. Our discourse needs to acknowledge that. We make things real and give them substance when we talk about them.

I believe one of the ways we can begin this conversation is to provide more of a balanced focus in health communication research between the physicians' and patients' perspectives regarding the success behind the physician-patient partnership. We can also carry the conversation over to the classroom. For instance, when we view medically-themed films such as *The Doctor* I argue for post-viewing discussions which illuminate the potential for positivity within the physician-patient relationship by focusing on specific dialogue between the doctor and patient characters. The reason this is important is because one of the universal truths of the human condition is that we all need a doctor at some point in our lives. It makes sense to attempt to create the most positive communication experience in that time of need that circumstances will allow.

In an effort to continue the discourse, I argue that we also need to begin conversing within health communication literature about the new plotline of partnership in medicine that exists between physicians and their patients. This is not a theoretical relationship. It is very tangible and treasured by each of the physicians I interviewed. Physicians want patients to be engaged with their own healthcare decisions, to the extent that they are capable, and appreciate when they do engage.

The stories present across my physician interviews would suggest that paternalism is incessantly declining from the story of medicine, and we need not resurrect its presence in future chapters of conversation. Contemporary physicians consider paternalism to be a blemish in medicine's story and do not want to continue forward with it.

Even though the medical education system has become cognizant of communication's vitality within its curriculum, a deficit a few physicians pointed out to me was a deeper introduction to intercultural communication. They would have liked to learn more than a handout listing main similarities and differences could share with them. There is a concern among physicians that they may inadvertently violate a patient's cultural norms—thereby violating his/her narrative fidelity and probability—and get into trouble in the course of trying to do their jobs. This concern expands alongside the ever-growing multicultural patient population they treat.

I would like to address the potential roots of this particular concern for a moment. Recall that the physicians I spoke with voiced their belief that compassion needs to be part of the communication process when they interact with patients. This belief carries with it the implication that these physicians care about how their patients are feeling physically and psychologically. The doctors I interviewed do not want to violate their patients' cultural expectations. To do so would violate their attempt to provide compassionate care.

While another interpretation might be that the physicians want to learn about other cultures simply to avoid legal situations. However, the potential for legal issues did not arise in our conversations. The topic that did arise was compassionate communication. Therefore, that is the root of concern that seems to fit into these doctors' stories.

From this perspective, the contemporary story of medicine would benefit from the introduction of a group of characters who could provide accurate, in-depth knowledge about external cultural customs. "In "x" culture, it's considered inappropriate to touch a

female unless you ask permission from the husband first, for example. I think that would be more helpful, to me, than to get a list of different cultural sensitivities that we may encounter… We're seeing more patients from different backgrounds. To have a little bit of knowledge as to what's appropriate and what's not appropriate can keep you from mistakenly getting yourself in trouble when you're just trying to do your job… I really do think we're seeing a greater Muslim population. I, for one, don't know much about the Muslim culture… Plus, we're getting a lot of Asian Americans. I think there is a whole host of issues you're going to run into, and it would help to have a little background" (See Appendix D, p. 134).

As I hope to have made evident, we need to engage in positive conversations in regard to the biomedical model. Such can be achieved within health communication scholarship and within the classroom. I believe it is important to recognize the strides that physicians are beginning to attempt to make when communicating with their patients. Even though I only spoke with 12 physicians and that number in no way nears the privilege of equating the majority, I do believe that represents a beginning. With the recognition of said beginning, I would like to direct the discussion toward future research.

FUTURE RESEARCH

Returning to the topic of biomedicine for a moment, I believe further research will aid in shifting the current dominant framework of biomedicine from a solo unit that is authoritarian in nature to a framework of a team that relies on partnership and empathic communication. One of my ideas for future research came from a statement made by Dr. B, "I don't think physicians ever have sort of debriefing sessions after situations where patients sort of assaulted them verbally, or questioned their good intentions, and acted emotionally and unjustly. Okay? Those are very vulnerable moments, for young physicians, of disappointment, and they expose them emotionally. They toughen them," (See Appendix B, p. 110).

I think it would be very beneficial to study the development of physician-patient communication from internship through and including the first year of practice establishment. Specifically, I see the focus as debriefing vs. no debriefing after negative patient encounters during internship, which is considered the first year of residency. A study like this could work toward proving that debriefing after negative patient encounters helps physicians to resist the instinct to exhibit a toughened exterior from that point forward. It could also lead to the establishment of formal debriefing sessions within the medical education curriculum, further changing the story of contemporary medicine in a positive way. It would also elucidate the seemingly forgotten fact that physicians are people, too.

Another interesting topic Dr. D suggested would involve looking at differences in physicians' communication practice across generations. For instance, are physicians of

the Information Age more adept at communicating with patients than physicians of previous generations? (See Appendix D)

As for additional ideas for future research, there are many angles that I did not have time or space to explore. For instance, a few physicians addressed the perceived differences between male and female communication styles as well as the differing personality types between the two sexes. Based on commentary, it would seem that male patients are more compatible with female physicians while female patients are more compatible with male physicians.

Also, I realized that some physicians stereotype other physicians in different specialties as 'bad communicators.' Two of those stereotyped specialties were surgery and emergency medicine—both of which are represented in my interview population. It might be fruitful to conduct interviews aimed at discovering the reason they, personally, hold this stereotype.

CONCLUSIONS

This project sought to make the physician's voice a bit louder in the vast sea of health communication research as the majority of physician-patient communication has focused on the patient's perspective. It has also been an earnest effort to reveal humanity's presence in the story of medicine and to demonstrate the integral nature of its biomedical and biopsychosocial areas. Contemporary medicine is a story of teamwork, partnership, and empathic communication.

Narrative fidelity of the healthcare teamwork storyline is established through values of trust, community, and goodwill toward humanity. Fidelity of the physician-patient partnership, in which empathic communication is key, is satisfied by values of friendship, empowerment, healing, and respect. Narrative probability of the collective story of contemporary medicine is established by the presence of structural coherence, material coherence, and characterological coherence.

Again, the dominant framework of biomedicine as cold and uncaring will change when the tone of the dominant conversation about it changes to reflect the warmth and care that emerged from my interviews with physicians. It is this warmth and care that fuels physicians' communication with patients as they partner with them to preserve the stories of their lives.

LIMITATIONS

There are a few limitations that I need to disclose. First of all, the semi-structured interview process was new for me. During the first couple of interviews, I was immersed in the conversational flow and may have shared my opinions a bit too soon. I did quickly learn, however, to phrase my questions in such a way as to describe a particular perception and ask the doctors whether they felt the perception was accurate.

Due to the hurried nature of physicians' schedules, several interviews were interrupted multiple times by the need to return pages or by a staff member requesting their immediate attention for a patient's sake. Secondary to that, certain trains of thought were derailed by the numerous distractions.

Lastly, one of the physicians I interviewed had a very heavy accent. That led to a few parts of the recorded interview that I could not completely understand. I, therefore, interpreted what made sense to me in the context of the discussion.

APPENDIX A

Interview with Dr. A:

Jennifer: First of all, I'd like to know how you feel physicians are portrayed by the media; and would you consider this a fair portrayal, or not? I'd also like the reasons behind your answers, please.

Dr. A: I think there are some good portrayals of physicians, and I think there are some bad portrayals of physicians. I think some of the portrayals of doctors that have come up are historical perspectives that people have. You know, I've watched some of the shows that are on TV, and stuff, especially when I was younger—not so much now—because I kind of need a break from it. When I was younger, I watched the *ERs, Chicago Hope, Trapper John, MD* and all those other things. Anyway, I think sometimes, the physicians are portrayed in the light of being saviors, and holding people's lives in our hands—which, I guess, to an extent, we do sometimes. Also, very paternalistic—whatever the doctor says goes kind of thing—that can be positive or negative, actually. I think a lot of that is historical because I think, back in the old days, that's how doctors were seen. It was a 'whatever the doctor said went' kind of thing, and they were put on pedestals. I'm not sure that's really the way it is anymore, to be honest with you. I really think the perception of some physicians has changed. I think the media—well, I still think the media portrays doctors pretty well. I think some of the portrayals are unrealistic, actually. I think *Grey's Anatomy* is a joke.

Jennifer: I can't get into that show.

Dr. A: To be honest with you, it's a little farfetched.

Jennifer: It's not focused enough on the medicine for me. It's all about the drama.

Dr. A: It's all about the drama—exactly. It's what sells. Then, people come up to you and ask you, "Is this how it really is?" Some things, yeah, I'll think, 'Yeah, that's funny. That just happened to me yesterday.' Then, there's a lot of it that's just based on the drama—relationships that happen in the workplace. Yes, I'm sure it happens sometimes but not to the extent it's portrayed on *Grey's Anatomy*—everyone sleeping with each other—that's not true. I think that doctors tend to be put on a pedestal and portrayed as being very arrogant. Those people are out there, but they're out there in any field. So, those are my thoughts on that. I hope that answers your question.

Jennifer: Yeah, now, how would you change the portrayal—if at all—if you could?

Dr. A: [Laughs]. That's really funny that you mention that because I've often thought about starting a business and doing consulting for Hollywood as a medical advisor. I think it would be great to do. First of all, I think it would be fun. I'd like to change the perceptions people have, but a lot of what the media does—it's to sell the show. They ramp up, or amplify some degree of the truth. You know what I mean?

Jennifer: Yeah.

Dr. A: So, I think it's hard to change these perceptions except just to kind of—you know, when patients watch that stuff, I don't really think they believe that's how all doctors are. Hopefully, their relationships they have with their doctors are positive and not like some of the stuff you see on TV. That's a tough one. I would love for people to come hang out with me for a day and really see what it's like.

Jennifer: You know I'm all for that as long as we don't go in the cath lab.

Dr. A: Right, right. Exactly, exactly. Cath lab and pass out—or almost pass out.

Jennifer: How do you feel that the pervasiveness of contemporary media impacts your practice? Does it help or hinder? Or, is there no noticeable effect, and as always, why?

Dr. A: I think it actually potentially hinders it, and the reason I say that is because I think people have certain expectations based on what they see the physicians doing.

Jennifer: There are studies that attest to that.

Dr. A: Really? I would be interested in that. I didn't know if they were joking—I think, partially, they were joking. I remember I saw a patient when I was a resident. I went in, and the patient was transferred to IU Hospital from an outlying hospital, and I came in with the CT scans [reports] and was looking at them. I said, "We've got to figure out what's going on with you." The husband of the patient said, "Boy, man, this would be a great time for Dr. House to be here." I mean…

Jennifer: Oh, geez!

Dr. A: Yeah, that's what I'm saying! I think there is this perception. It doesn't work like that.

Jennifer: I know.

Dr. A: You don't sit at a table like that, and it doesn't come like that [snapping fingers]. It just doesn't.

Jennifer: And, what they need to realize is that when he gets a diagnosis 15 minutes into the show, he's wrong.

Dr. A: Right. So, it's not quite so simple as that, and I think people have some expectations because of those things.

Jennifer: There are—I haven't watched it for a couple seasons now—but, anyway, there was one that I know he screwed up majorly. I went back to my physiology book and

reread it and reread it. This was one was a repeat. I was like, "I thought that's what he said!" This person would've been dead! He would've given him the wrong blood. He would've been gone.

Dr. A: Mm hmm. Mm hmm.

Jennifer: His diagnosis just didn't make sense.

Dr. A: I think people have those expectations, and I think that the media—see, now you're really going to get me going. The thing I hate that the media does is when they talk about studies. The one thing that comes to mind, most recently, is the COURAGE Study in 2007, roughly. There was a very pivotal trial that came out that found that patients—not the heart attack patients like you deal with—but the patients who have chronic, stable coronary disease…unstable are the MIs…so, stable is chest pain every once in a while.

Jennifer: So, when they say, "unstable angina," it's not MI, right?

Dr. A: No, but there is another category called "stable angina." It means they have it, it doesn't change, and they know how to treat it. It's just there. Are you following me?

Jennifer: Uh huh.

Dr. A: When it's unstable, it accelerates, or gets worse…becomes harder to control with medications.

Jennifer: Like Ranexa?

Dr. A: Exactly. So, that's what I mean by unstable. Do you get it?

Jennifer: Okay, unstable but not necessarily infarcting—got it.

Dr. A: Okay. So there was a study that showed people with chronic, stable angina—or chronic coronary disease—that when you took those patients and randomized them to

optimal medical therapy, meaning beta blockers, aspirin, statins, good diabetes control, smoking cessation—that's what I mean by optimal medical therapy.

Jennifer: And dietary control?

Dr. A: And dietary control. Or, randomized them to optimal medical therapy plus intervention, meaning getting a stent, there was no difference between the two groups as far as outcomes. There was no increase in death, no increase in heart attack. So, basically, it translates that if someone has chronic, stable coronary disease, there is no difference in mortality whether you put in a stent, or not. You don't prolong life by putting in a stent.

Jennifer: This is a stent *just because*, right?

Dr. A: Mm hmm. You may make them feel better, right? You follow me?

Jennifer: Because of increased blood flow.

Dr. A: Because of increased blood flow—you relieve their angina, but there is no difference between those. Well, the media took this and ran with it. I mean, I had patients calling up the office. I was a fellow at the time, but they wanted their stents out!

Jennifer: Oh! Because…

Dr. A: Because they didn't think they needed them! Calling up saying they want their stents out!

Jennifer: That can't happen.

Dr. A: Mm hmm. So, that's what I mean. The media—they don't give you the details. They tell a very one-sided thing, and it makes our jobs, as physicians, very, very difficult.

Jennifer: That's why I was asking you about the stents causing clots, so to speak, because that's the impression I was under. I didn't know the history, but you explained it

to me. That's also why I asked you about Vytorin because I've read articles that said it doesn't seem to help.

Dr. A: Mm hmm. We can talk about that, too.

Jennifer: We did, remember? You explained it the day that we went over the enzyme lecture—that that's not reflective of our patients.

Dr. A: No, those are not our patients, but that's what the media does. The media will go on and say, "Oh, there was a study published that said, "Vytorin is not good for patients—blah, blah, blah, whatever." Whoa, wait a minute. Talk about the patients you used. You used the patients with familial hypercholesterolemia—not *my* patients that *I* take care of. Most of my patients don't have cholesterols like those patients had. Those are patients with total cholesterols of like 300, 330, and 350. Mine don't have *that*. They just have a little bit of hyperlipidemia. You know, LDLs of 200 and 250—those aren't my patients.

Jennifer: Another thing that aggravates me is One-A-Day Vitamins. I refuse to take them because I think they are false advertisers. It goes back to—they've since been slapped on the wrist for this—but they came out with a *Cholesterol Plus* vitamin line with policosanol which, turns out, has absolutely no effect on cholesterol whatsoever.

Dr. A: Absolutely.

Jennifer: But, it was explained to me that these media people do not wait for final results of studies. They get preliminary information that looks like it might be going a certain way, and they broadcast it to the entire world.

Dr. A: Right, and that's the problem. So, it's the way they spin it—without giving all the full information. Therein lies the problem. You know, I think it's even worse now

because the pharmaceutical companies advertise, and, "Oh, ask your doctor about being on Plavix." You're just sitting there, thinking, these are the wrong patients. Patients come in and just say, "Oh, I want to be on Plavix because I saw it on a commercial." That makes our job incredibly, incredibly difficult. It's frustrating that the media lead people down the wrong way.

Jennifer: Okay. To piggyback on that, with increased Internet access, have you noticed that patients are now more inquisitive about their health than in previous generations? Or, are they asking less questions than they used to? If they are asking less questions, do you think it's because they trust the media, or Internet, more than they do their doctors?

Dr. A: I certainly can't comment about previous generations because I've only been at this a year and a half, but I think from the time I have been involved in medicine, which is from the year 2000 when I was a third year med student, I think the answer is, "Yes." Patients have more access, and they come in more informed, but I also think they've gotten stupider because of the stuff that they read.

Jennifer: With no context?

Dr. A: With completely no context, "Oh, I just found this on the Internet." I'm okay with patients reading on the Internet. I'm okay with patients being engaged with their healthcare. They should—*absolutely*, they should.

Jennifer: But, ask questions first?

Dr. A: Well, I also want them to read the right thing. I don't want them reading some garbage blog that someone wrote about something. I'm okay with them reading and being engaged. They're perfectly welcome to look stuff up. I just want to make sure that they're reading the right websites. I, a lot of times, will direct people to certain websites.

If you want to read about this, go to *this* website because I know it's credible and not just garbage that someone put up there.

Jennifer: Alright. So, they are more inquisitive?

Dr. A: I think so.

Jennifer: Now, this is venturing off into a bit more communication-based questions. How do you respond when you hear that the majority of the public—and this is based on some of the stuff that I did for the *Wit* thing—but it's coming off of the lit review that I've done as well. So, I'm not just going off of 11 people that I talked to, but how do you react when you hear that the majority of the public feels that physicians are bad communicators?

Dr. A: As much as I hate to admit it, I do think there is some truth to it. I'm not here to toot my own horn. I'm just looking at the feedback that I get from patients. I *think* that's why patients like me is because they think I'm a good communicator. I take things, and I boil them down to a very simple way to explain it. I don't try to talk all of this medical jargon with them. They're not going to understand. So, from what I've been told, I'm a very good communicator. They feel like they can always understand me. I think a lot of physicians are not. I think a lot of physicians are very, very brilliant people, but they have a lot of difficulty, sometimes, bringing those things down to an everyday level with analogies or examples of how things are. You know, I've used car examples to describe the heart for mechanics. They get that. They can relate to those kinds of things. So, you've got to kind of bring those things down. When I talk about a blockage with post-stenotic dilatation, I'll be like, "Okay, imagine you have a garden hose with a blockage. What happens when you have a garden hose with a blockage? It gets big after that.

That's what's happened inside your artery. So, I use these sorts of examples to explain things to people. I think there are many physicians—and many people all over the world—but with physicians, I think there are some of them, and this is purely my opinion, okay? I think there are a lot of physicians who are people who just have a certain personality type. There is a certain personality type of some people who become doctors, and a lot of them are not the most social people. They may be very book smart and may be incredibly intelligent, but a lot of them are just not very good social people. I think they have trouble communicating as a consequence of that. Maybe, that's something you can teach. I don't know. I think you're either born with it, or you're not, personally. I also think the public has this perception because doctors are always in a hurry. Whenever I see patients, personally, I always try and sit down so that they know that their time is important. Just sitting down may make a 5-minute visit feel like 10 minutes because you sat down and looked them in the face. So, there may be a little truth in that. It may be blown a little bit out of proportion, but there's probably some truth to it. I think a lot of doctors maybe get short because they're in a hurry. Does that make sense?

Jennifer: Mm hmm. Okay. You sort of touched on this, but when do you feel that your communication with patients is successful? What are the components of that successful conversation, or series of conversations?

Dr. A: Good question. A lot of these things I wasn't trained to do. A lot of things I do because it's just me. I've noticed, as I think about it and what people have said to me, I'm like, "Oh, I didn't realize I did that." I always sit down—most of the time—so that they know their time is important. I'm never reaching for the door. I look them in the face and try to have a conversation *with* them as opposed to *at* them. I try to engage them

in the decision-making, too, which I think most patients appreciate. I try not to be paternalistic, and I think that's very successful with patients. I think some patients want you to be paternalistic. They want you to make the decision.

Jennifer: I had a patient I was consenting—maybe last week—and these were the quality of life questions. When we got to the health scale—zero being the worst you've ever felt, 100 being the best, where do you feel like you're at on the scale today—"Oh, gosh, I don't know. Help me. What do you think?"…I don't know.

Dr. A: Yeah, some patients want that, but I'm not like that. I tend to be more…

Jennifer: Do you go a little bit more in that direction if they're asking for it?

Dr. A: Sure. My approach has been I always give them the options of something. I say, "Okay, we've got this option, this option, and this option."

Jennifer: Then, they say, "What would you do?"?

Dr. A: Then, they say, "What would you do?" Then, I voice my opinion, but I don't ever want them to be swayed by my opinion. I'm just not that type of person. So, I tend to give them the option, and say, "This is what we can do, or this is what we can do. Here are the risks of this and the benefits of this." Then, if they say, "What would you do?" or "What would you do if this was your mother?" Then, I give my opinion. I say, "Okay, this is what I would do." Another thing I always do—and I got this piece of advice when I was in medical school—I never leave the room without touching—this is going to sound funny, but don't laugh. I never leave the room without touching a patient—whether it's a handshake, whether it's examining them, or whatever. I always try and make a physical contact with the patient.

Jennifer: That's good.

Dr. A: Someone gave me that piece of advice when I was a med student. I think, a lot of times, what makes my communication successful is I just listen to them. I don't talk. That was another piece of advice from Dr. Morton Greenberger, who was the Chief of Medicine at my medical school. He is now a professor at Harvard and has written many different articles and chapters. He's a well-published guy. I remember he always said, "The problem with doctors is that none of them ever shut-up and listen." It's true. They never just shut-up and actually listen to the patient. Just listen to them talk a good portion of the time, and I think a lot of it has to do with that hurried thing. You know, you've got three other patients that are waiting for you. You've got to get done—instead of just shutting up and listening to what the patient says because you'll probably get your diagnosis if you just shut-up and listen.

Jennifer: When I hear people complain about having to wait, I'm like, "You *want* to see the person you have to wait for because that means they're taking time.

Dr. A: Mm hmm. Exactly.

Jennifer: By the same token, have you ever felt your communication with patients was unsuccessful, and was there something specific that made you feel that way?

Dr. A: There are those people with whom you talk that are just not on the same page. You can recognize it pretty quickly when the two of you just are not jiving.

Jennifer: Does it come down to personality?

Dr. A: Yes, listen. I've always…the one thing I always say to patients after an initial encounter, I always ask them, "Would you like to proceed with me as your doctor? Was our interaction okay?" because I want them to always feel empowered to say, "Yeah, I don't like you," or whatever, and I'm okay with that. There are people who just don't

gel, and you have to deal with people differently. There are some patients who need to be coddled. You know, they need to be babied, and there are some who don't need to be babied. Your job, as the doctor, is to get a sense of who these people are. The good physicians are the ones who can read people—"Oh, I've got to cater to this patient; I've got to coddle her; but this one—he just wants to come in, do his thing, and get out." You have to gauge that as the doctor. The people who are good are good at reading people. I'd like to think I'm good at reading those things. So, yeah, a lot of times, it comes down to personality types. People are different, and maybe even culture, too. I think there are all sorts of things that can play into a doctor – patient relationship and its communication or lack thereof.

Jennifer: Were there specific courses for you in med school that dealt with doctor – patient communication?

Dr. A: That came up in ICM—Introduction to Clinical Medicine courses. Those are called "ICM."

Jennifer: Those are required courses?

Dr. A: Yes, those are required, where you learn about the physical exam and things like that. I remember one of our professors saying that you can teach a bedside manner. I have trouble with that statement. I don't believe it. I don't believe you can teach someone to have a bedside manner. People either have a bedside manner, or they don't. My bedside manner is just my personality. That's got me through life so far. That's my bedside manner. It's just my personality. I don't have to 'put on' a bedside manner. The way I talk to patients is the way I would talk to my friends or anybody else. So, there are some classes where they teach you and walk you through things to say and not to say, or

how you should phrase certain things. Some of the things, I think, are inherent. They're either there, or they're not. One of my partners has a very, very loud voice, and you can hear him talking to patients through the walls. When I'm listening to him, I'm like, "Seriously?" You know, that's not for me to judge. I shouldn't judge any other person, but I'm just like, "How are these patients even comfortable with the way you communicate with them? You're not even communicating with them appropriately, you know?" So, I mean there are classes, but I think you're either born with the ability to do it, or you're not. That's just my opinion.

Jennifer: So, the focus was trying to teach a bedside manner?

Dr. A: Well, it wasn't the focus, but there were components of those things. From the communication standpoint, we had patients who were paid to play patients. You'd go in, examine them, and talk to them. They would give you feedback on what you said and what you didn't say. So, some of those things are definitely in place.

Jennifer: Okay. We're down to the bottom. Can you believe it? Do you feel the way in which biomedicine is framed by the media, by academia, and by the general public is accurate? My perception of that frame is that it is detached, emotionless, and uncaring. Do you share that perception, first of all?

Dr. A: I think your perception is correct. I don't agree with it.

Jennifer: How would you change it?

Dr. A: Change the perception?

Jennifer: Yes.

Dr. A: Give me a second and let me think.

Jennifer: Okay. It's not a problem…I don't know how many articles you've read about the biomedical model. The way in which it is discussed is that biomedicine exists on one end, and the biopsychosocial model exists on the other end. There is no integration. They are polar opposites. People associate physicians with the biomedical model and nurses with biopsychosocial. How would you change that perception so that they are more merged? So that the biomedical model is encompassing of the biopsychosocial…

Dr. A: I'll give you an example of what I do.

Jennifer: Okay.

Dr. A: To meld those two things, one thing I always do is engage the nurses. Some physicians, they just pull up the vitals, pull up the labs—which is probably the biomedical model—pull up all these things. "Okay, Mr. Smith, we're going to cath you today. We're going to do this and this and boom, boom, boom." The thing about nurses and the biopsychosocial model is the nurses are at the bedside a hell of a lot more than I am. They're learning who these people are. They're learning about their families. They're learning about the fact that they were in jail for 5 years. They're learning all these things that I'm not even cognizant of. So, I think, a lot of times, interaction with the nurses and discussing, more frequently, what's going on with the patients is really helpful. I think that that's one way that you could break down, or mend together, those different models.

Jennifer: Okay. So, involving the nurses, by extension, makes the patients feel more comfortable with medicine?

Dr. A: Mm hmm.

Jennifer: Even further, then, more comfortable with you?

Dr. A: Sure. Mm hmm.

Jennifer: Okay. This isn't on my list, but I've seen several articles about nursing, and I've seen some nursing textbooks in which they do not use the term, "patient." They use the term, "client."

Dr. A: Right.

Jennifer: Now, my question to you is, were medical textbooks the same way?

Dr. A: Uh…no—at least, mine weren't.

Jennifer: Okay. To me, the term, 'client' is very impersonal. Attorneys have clients. Nurses and doctors have patients.

Dr. A: Right.

Jennifer: Isn't ironic that nurses are associated with compassion? Yet, they are learning how to care for 'clients,' and doctors are the ones learning to care for 'patients.'

Dr. A: I see that. That is interesting. That is kind of ironic, isn't it?

Jennifer: It *is*. I've seen several articles—even contemporary nursing texts—that talk about 'clients.'

Dr. A: I wonder if this is because—and I hate to say this—but medicine is becoming about business. So, I wonder if that's one of the reasons behind it.

Jennifer: I know, at least, within the last six years, I've seen the term, 'client.'

Dr. A: Interesting.

Jennifer: I can't vouch for any time before that, obviously, but I am seeing it more and more. I don't see it in the articles that doctors write, but in articles about the nursing profession, I see the term, 'client' in place of the term, 'patient.'

Dr. A: Interesting.

Jennifer: I've never heard anybody use it on the floor or in practice. Although—I don't know—home healthcare might be different, but every time I hear the term, 'client'…

Dr. A: You kind of shudder?

Jennifer: Yes.

Dr. A: I don't like thinking of my patients as 'clients' or 'customers,' either. Yeah, we cater to them, but they're 'patients.' If you look at them as 'customers,' you seem them in business terms, and I just don't buy into that.

Jennifer: Well, those are all my questions unless there is anything else you'd like to say.

Dr. A: [Laughs]. Hi, Jennifer.

-- END --

APPENDIX B

Interview with Dr. B:

Jennifer: Thanks for doing this. Some of these questions might seem like they're coming from left field, but there is a purpose for every one of them.

Dr. B: Okay.

Jennifer: First of all, I want to get a feeling for how you feel physicians are portrayed by the media. I would like to know whether you feel this is a fair portrayal, and why, or why not?

Dr. B: Majority of portrayal of physicians by media is fair. The experts, like Sanjay Gupta, create a positive and very professional image. So, that portrayal—I guess there are two types of portrayals of physicians. One is issue-based, right—when experts are talking about issues. The other is event-based when something happens, and there is a portrayal of physicians. The issue-based portrayal is usually very positive. The event-based, at times, can be emotional and may not be completely accurate. So, that will be my answer.

Jennifer: I don't know if you get to watch these shows, but how do you feel about medically-themed shows?

Dr. B: Never watched them. Sorry about that. I never go there.

Jennifer: Okay. That is absolutely fine. How do you feel that the pervasiveness of contemporary media impacts your practice?

Dr. B: Pervasiveness? Explain what you mean by pervasiveness.

Jennifer: Internet access and the fact that there are so many medically-based shows, so many medical dramas, if you will. Patients may watch these shows and have

expectations of how doctors should be—like watching *Dr. House* or watching *Grey's Anatomy*.

Dr. B: Since I don't watch those shows, I have no clue how they impact me. Patients—when they come to me, they never refer to these shows. The Internet, on the other hand, does impact that practice greatly because you have informed patient. There are situations where patients come with their own ideas and need explanation. There are situations where you can refer them to the Internet for further research. You may feel that when they are coming with their own ideas, based on Internet research, that are not applicable to their care—at times, you may feel like why do you need to deal with that? But in fact, the bottom line is the patients' understanding of the issues deepens even if they come up and ask you something that is not applicable or something that is not necessarily good idea for them. The fact is that it's based on their research of the issue. So, patients and family, in general, now are much more educated.

Jennifer: So, do you feel that they ask more questions now than they did in previous generations?

Dr. B: They absolutely ask more questions. Those questions can be appropriate, or not appropriate, but still, they at least initiate discussion. Even if the question is not there, connected with the current issues, it is a conversation-starter. You can always offer something more to a patient who, actually, is asking questions because the fact that they are asking questions sort of exposes their knowledge base. So, most of the time, you're kind of thinking—you assume—physicians tend to assume patients know much more about their illness than they actually do. We all are—when we talk to somebody, we assume that somebody already knows what we are thinking. 'I think you know what I

know.' When the patients, or families, ask questions, it brings you down to their level, and it helps with building up that knowledge. Sometimes, you actually say, "Wow! You know a lot about this," and it can set up your knowledge base a little bit higher because you know that education is there. So, it is very helpful.

Jennifer: Okay. Good. I'm going to ask you some more communication-oriented questions now. This is based on some of my own previous research. I've talked to some people about this. How do you respond when you hear that people in the general public tend to regard physicians as bad communicators?

Dr. B: I think we are bad communicators. I think, by this assumption—there are two ways. Some physicians just don't bother and keep the knowledge to themselves. "Oh, you'll be fine," instead of telling patient that they have heart failure, they tell patient that, "Oh, your heart got a little weak," and *that message is not correct*. So, one way, we may be trying to protect patient and family from more anxiety. On the other hand, time restraints—if you bring up more issues, there will be more questions, and we all are quite hurried. The other barrier is just this lack of appreciation how huge is the knowledge gap between what you know and what the patient actually knows. So, where do we start? That is it, in general. On the other hand, I think physicians are trying.

Jennifer: I agree.

Dr. B: The problem, sometimes, is that they've tried hard enough and long enough, and they didn't appreciate that it actually got them anywhere. So, I think that one is that it's old, and it didn't get them anywhere because methodology of communication is not there. They are talking above patient's head, and they come back and see that nothing stuck. So, they just give up. I don't think we are assessing patient's knowledge base and going

from there. That's number one, and number two, we don't appreciate the value of patient's involvement in care and self-care and value their understanding of their illness. It's sort of a tendency of 'do what I tell you' instead of 'you need to understand this. You need to own your disease.' That's the other problem. We are trained in something, and we are not trained in education.

Jennifer: Okay. Just kind of thinking back on your own experience, when would you say your communication with patients has been successful? What are the successful components of that conversation, or series of conversations?

Dr. B: When a patient says, "Ah! No one ever told me that before." I think that successful communication is when patient is able to actively engage and ask questions. If they ask questions that is in line with what you're teaching them, then you know that you're successfully communicating. So, that's when I know that the communication is going somewhere.

Jennifer: So, do you ever begin by asking patients what their knowledge base is, or do you wait for them to start asking you questions to gauge where their knowledge base is?

Dr. B: I usually start by asking, "Please tell me what do you know about your illness?" That tells me. They tell you what's their understanding; what do they have, and sometimes, it's pretty accurate. So, that's my opening statement.

Jennifer: I know that, sometimes, compliance can be an issue with heart failure. I was reading an article, last night, where the author's suggestion was to simply ask for the patient's cooperation up front. I thought that was—I didn't really like that because I thought it was…

Dr. B: Offending?

Jennifer: Yeah, I mean, it would go on a case-by-case basis, but I would think if you were communicating with someone you'd never met before, that's kind of displaying your lack of faith in patients from the get-go. I think that would make them more defensive, don't you?

Dr. B: The—well, I would not use that technique. The patient is there, totally emotionally exposed. They always want to learn more. The problem—we call it 'non-compliance'; but heart failure patients have memory disturbance—short-term memory deficit. We demonstrated that. So, we call it 'non-compliance,' but in fact, it may be 'memory deficit.' That's number one. Number two—how successful people think they are in changing people's *lifestyle*—we're talking about total lifestyle change. How successful are people lowering cholesterol by changing diet, or lowering body weight by changing diet, or increasing people's exercise by educating them? Success rate of this is pretty slim. I don't think the success rate with heart failure patients is any different when you tell them to change their life completely. Right? It kind of follows the trajectory of our overall habits. However, let's go back to that education. If you're able to successfully demonstrate that you're going to make them feel better and make them understand *why*, suddenly, they are salt sensitive. Then, the success rate is much higher. It may not be persistent success rate, but at least short-term success rate is much higher.

Jennifer: Okay. Now, by the same token, we talked about successful communication. Have there been times when you felt your communication with patients was unsuccessful? Is there something specific you could point to that you felt made it unsuccessful?

Dr. B: [Thinking].

Jennifer: That could be in either party, or just the situation, in general.

Dr. B: When you're asking for what patient perceives, it's too much, and it's unsuccessful.

Jennifer: Is it because of the sheer volume of things that you have to tell them?

Dr. B: The patient's perception of, "You want me to stop eating?" type of thing, but it's *perception*. If you're really not successful in communicating, then something is necessary. If patient is kind of in denial—sometimes, you can tell them what's happening, but they just say, "But, I really don't feel that bad," when, in fact, they are sitting in front of you with swollen legs or having trouble going to the bathroom. So, it's perception on both sides sometimes. Of course, there are patients who are addicted to drugs, and you're not going to be successful in persuading them to quit—or alcohol.

Jennifer: That's true. Now, when you were in med school, were there specific courses that dealt with doctor-patient communication?

Dr. B: No, but there was a lot of—well, personal example. So, you really cannot provide patient education from courses. I don't think so, at least.

Jennifer: Because people are so different, right?

Dr. B: You have to teach just like psychologist will teach patient certain techniques of dealing with anxiety and all that stuff. The physician has to learn how to communicate with patients in different communication methods from their teachers. This is the part which is the art of medicine. There are different doctor personalities. Something, which works for me, will not work for a young male doctor, right, because he is a different substrate. I see it all the time where, for example, you have a patient who is a relatively young male, laying down in bed—so, obviously in a sort of defensive position. Young,

robust physician comes in—male—comes and stands above him, and the conversation goes like this.

Male Doctor: "So, how do you feel?"

Male Patient: "I feel great!"

Male Doctor: "What can you do?"

Male Patient: "I can do anything!"

And, it's unsuccessful communication because it's thousand, thousand years of male dominance comes to play, and it just doesn't work. And, *you* [gesturing to interviewer] come and sit down, right, and say,

Female Doctor: "Hmm, can you walk to the bathroom without getting short of breath?"

Male Patient: "No, I can't." [Meek tone]

There's the problem, right? So, what I do will be different for different people. I'm non-threatening woman, and he probably was perceiving two males talking, right? [Pounding on chest]. You have to avoid this kind of stuff, okay? Women are sensitive to being perceived as dumb. So, sometimes, they will have more tendency to get in your face. You have to understand that part—that they just want to be appreciated as partner, and they're very sensitive if you tell them what needs to be done. They don't like to be told what needs to be done. The mother and father told them what needs to be done, and they've had it.

Jennifer: Have you ever had to talk to people in such a way as to make them think it was their idea?

Dr. B: It's not necessarily their idea but a partnership of sort where you really have to make sure that they feel like a partner of a discussion rather than—you have to avoid creating a stereotypical environment for them—woman being told about something. She's had it, okay? This is not the way she's going to operate. Right?

Jennifer: Right. When you hear the biomedical model being talked about—have you heard of this? Biomedicine?

Dr. B: [Shaking head "no"].

Jennifer: Okay. Well, let me just kind of explain to you the models that are out there and the perceptions that are attached to each. The biomedical model is the one that people associate with physicians, and it is considered to be one that is just all science, very mechanistic. Basically, there is no art portion that you were talking about. I've heard the parallel of doctors being compared to mechanics. They look at the body as a machine, and that's it.

Dr. B: So, they're a scientifically-driven model.

Jennifer: That's the perception associated with that. At the other end of the spectrum is the biospychosocial model which people associate with nurses. It's more of the whole picture—helping, healing, humanity. My argument is that the biomedical model has been framed as emotionless, detached, and uncaring. I would really like to get physicians' input on ways to merge the biomedical and biospychosocial models so that the biopsychosocial model is a *branch of*; it's not biomedical model over here, and biospychosocial over here. How would you merge those two so that they're thought of as one and the same—that patients feel for doctors as they feel about nurses—as far as the caring? Do you understand what I'm trying to ask?

Dr. B: Yeah, I do, but not how to do it except to just lead by example and stress importance of proper patient communication. In the competency-based curriculum, communication is one of the competencies.

Jennifer: At the med school, right?

Dr. B: Right. So, it is named as a need. As a teacher to residents and students, I am greatly appreciating how emotionally invested they are into care. They are invested in care. So, we have great material. This is not a group of people who are uncaring, or—I think that there is something—a transition of the learner/student fascinated with medicine and their potential role into a machine—a routine-driven [snapping fingers], task-oriented. Where does it occur? Not in the areas which I observe. It really—the residents, the fellows are still very caring physicians…less so when they're post-call when they cannot find their way to the bathroom; but, altogether, those are really very good. Their heart is in the right place. The question is are we teaching them enough to give them the true satisfaction of human interaction? Or, are we not giving them tools, and the lack of success of that communication is just making them little bit discouraged. I don't think physicians ever have sort of debriefing sessions after situations where patients sort of assaulted them verbally, or questioned their good intentions, and acted emotionally and unjustly. Okay? Those are very vulnerable moments, for young physicians, of disappointment, and they expose them emotionally. They toughen them. If you don't kind of say, "Oh, you know…this and that," it does tend to linger. It will influence your next encounters and make, especially if the resident, or intern, invested a lot emotionally into the care of the patient, and the family is unjustly critiquing their work—those are the

times when we don't do anything. Okay? And those may be contributing to sort of getting that emotional shell closed so that you don't get into those situations. Right?

Jennifer: Yeah. I can see that.

Dr. B: And everybody has a share of those. It might create a situation where you really are protecting yourself. Right?

Jennifer: Yeah. See, I can see that, and a lot of times, I don't think society knows what it wants from doctors. It doesn't seem like anything they do is ever enough or quite right.

Dr. B: Yeah, you know, American society, especially—this is a culture difference—not that Polish doctors aren't regarded as highly in Polish society, but it's a little bit different. The problem with American society is that American people think that death is an optional thing. Death is optional. It's not a part of life. It's a failure of healthcare. If they live, "Thanks, God! God bless!" But, if they don't, then the doctors didn't do enough. Okay?

Jennifer: Yeah, I agree, and one of the reasons I'm so interested in doing this is because I continue to read about biomedicine and how academics, the general public, and even some of the fellow physicians—and these are from articles back in the 1980s—that just were really associated with non-caring science. I try to get people to understand that there is humanity in medicine.

Dr. B: There has to be, and the competency curriculum is putting great emphasis on it, but I don't think it's the answer. The answer is to continue stressing the importance of it. You know, we tend to hold onto bad experiences much longer than to good experiences. Then, society is putting doctors in an environment where they put the rewards system on speed. So, every 15-minute patient visit is rewarding physician with higher income.

Jennifer: That's kind of an insurance thing, right?

Dr. B: That's kind of practice management. So, it's not insurance. It's practice management. Insurance is paying less, so let's see more patients—and not rewarding personal contact but procedural approach. So, if you do a cardiac cath, you're much more rewarded than by explaining to patient that "you really don't need that." Right?

Jennifer: Yeah. Now, do you ever come across the patient—let's say they're anxiety-ridden—and you explain to them that they don't need a cardiac cath, but they want one anyway?

Dr. B: Oh, all the time. That is patient's perception that trumpets technology over knowledge. If the doctor ordered five tests, they are the caring doctor. They care, right?

Jennifer: Because the more they ordered, the more they showed how much they care.

Dr. B: Right—the nuclear stress test, the Holter monitor, and then they ordered cath. Wow! They really must care about me. They just care about the pocketbook. That doesn't translate. That may be a strong statement. What I'm saying is if the doctor does nothing, it's perceived as uncaring unless—doing nothing requires so much more time of explanation than ordering tests. The patient hurts this, or hurts that, "Oh, let's do an x-ray," end of discussion. You don't have to explain anything. Then, after the x-ray, there's nothing wrong with them, instead of saying, "Your pain—let's talk about this."

Jennifer: Thank you so much for all of this! It does help because I'm talking to others, too.

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APPENDIX C

Interview with Dr. C:

Jennifer: Thank you, first of all, for doing this. I would like to know how you feel physicians are portrayed by the media and whether you feel this is a fair, accurate portrayal.

Dr. C: Do you mean by the general media, by the advertising media, or by the entertainment media? Because it's all over the board.

Jennifer: I'm going a little bit more towards entertainment and advertising.

Dr. C: I'm just thinking about shows I know about. People watch these doctor shows with the MDs, *Dr. Oz*, and all that stuff, and my concern with all those shows is the lay public tend to believe everything those folks say is gospel even though they may be the furthest thing from experts in the things they're discussing—not that they're not educated in it. I don't think they're giving wrongly, biased stuff, but it may not necessarily be accurate, or reflective, of what reality is.

Jennifer: Even *Dr. Oz*?

Dr. C: Mm hmm.

Jennifer: Oh. Good to know.

Dr. C: That's just entertainment and media, you know? They want to sell what people want to hear.

Jennifer: Yeah, have you ever had patients come to you and say, "Well, I saw such and such on *Grey's Anatomy* or *Dr. House*,"?

Dr. C: Yep—all the time. Now, I didn't even want to get into that because most of that stuff is really inaccurate. That's just pure entertainment. I think, at least with the other

stuff, where they're doing the TV shows, they're at least well versed and somewhat accurate. But, the TV shows, I don't pay any attention to. That stuff is way off base.

Jennifer: How would you change the portrayal of physicians in the media if you could? [Pause]. Is there something particular that just bugs you over and again?

Dr. C: It's hard to really answer that because the only time this really comes up is if something has happened. Let's say the President gets shot in the chest. Then, the next thing you know, all of the TV stations are dragging out these doctors to comment on and speculate on things. Sometimes, they're perfectly capable people to talk about it, and they usually get it right. Nine times out of ten, they call the right doctor to discuss something. In other words, if it's a gunshot wound to the chest, a lot of times, they'll call a heart surgeon and talk to them about it. Now, where I have a problem with that is, often, they just kind of go on the Internet, or to somebody they know, and get a heart surgeon. Not all heart surgeons are the same. You may get one who has never taken care of a gunshot wound to the chest but can, at least, comment on some of the potential injuries, and things like that—not that that's inaccurate, but it's just that it may not be reflective of what really happened. The only way to battle that is to get multiple input from different people, and they just can't do that. So, I just wish they would do more research in deciding who they want to come on and make comments like that. It's no fault of the people they do call. Of course, they're going to be flattered and want to get on. For the most part, if it's something they're not comfortable with, they're not going to take it on, but let's face it. Anything, anymore, is all about visibility, marketing, and advertising. If you can get a physician from your hospital to comment on it, that's good for you, whether it's something they do at their hospital, or not. So, I think just to answer

your question—that was a long-winded response—but I wish they would do better background research in making sure that they've got the truly most qualified individual commenting for something.

Jennifer: I know what you mean because it kind of happens with celebrities.

Dr. C: Mm hmm.

Jennifer: If a celebrity has been diagnosed with—usually, it's some sort of psychiatric thing.

Dr. C: Right.

Jennifer: But, they'll have psychiatrists from all over the world speculating on your textbook case, and it may not be that.

Dr. C: Precisely, and that's hard to convey to the general public. They take what that person is saying as gospel.

Jennifer: So, how do you feel that the pervasiveness of contemporary media impacts your practice? Does it help or hinder? Or, is there no noticeable effect?

Dr. C: I think it does both. It helps and hinders at times. You just have to press on—marketing and advertising—I think media, for the most part, is helpful. Again, they just need to be cognizant of the fact that they don't need to be biased in their reporting. As long as they're not biased, then I'm comfortable with it.

Jennifer: There's always a bias.

Dr. C: Yep, there is.

Jennifer: We kind of have a saying in Communication, "Objectivity is a myth."

Dr. C: Right.

Jennifer: With increased Internet access, are finding that patients are asking more questions now than they did in previous generations?

Dr. C: Oh, yeah, they come in the office now with print outs of stuff they've downloaded off Google, and that's not bad. I prefer they do that. Then, I can go over it with them and tell them whether I think it's an accurate reflection because, a lot of times, they'll come in and will have pulled something off that's just experimental, for instance. They don't understand why they can't have it done. Once you explain it to them and why it's not being done in the United States, they're comfortable with that. So, I actually encourage patients to go online and look up stuff when I see them and to ask me if they have any questions about it.

Jennifer: Do you give them particular websites?

Dr. C: I just tell them to go to Google.

Jennifer: And then bring it back to you?

Dr. C: If they have questions, yeah.

Jennifer: Okay. I'm going to ask you some more communication-oriented questions now. This is based on some of my own previous research, too, as well as reading certain articles. I've noticed that the majority of the public seems to regard physicians as "bad communicators." How do you respond when you hear that a lot of people, in general, consider physicians to be bad communicators?

Dr. C: Well, I think you're referring to bedside manner—the ability to communicate and talk to patients.

Jennifer: Yeah.

Dr. C: I think that's probably accurate, and they perceive that because—it's multifactorial. A lot of times, the discussion is so far over their head. I'm not trying to be condescending, but sometimes, it's very difficult to bring it down to a level of understanding that people are comfortable with without occupying a significant amount of the physician's time. Quite frankly, at the end of the day, that's why a lot of people perceive physicians as poor communicators because they're so busy, trying to get on to the next thing. Even though, to them, they might have thought it was a proper explanation, the other person didn't digest it properly. That's where I think physician extenders are very helpful—having a PA that works with me. A lot of times, I'll have a discussion with the family. Then, I'll leave and let the PA sit there and spend more time with them and clarify some of the things that were said. So, that's probably the biggest reason why they're perceived to be poor communicators. Don't get me wrong. Some probably are bad communicators, just like anything else, but I think a lot of it is just perceived as poor communication because they don't understand, and the physician just really hasn't had that much time to spend talking to the person.

Jennifer: When do you feel your communication with patients is successful? What are the successful components of that conversation, or series of conversations?

Dr. C: I think leaving the room and making sure nobody has any questions and they're comfortable in understanding everything we've gone over.

Jennifer: Have you ever had patients look at you and say, "No, I don't have any questions," and then the PA winds up answering more after you leave?

Dr. C: Sometimes, but that's not that common.

Jennifer: By the same token, when do you feel that communication is unsuccessful with patients? Is there something specific that you've noticed?

Dr. C: It seems like communication is the most important thing in terms of avoiding future conflict, which is what I don't like. What I do is shortly after you have done what it was that you had talked to them about doing, if it's immediately obvious that they don't understand it, or are asking questions about it, you've got to regroup and start all over again. "Now, remember, we talked about all of this, and we told you this could've happened,"—refreshing memories and things like that.

Jennifer: Were there specific courses that you took in med school that dealt with doctor-patient communication?

Dr. C: Mm hmm. It was our physical exam course. We went around with 2nd-year medical students, talking to patients, taking histories and physicals. You were taught how to do both history taking and physical examination, but the history taking part—a lot of it was just learning how to ask questions, how to redirect the discussion. Patients often get off track and go on tangents. You've got to know how to interrupt them and get them back on track without offending them. You've got to do things like that. So, there was a specific course—part of your medical school training is directed specifically at how to interview a patient, and how to communicate with a patient and family members.

Jennifer: Was communication part of the competencies back then? Was communication part of the nine cores when you graduated?

Dr. C: I don't know what you're talking about.

Jennifer: Ok.

Dr. C: The way it happened was you would learn because the physician would bring a patient in and interview them, and then, you were sent off on your own. You would go and interview patients and then come back later, write your history, and be critiqued by the attending physician that was teaching the course. This is different than bedside manner. Most people's bedside manner, I think, is learned through their training and observation, by watching other physicians do it. I think the basic skills of knowing how to get the proper information out of patients and convey the important things to the patients—I think that is part of a curriculum, you know?

Jennifer: Mm hmm.

Dr. C: Informed consent—things like that—what makes up informed consent?

Jennifer: I've been told, opinion-wise, that you can't really teach a bedside manner. Is that…

Dr. C: That's why I said I think most of it's observed. It's a lot of just your ability to interact with other people.

Jennifer: Now the last question that I have—are you familiar with how the biomedical model is perceived? Do you know what I'm talking about when I talk about the biomedical model?

Dr. C: [Shakes head "no"]

Jennifer: Well, in the literature, there are a couple of models, in particular, that are talked about with healthcare. Over here [gesture], is biomedicine, or the biomedical model, which is associated with physicians. That's basically per academia. In a nutshell, it's all about science. They parallel the physician to a car mechanic in the way they approach the human body.

Dr. C: Mm hmm.

Jennifer: No humanity whatsoever—and I've heard in some interviews that I've done with students at IUPUI, for instance—I've often heard them refer to physicians as "mechanistic." That's all associated with the biomedical model.

Dr. C: Mm hmm.

Jennifer: Then, you have the biospychosocial model that people associate with nurses. You know, everybody sits together at the Heart Failure meetings. You've got Social Work, all the nurses—everybody comes together. What I'm kind of interested in, and what I would like to see happen is to have the biomedical and biopsychosocial model be merged into one. I would really like for patients to feel about doctors the way they feel about nurses. How do you foresee the best way, or at least *a* way, for that to happen—for those models to kind of merge? Does that make any sense to you—what I just said? [Laughs].

Dr. C: Yeah. I don't know because I think that it's just physician-dependent. At the end of the day, you can have the worst doctor in the world that doesn't know his…uh…you know…doesn't know anything. Because he has such an excellent bedside manner, he is going to be perceived like he is the most wonderful doctor in the world. Whereas, you can have the doctor who is the smartest, most competent, and well trained individual but can't communicate. So, he's perceived as an idiot. At the end of the day, I really think it comes down to the ability to communicate with patients and patients' families and be comfortable in that environment—recognizing that it doesn't always work. Even the best communicator—sometimes, patients and families are almost impossible to deal with, and it's just part of the business—like any other business. You've just got to take it.

Everybody's got a breaking point, too, and everybody's got a *different* breaking point where they just really lose it and are *really* perceived to be jerks or idiots.

Jennifer: Sometimes, I think that society just doesn't know what it wants from doctors because it doesn't seem to be enough, or it wasn't done in the right way.

Dr. C: Mm hmm. Right. Well, it's also patient-dependent with different education levels. Some people will just assume that everything they're being told is accurate and won't question it. They just take it as gospel. Whereas, you might have somebody who is very well-educated, and they want to know everything in detail and ask questions that physicians aren't used to being asked by a lay person. So, it's really dependent on the patients as well as the physicians.

Jennifer: That would be me! I'd be asking all the questions.

Dr. C: Exactly—you could get two different responses if the same physician went in and saw two separate patients. One might think he was a great guy and seemed to know everything he needed to know, but maybe, they didn't ask a single question. Whereas, the next person may say, "That guy is an idiot, and he doesn't know what he's doing," based on their perception of what they asked of him. So, it's tough to pin it down.

Jennifer: Mm hmm. Now, I appreciate this. I'm talking to a lot of people, and I'm getting a lot of good stuff. One of the recurring themes is that 'doctors are people, too.' I think there has been a negative stigma against what people talk about as the biomedical model. It's been polarized so much with compassion. Medicine is not communicated about in a compassionate way. I, for one, think there is humanity in medicine.

Dr. C: There is. There is. There is no question about that.

Jennifer: So, it's helpful to talk to doctors, see where they come from and how much they *do* value communication.

Dr. C: Does that help you?

Jennifer: It does! Thank you very much!

Dr. C: No problem. I look forward to reading all of it.

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APPENDIX D

Interview with Dr. D:

Jennifer: I just want to tell you that some of the questions may seem like they're coming from left field, but I have a purpose for every one of them.

Dr. D: Okay.

Jennifer: I want to ask you some questions about media. First, I'd like to know how you feel physicians are portrayed by the media, and do you feel that it's a fair and accurate portrayal?

Dr. D: Well, so physicians, in general, or medical knowledge in general? Because I think that there is a lot of information given out in the newspapers that aren't totally accurate. You see it on the cover of the Wall Street Journal all the time. "Stents Kill!" was about three years ago, and that's not totally accurate—actually, not even close to being accurate. That generates *a lot* of phone calls to the physician's office, but are you asking, specifically, about how physicians are portrayed in the media?

Jennifer: Yeah, pretty much, the physicians themselves—whether that be through entertainment media; whether that be through *Dr. Oz* or the show, *The Doctors*. Has any patient ever come to you and expected a medical situation to play out like it would on *Grey's Anatomy,* or on *House*, or something like that?

Dr. D: Oh, okay. I understand what you're saying. Okay. I think that in the mainstream media entertainment, at least, physicians are glorified a little bit, and rarity is the norm. Like, people that have terminal illnesses—I think when it comes to end of life issues, families will want everything done when we know that the inevitable outcome is going to be death. They're thinking, "What if there is a chance?" because they see it happen that

way on TV. There is a little bit of glorification in Hollywood that sets up for misinterpretation.

Jennifer: Well, would you change the portrayal of physicians—how they come across—in the media if you could? I know some of these questions might be hard to answer because you guys probably don't have time to watch much TV.

Dr. D: Well, I think it's kind of a loaded question because I don't think it would be entertaining if they showed people dying all the time. You know, someone coming in with cellulitis isn't going to make for good TV.

Jennifer: Well, that's true.

Dr. D: So, that's a business. They're in the business of entertaining. So, the plotlines and outcomes are to entertain people. The problem comes when people take that entertainment and try to apply it to real life. Would I change it? I don't know. I find some of those shows entertaining. When I was a medical student, I used to watch *ER* way back when, and I thought it was it was entertaining; but we knew half of it was bunk and was pure entertainment value.

Jennifer: There are actually studies that have been done that show people who don't have experience with something in their own lives will replace it with the televised experience, and it just becomes part of their working narrative because that's the only knowledge that they have.

Dr. D: Right. Absolutely. I can totally see that.

Jennifer: I've also had something shared with me. Even with some of the 'reality' medical shows, you have to be careful with the term, "reality."

Dr. D: True, and some of them are scripted. At least, some of the reality shows that are non-medical, I think those shows are partially scripted. There may be some ad-lib that goes on, but it's never reality if it's on TV! Unless it's the news.

Jennifer: I said, "Even Dr. Oz?" He said, "Even Dr. Oz."

Dr. D: Even if it's something as simple as they're only going to portray their good outcomes. Dr. Oz may have a guest who is difficult to deal with, so they decide not to air that episode. I don't know if that happens, but I'm saying you have that control when it's TV, and it's something you can choose how to portray. So, it's not real life.

Jennifer: Yeah. I took a class about a year ago. It was Perspectives in Film on Medicine, or something.

Dr. D: They *have* that?

Jennifer: They do. It's Medical Health and Humanities.

Dr. D: Wow. Okay.

Jennifer: I'm taking a Sociology of Health and Illness class right now. This class isn't nearly as frustrating as the humanities one, but there are a lot of negative stereotypes out there about doctors. So, that's why I want to get doctors' perspectives on this kind of thing. There's a movie, *The Doctor*, which I think is fantastic, with William Hurt. Then, there is *Wit* with Emma Thompson, and a lot of these movies, I had never heard of until I took the class. In *Wit*, in particular, she plays a professor who is diagnosed in the very opening frame with Stage IV Ovarian Cancer.

Dr. D: Oh! You know, I think I saw that several years back.

Jennifer: She is treated at the academic hospital.

Dr. D: Right.

Jennifer: And she is treated like a petri dish.

Dr. D: Right, I did see that. It was a long time ago. I thought it was an interesting movie.

Jennifer: So, when I see that, and these are the films that professors are using to compare doctors to—it's not all like that! I work with them!

Dr. D: Yeah, that show portrayed a lot of doctors as callous—very cold and calculating with no compassion component whatsoever. I think most people, at least, a lot of my patients—they look to us for knowledge, guidance, and compassion goes with it. I think there are probably—just like any profession—there are going to be physicians who are very book smart, and very good, but just have no people skills. They can't provide empathy. I think people have probably experienced that in situations when they're terminally ill. Anything that is sensational gets told. You don't hear the good outcomes. There is always a complaint box. No one ever writes, "I had great service!" It's always if you're angry enough to write something down, it's because you had a bad experience. I think the same thing happens with the portrayal of physicians. Somebody has a bad experience. The story gets told about how someone was dying, and it was not a very compassionate or empathetic soul who was there with them.

Jennifer: It has been shared with me that you can't really teach a bedside manner.

Dr. D: No, you can't.

Jennifer: You either have one, or you don't.

Dr. D: There was actually a class, when I was in medical school, where they tried to actually teach patient interaction. I would just laugh. You know, you can't teach empathy. It's the same thing when I would teach some of the medical students. You

can't teach someone to look at somebody and tell if they're sick. Now, they can look at their labs, and they can look at their x-rays and tell you what's wrong them. Some people just can't look at another person and say, "Gee, that patient is sick. We need to do something soon, or they're going to crump." There are things you can't teach. You either know it, or you don't. You either have empathy, or you don't have empathy. It's not a teachable trait, I don't think.

Jennifer: Do you think that eye for recognizing sickness can be learned over the course of experience?

Dr. D: I think, for some people, it can be, but I used to use the term, "clinical-factual dissociation," where someone can read to you the textbook version of what a disease should be, but they can't recognize it in front of them! They have the book smarts, but they can't apply it clinically. Now, I use that term to describe some of the residents and interns that I saw. I don't know if they went on, in their careers, and did finally get the connection, but I did see it. It's an interesting phenomenon because there are some people who are incredibly smart and can retain vast amounts of knowledge, but they have trouble applying it.

Jennifer: That *is* interesting. It is. Well, how do you feel that the pervasiveness of contemporary media impacts your practice? Does it help? Does it hinder?

Dr. D: I think it's a double-edged sword. I'll say that because patients come to me now with more information than they've ever had because of the Internet—more information than they've ever had about a disease, about a question, or a medication. The other side of that coin is they also come with a lot of information that is inaccurate. So, it's frustrating because I have to spend more time telling them why what they've read is

wrong, but it's empowering for the patients to actually have some knowledge. I think that's a good thing. I think there are some physicians who miss the good old days when they'd say, "Take this medication because I said so." I think we're dealing with a whole new population—a much more educated population, a much more involved population, especially with their own healthcare. So, I think it's a good thing that they have that ability.

Jennifer: So, patients are definitely asking more questions now than they used to?

Dr. D: Oh yeah, oh my gosh, absolutely! They're equipped with more information—whether it's good information, that's a whole other question—where they get it from. The Internet is pretty wide.

Jennifer: Exactly. Do you ever provide patients with specific websites to go to so that they don't get a lot of the garbage?

Dr. D: You know, that's a great idea and question. I've not searched enough online to know where to go. Usually, I tell them to go to mayo.com, but I don't know specific websites for specific issues. That's a good question.

Jennifer: You would, obviously, prefer that they bring those questions to you rather than to read the wrong thing?

Dr. D: Absolutely. Absolutely. You know, I have a lot of patients who don't want to take western medicines. So, they won't take their statins. They'll take Red Yeast. I say, "Okay. That's fine. I just need you to understand that Red Yeast is an unregulated statin. In fact, it's the derivative of Pravastatin—or, I think it's actually Lovastatin. So, you are basically taking a statin where one day, you might get 2 milligrams. The next day, you might get 10 milligrams depending on which sample you buy because it's unregulated.

Because it can have partial contaminants in it, being unregulated, it may cause kidney failure. So, if you're okay with all those things, keep taking that Red Yeast." They feel empowered that they don't need a prescription. They're taking some homeopathic medication.

Jennifer: Do they honestly say, "Okay"?

Dr. D: I have three patients who are on Red Yeast. They refuse to take the statins, but I'd rather them take that than nothing. They have coronary disease. I know it's a statin. So, at least, they're getting something. If I tell them not to take it, they're not going to take it, but we deal with all types of personalities.

Jennifer: I don't know about all the homeopathic stuff. That scares me.

Dr. D: There are a lot of homeopathic things that work. All of our medications today are derived from natural plants, but the thing that scares me is that it's unregulated. Depending on which brand you buy, you might be getting different doses, different contaminants.

Jennifer: My dentist told me that it doesn't matter what that label says. It could just be peanut butter in that jar mixed with something else.

Dr. D: That's right. They're not liable for that. It's a supplement. It's not a drug. They're not regulated through the FDA. So, they can do whatever they want.

Jennifer: I think the only natural product that doesn't scare me is aloe.

Both: [Laughter]

Jennifer: Now, I'm going to get into some of the more communication-based questions.

Dr. D: Okay.

Jennifer: This is based on some of my own previous research along with the literature in the review that I've done. It seems that a lot people—and I think I'd be comfortable going so far as to say the majority of the public regards physicians as bad communicators. How do you respond when you hear something like that?

Dr. D: Wow. Bad communicators in their ability to communicate about the illness their patient has?

Jennifer: Bad communication is something that goes back to the cold, the callous, the lack of empathy…

Dr. D: Or, do you think it's more the old school physicians who said, "Take this because I said so, and quit asking questions"?

Jennifer: I think it encompasses all of those things.

Dr. D: Because as the population has changed, they're more media-driven, Internet-driven, and more information-driven. It's really an information society. I think patients aren't willing to accept,

Doctor: "This is what I want you to take because I said so."

Patient: "Well, why do I have to take a cholesterol-lowering medication? What's it going to do fore me?"

Then, you have to go through everything. So, I think there are probably some older physicians who are frustrated by the new information-driven patients. They probably could come off as bad communicators. I'd be interested to know if you looked at it and dissected it—physicians who graduated after *this* date are better communicators than physicians who graduate earlier. I grew up in the information society. So, I'm used to them asking questions. Now, I think as you get into a busy practice and have 15-minute

time slots, by the fifth question, you may be just a little annoyed. You need to get things moving because you've got three other patients waiting. There probably is time constraint leading to the perception of bad communicating, and there are probably some physicians who don't feel the need to explain themselves.

Jennifer: I don't think it helps anything that the movie, *Wit*, came out in 2001. It's still relatively recent by today's standards.

Dr. D: Right.

Jennifer: So, when do you feel that your communication, in particular, is successful with patients? Is there a component that helps you to recognize that it is successful?

Dr. D: You know, that's a good question. I guess I find that some of my better-educated patients—I find that I have more success with them understanding their treatment course. My less-educated patients—I feel like I could be in there all day explaining myself, and it wouldn't do any good. I can't get them to understand. Even if I try to make analogies, it's not sinking in. They just don't get it. They have no insight to their own disease. They don't realize how sick they are or the severity of what's going on. So, I don't know. I guess I'm not sure how to answer that question. I know it when I see it. [Laughs]

Jennifer: It seems like you have some pretty particular ones for unsuccessful.

Dr. D: Just the patients who are continually non-compliant, and you've tried to explain to them why they have to take their medications. You've worked with them as far as getting them the medications that they can't afford. Yet, they choose not to take the medication and buy a pack of cigarettes, which is more expensive than the medication. No matter how many times I tell them, "Your congestive heart failure is going to

continue to worsen if we don't keep you on these medications. The eventual outcome is going to be death," they don't seem to get it. No matter how directly I say, "You're going to die if you don't do this." It doesn't affect it.

Jennifer: Are they feeling okay in those moments and just not getting it? Are they still in denial at that point?

Dr. D: I've had it both ways. I've had patients in my office who are feeling okay and don't get it, and I've had patients who are acutely ill in the hospital—who are on the Cath Lab table, in the throes of an MI, and they're asking me when they can go smoke. That happens. You can ask [Dr. A]. I'm sure he's had the same experiences. It's like, 'Are you kidding me? You're having a heart attack, and you want to go smoke? You're dying, here.'

Jennifer: I'm actually doing a paper right now—or a meta-analysis—about non-compliance in general, but specifically with cardiac patients. One of the articles that I think is going to be interesting to read is called something like, 'Why smokers don't feel it's bad to smoke: Why smoking is okay.'

Dr. D: They all have a story, "My grandpa smoked until he was 95, and he died of 'whatever.' It had nothing to do with his smoking."

Jennifer: I always think about this scene in *ER* where "Dr. Carter" was talking to this lady. He asked what she had for breakfast, and she says, "Eggs, bacon, blah, blah, blah." He told her she was going to die soon if she kept eating that way. She said, "My mother ate the same breakfast every day for all of her years. She died at 94…car accident."

Dr. D: Yeah, it's denial. You look for the outliers. You point to them and say, "They did it, and they were fine." You might be, too, but statistically, you probably won't be.

Jennifer: Right.

Dr. D: You look at the statistics, and smokers have this much greater chance of having a heart attack, this much greater chance of having lung cancer than the general population. Now, you may fall on the other side of the Bell Curve and get away with it your whole life. If you want to throw those dice…

Jennifer: Yeah, I came from Oncology before I started doing cardiac stuff. Apparently, it's not so much the length of time that you spent smoking but the age at which you started because of the lung tissue that is still—I don't want to say developing—but, you know, still going through changes. So, then, I think back to all the people I know who started smoking at 9 and 11, and I'm like, "How would you like cancer of your eye sockets?" because that can happen! I worked on a head & neck cancer study, and tumors can grow in places that you would not believe!

Dr. D: That's the worst! Oh, my god—head & neck—those surgeries are just horrific. It's like the House of Horrors when you walk into those patients' rooms.

Jennifer: Well, that was the contract work that I did, and I'll never forget the first time I heard someone with a laryngectomy try to talk. I think I jumped.

Dr. D: [Nods in agreement]

Jennifer: Okay. You did mention the class that you took in med school that was kind of focused on doctor-patient interaction. Was that an elective class, or was it required?

Dr. D: No, it was required. It was part of this thing they had called ICM—Introduction to Clinical Medicine, and one of the weeks, they had cultural sensitivity training plus patient-doctor relationship. It was mandatory at the time.

Jennifer: It doesn't sound like it was very…

Dr. D: I just don't think those are things you can teach!

Jennifer: Well, just think back on the subject matters that they focused on. Could they have done something different that would have made it more applicable, or help more?

Dr. D: I think, yeah, if they would have gone through different cultures and gone through what is perceived as an insult. In "x" culture, it's considered inappropriate to touch a female unless you ask permission from the husband first, for example. I think that would be more helpful, to me, than to get a list of different cultural sensitivities that we may encounter.

Jennifer: Nonverbal as well. [Provided extraneous example from high school].

Dr. D: Right, exactly. So, that would be more helpful to me, even now, as the cultural diversity continues to become a more common occurrence. We're seeing more patients from different backgrounds. To have a little bit of knowledge as to what's appropriate and what's not appropriate can keep you from mistakenly getting yourself in trouble when you're just trying to do your job.

Jennifer: That's good to know. The professors in my program do advise the med school. So, anything that you guys think could help future generations, I will pas it along.

Dr. D: I really do think we're seeing a greater Muslim population. I, for one, don't know much about the Muslim culture.

Jennifer: Well, talk about sensationalism in the media!

Dr. D: Right. Exactly, exactly. Plus, we're getting a lot of Asian Americans. I think there is a whole host of issues you're going to run into, and it would help to have a little background.

Jennifer: Okay. My last question—only one of the doctors that I've talked to has been familiar with this so far—but do you know the term, "biomedicine," or are you familiar with the biomedical model in any way?

Dr. D: Explain it to me. Then, I'll let you know.

Jennifer: Okay. Well, in a lot of the articles I've read, there are a lot of models about which healthcare is discussed. Over here, you have biomedicine, or the biomedical model, which is all science. This is what is associated with physicians. Over here, you have the biopsychosocial model which is all of the layers. Well, guess who is associated with that one? Nurses. They see doctors over here [one side]; they see nurses over here [other side]. From a lot of what I've seen and heard, people say that physicians are very mechanistic. They approach the body like a mechanic would to a car, and they reduce the human being to a pile of diseases. I've also heard the comment that, "Doctors treat diseases. It just so happens that the disease they treat is inside a person." Do you think that is an accurate representation and understanding of how medicine is practiced?

Dr. D: I think that is probably a perception that some people have.

Jennifer: But is it really founded? My feeling is there is humanity in medicine and that biopsychosocial is a branch of biomedicine. You have to have the medicine!

Dr. D: Yeah, you know what I think happens? In the situation you're talking about, the nurse is with the patient for 8 – 10 hours, or however long her shift is. She is there most of the time, and she's there with the family. They interact quite a bit in that 8 – 10 hours. The physician is in there for 15 or 20 minutes a day—may, or may not, see the family depending on the time of day. If they're rounding early, the family may not be there yet. The physician doesn't have time to stay in the room all day unless there is an issue. So,

they're in; they're out. I think the perception is, "The nurse cares about us. They're taking care of us. The doc was here for 15 minutes, and all I got from him was a bill." I think that has a lot to do with it. Let's face it, the nurse's job is *very* important. It's probably underappreciated, and they get frustrated, too. They're there with the patient—changing the bedpan, dressing them, giving them a shower—really taking care of the patients' daily needs; helping them eat if they need help eating. We're in there, examine quickly, make some decisions as to what we want to do with their therapy, and we're out the door. We may let them know how they're doing, or how we perceive that they're doing, and we may let them know what our plans are. Other than that, we're not in there very long. That's where that perception comes from. Do you agree?

Jennifer: Yeah, I can see that. Do you foresee a way, or can you conceive of a situation in which it's not so dichotomous? Physicians are this way, and nurses are this way, and that's it! Is there hope for a merging of those perceptions?

Dr. D: I think if the problem is what I perceive as the cause—no because we have different roles. Our role is to round on 30 patients. Their role is to take care of three all day. I think as we get busier and busier, I think that divergence is only going to get greater, unfortunately.

Jennifer: Well, as you're talking, I'm sitting here thinking that's why there are nurses, and there are doctors.

Dr. D: We have two different roles that are synergistic.

Jennifer: But, you're a team.

Dr. D: Exactly, but the roles that we play are distinctly different; but we work together. So, I don't know how to change that.

Jennifer: My whole thing is, doctors are people, too. I come at things from a completely different perspective as everyone else. I look at the nurse and say, "Oh, you're so nice, but the doctor is telling you to do everything that you're doing for me," in my head because I know that the buck stops there.

Dr. D: But, don't you think the nurse is probably the greater patient advocate? I can think of countless times when a nurse as called me and said, "Hey, you forgot to give the patient a diet, and they just got back from their test." That was a huge oversight on my part. I had made them NPO and then forgot to give them a diet because I was thinking about other things. The nurse is the one talking to the patient, going, "You're hungry. You haven't eaten anything." So, yeah, ultimately, I'm the one ordering the diet, but the nurse was the advocate for the patient, saying, "Hey, the patient hasn't eaten. You forgot to give them a diet. Do they still need to be NPO?" So, I think that because they're with them so much, nurses become advocates for the patients. I think patients perceive that.

Jennifer: Does it kind of shift a little bit in the outpatient? Obviously?

Dr. D: I think it does. Outpatient—you're with the physician. It's your appointment time. You've got them one-on-one. They come in, and they have a list of expectations that they want to have met. If you meet all those, and you answer all their questions, then you've been the greatest guy ever—or greatest woman ever. So, I think it's different than when you're sick, acutely, in the hospital, and you're waiting for people to take care of you.

Jennifer: I've never been inpatient [knocks on table].

Dr. D: Yeah, me neither.

Jennifer: I know when I go to the doctor and the nurse comes in, I give her the bare minimum. Then, when the doctor comes in, I'm verbally throwing up all over him.

Dr. D: Yeah, and there are plenty of people who bring a list with them, "Here are my questions."

Jennifer: I do that, too. I do that, too.

Dr. D: We go through them and check them off as we go.

Jennifer: My endocrinologist will say, "Well, get out your list. Let's go through the high points."

Dr. D: When you leave that appointment, if they've answered your questions to your satisfaction, you're happy when you leave. This was a great interaction.

Jennifer: Yeah, it's all a matter of perception. It really is. It has been very interesting getting MDs' perspectives on these things. Sometimes, I read things about doctors that tick me off because I don't think they're like that. Then, I come to you guys, and you can see where the perception might come into play. It has been very surprising.

Dr. D: I think we have to understand that medicine is not a complete science. There is an art to it. You can have a disease present 50 different ways in 50 different people. So, we have to tailor our treatment to that individual. Especially on the inpatient scene, I think a lot plays out behind the scenes that patients don't realize—where there's a pulmonologist, a nephrologist, and a cardiologist all involved in the care of a patient. They get together, at various times during the day when they see each other, and say, "Hey, patient x—what do you think about the kidney function. I'm really worried that there is a little bit of heart failure present, but the kidneys are getting worse. Do you think there is a need to look toward dialysis? Is this person a candidate for dialysis?" You

know, I think there is a lot that goes on behind the scenes. The doctors don't go in the patient's room and talk about the patient. They talk amongst themselves, make decisions, and try to figure out what's best for the patient. Is this person really going to thrive on dialysis? Is that a bad option? Are they, ultimately, going to succumb to infection? Are they just not going to tolerate dialysis? Should we look at another option here? I think a lot of that goes on, and I think that is part of the humanity, or compassion. We're trying to figure out what's best for somebody from a medical standpoint, and thinking about them down the road. Ethically, is it right to subject them to this treatment? And, the patients don't see that.

Jennifer: Right, they don't see it. So, they don't conceive of it. Yeah, that makes sense.

Dr. D: Now, I think when we have a real serious, critically ill patient, we have a family meeting. All the physicians of the different specialties are represented in that family meeting and talk about what their perspective is. I think, then, the family sees that everyone is involved, but that's rare. You don't always have the big family meetings with all the physicians unless somebody is dying, and we're trying to figure out the best next move. If someone is in here with just a little bit of dehydration and heart failure, their renal function isn't that bad—we're probably not going to have a family meeting about that.

Jennifer: Right, usually when I see something about a family conference, I think 'uh-oh.'

Dr. D: It's a bad sign.

Jennifer: Although, with the VAD patients—some of them have multiple family conferences.

Dr. D: Yeah.

Jennifer: I do INTERMACS for the VAD patients, too.

Dr. D: Do you?

Jennifer: Yeah, Dr. [C] takes care of the worst of the worst. I don't mean that personality-wise.

Dr. D: No, I know. He takes care of very sick patients. That's what he has chosen to do—what he finds interesting and rewarding. Thank God there are people like him that do it.

Jennifer: Yeah, so, obviously, if I have a VAD question, I'm not going to ask the patient, I'm going to ask the doctor. That just speaks to the behind-the-scenes scenario. You never know what kind of orchestra is keeping you going in the background. Well, this was very helpful.

Dr. D: I hope it was.

Jennifer: It was, and I appreciate it very much.

Dr. D: My pleasure.

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APPENDIX E

Interview with Dr. E:

Jennifer: Some of these questions might seem like they come out of left field, but I have a purpose for every one of them.

Dr. E: Okay.

Jennifer: Well, my first few questions are media-related. I would, first, like to know how you feel that physicians are portrayed by the media, and whether you feel this is a fair, or accurate, portrayal?

Dr. E: I guess it probably depends on what media you watch. So, just to give you a perspective of what my media input is, it's mostly just FOX News, some CNN, and financial/business channels—that kind of thing. I don't watch many TV programs, and I don't, frequently, go to the movies. Then, I spend a fair amount of time on the INTERNET, looking at PubMed or CTS.net. So, I haven't found, or come across, much physician representation in the media to be able to comment on that very much.

Jennifer: Have there been any medical issues that have been discussed on CNN? For instance, the guy that comes to my mind is Sanjay Gupta. He went from Accent Health to CNN. I've always perceived him to be fairly reputable and a good representation of doctors. Would you agree with that?

Dr. E: I think so. I haven't really watched him the whole way. I know Mehmet Oz. I haven't really watched him on Oprah, or his own program a whole lot, but he's probably a good representative of cardiothoracic surgeons. He's probably fair. He *is* one. He's not an actor, pretending to be one. So, I guess in my mind, I know it's fair.

Jennifer: Now, have you ever had patients come to you and bring up an issue that they've seen on TV, or ask you why they can't have a certain procedure done, or bring up something that they've come across on the Internet?

Dr. E: Never from a TV show. I think people take those with a grain of salt and not as fact. Some, obviously, don't. There's a spectrum of people, but more and more people come in with papers that they've pulled from the Internet, pictures from the Internet, which I think is good and helpful. At least, they've got a foundation from which you can build—whether it's right on, or close, or way off—you can still work from it.

Jennifer: I *will* say that there are some studies that have found that for individuals who don't have experience with a certain illness, or know someone who has been through the process—say cancer, for instance, or a heart transplant—if they see something on TV, fictional or otherwise, they *will* substitute that virtual experience in place of a real one. That becomes their knowledge reference for whatever health issue it is.

Dr. E: I can see that. I can see that, for sure.

Jennifer: We talked a little bit the Internet, but how do you feel the pervasiveness of contemporary media impacts your practice? Does it help or hinder? Or, is there no noticeable effect as you go throughout your day, interacting with patients?

Dr. E: I think it depends a lot on your patient population, how sophisticated they are, and whether your practice base is more emergent or elective. If you have an elective practice, patients are going to be able to spend a little bit more time looking up their condition, thinking about it, and getting more media. I think that, for patients who have elective surgery, I think advertising does affect them. I don't know if you include that in there.

Jennifer: Oh, absolutely.

Dr. E: I think patients will come because they've seen such and such advertised for St. Vincent and want to know if we do that, too. So, I think that that does have an effect.

Jennifer: I keep hearing a particular surgeon from [an outside organization] advertise that they've got the best VAD outcomes in the country, and I'm thinking to myself, "based on what?" We are the go-to place for the worst type of patient. I've noticed this just from the charts that I've read. Some of these smaller, outlying hospitals don't have the means to take care of the critically ill cardiac patients. So, right here, they come. So, I wonder what they're basing those outcomes on, because I would think that if you get the worst of the worst—and they leave the hospital alive—I think that's a pretty darn good outcome!

Dr. E: I think it does affect people. They do tend to believe what's advertised, and you can look at statistics different ways as you point out.

Jennifer: On that note, this class I'm taking right now is an elective—Sociology of Health & Illness. Last week, the discussion came to settle on direct-to-consumer advertising from pharmaceutical companies. One of the people in the class thought that these companies might be shooting themselves in the foot because the viewers will hear all of the side effects and not want to take the drugs.

The professor pointed out that because the pharmaceutical companies don't advertise directly to doctors anymore, their ads mimic the Physicians' Desk Reference and provide all the information that the physician, otherwise, would. He also said that it helps the pharmaceutical sales because the patients will think that they can just go ask their doctors about this drug. He said that, "Eighty-five percent of doctors will give it to them." I thought, 'What?!' Of course, there were people who sat there and said, "Really?!" just

because the professor said it. Sometimes, I don't even think it's worth it to raise my hand and dispute it because people will just smile and nod.

Dr. E: I bet that there probably is a study out there that shows that for some patient population. So, physicians want to please their patients, too. So, they want to be collaborative. It's probably more for pervasive in primary care specialties because of the relationship. They probably have more input on medicines. You know, one blood pressure medicine over another, or something.

Jennifer: Yeah, I just wondered about it because a lot of the articles we read in that class are from 1960.

Both: [Laughter]

Dr. E: Right.

Jennifer: So, I'm like society and medicine have changed since then—thank you!

Dr. E: Definitely. Definitely.

Jennifer: So, they sit around and talk about all this stuff like it's going on today. I'm thinking, you guys are sitting around in a classroom talking about doctors. I'm working them. I don't say that, but I *so* want to!

Dr. E: Well, you should.

Jennifer: Well, if I get to do my presentation on the very last day of class where I never have to go back there again, I just might.

Both: [Laughter]

Jennifer: Anyway, I digress. With the increased Internet access and the fact that patients are bringing information to their appointments, would you agree that patients are asking more questions now than they did in previous generations?

Dr. E: Definitely—more questions—more educated questions, and I think it's a good thing. Now, with the older generation still, I think you see a lot more of the, "I trust you, Doc. Do what you think is right," and they seem a lot more trusting. The younger generations, I think, seem a lot more selective, discerning, and maybe less trusting.

Jennifer: Really? Interesting—I always ask a lot of questions, but that's just because I want to know. I always want to know.

Dr. E: And that's another reason. I think it may change as we get older. We may just want to get fixed and not have long discussions. I don't know. I don't want to generalize too much. I think some of the older generations do ask a lot of questions, but it just doesn't seem to be as common.

Jennifer: Of course, they've never had all the information at their fingertips, either.

Dr. E: Mm mm. Mm mm.

Jennifer: Maybe, one of the reasons the younger generation is more discerning is because you have to be when you're on the Internet. I don't mean to say that everybody is meticulous about the sites that they go to which brings me to another question. Do you have Internet sites that you recommend people go to in order to learn about procedures, or do you just defer them to Google?

Dr. E: No, I refer them to CTSnet.net. You've been on there?

Jennifer: No, I've been on the ACC website, but I can't get into it. You know, Dr. [A] has become far busier these days, and I feel bad if I just zing him all my questions because he wouldn't get anything else done. For instance, if I'm trying to figure out the location of an MI, the most complicated patient to do that for is one who has had bypass surgery. With all the vein grafts, I'm kind of at a loss. In those situations, I tend to select

the Non-Q-wave option. On my data sheet, that is the only option that doesn't require me to select a location for the MI. If I've got a STEMI, I have to put the location. If I've got an NSTEMI, I've also got to put the location. If I pick Non-Q-wave, I don't have to put the location. So, a lot of times, that's the one I'll pick if I can't figure out where it might have occurred. There was a patient for whom I had tried to figure out what had gone on, and the patient wound up dying. I had read, in another dictation, that they didn't detect the presence of Q-waves on the EKG, which meant that there was no permanent damage. Does that sound correct? No Q-wave = no permanent damage? I thought, well, if I pick Non-Q –wave, and this guy is dead—that doesn't really seem too accurate to me. So, I went to this website, and I've got the cath note there, trying to figure out what happened. The EKG interpretation said something completely different. I think I wound up picking Anterior because—I mean, this guy had massive blockages everywhere. The cath note said that the Circumflex was 100% blocked, but I thought, 'That means that blood is getting by, somehow.' The LAD only had a 90% blockage, but several EKGs said something about anterolateral damage. So, I picked Anterior because I went to the website, trying to learn about some of these extraneous vessels that branch off the main ones while I'm trying to piece everything together.

Dr. E: Well, you'll like CTS.net because it's mostly cardiothoracic surgery information. If you want to know how a procedure is done, it's all there, and there are lots of pictures. You'll like it, and you don't have to be a member, or anything, to have full access.

Jennifer: Cool. Sorry I probably told you way more about my job than you cared to know.

Dr. E: No, I'm glad to know. I like to know what everybody does. So, what else you got?

Jennifer: Well, this is based on some of my own previous research in various classes along with a lit review. How do you respond when you hear that the majority of the public regards physicians as bad communicators? What do you have to say about that?

Dr. E: I would say we have to work on that and become better communicators.

Jennifer: Do you agree with that assessment?

Dr. E: Well, that's their opinion. So, they're the ultimate deciders of whether we're bad communicators, or not. If they think we're bad, then, we're bad.

Jennifer: From personal experience, when do you feel that your communication with patients is successful? That is to say, what are the successful components of that conversation, or series of conversations? Are there specifics that you could point out?

Dr. E: Certainly, if they tell you that they feel you communicated with them well and that they've had all of their questions answered—that they're grateful for it. That's a pretty good sign that you did it right. What else can I tell you about that? Is there something…?

Jennifer: Well, I was just wondering, over the course of time and experience, if there were things that popped out to you that let you know you communicated successfully with that patient. Could you hone in on that?

Dr. E: I think just good rapport, spending time with them, listening to them. I think if you try to understand them, first, before you make sure they understand you, that usually works pretty well. It's just getting enough time—unfortunately, we don't have a ton of time. I know that they like to have things explained to them pretty thoroughly, especially

heart surgery. I know my PA is really good. She's better than I am at communicating with patients and fills in a lot of gaps. Sometimes, if I haven't done a good job, she makes it seem like I have done a good job because the patients have their questions answered one way, or another. So, having a good *team* is really important. I never leave without giving them my cell phone number. So, they all have access to me. Many times, they don't have a long time to get to know me before they have heart surgery. It's usually scheduled within a couple of days. So, you walk in the room and are in there for however long. You know that it's all knew, and they're just trying to process everything. They're going to have a million questions after you leave, but then, you're going to be gone. They're going to feel like they weren't fulfilled in terms of their interaction with you. So, then they have the opportunity to call at that time. Or, you talk to them alone. Then, their family member shows up, "Did you ask him this? Did he tell you that?" The person gets frustrated, and the family member gets frustrated with them because they don't remember, or they didn't ask. So, immediately, they can just call, and I tell them that it's going to happen. They're going to have questions. So, I just have them call me. Right away, it takes them off the hook and gets them out of the middle. That works pretty well. They don't abuse the privilege of having your cell phone.

Jennifer: That was going to be my next question.

Dr. E: They really don't. It's astonishing, but just that they have that power—it relaxes them.

Jennifer: It's like a security blanket.

Dr. E: Mm hmm. Then, they think, 'Oh, I don't want to bother him with this,' but they know they could've.

Jennifer: Interesting—so by the same token, have there been times when you have felt your communication has been unsuccessful with patients? Would there be something specific to that/those situation(s)?

Dr. E: Yeah, I think that you can tell more with family members. If you have a family member who is stuck in the ICU for a while, they, themselves, cannot be part of the triangle of discussion—you, them, the family. It's just you and the family. The patient is kind of the out-of-it third party. They're intubated and sick. Sometimes, family members, who have some medical background, want to direct things. They just want things to happen their way. They don't want to listen to why you want to do it a certain way, or why you're not going to take their suggestion—or prescribe the medicine that they saw on the TV. So, when they are like that, that's hard. Usually, they're not receiving information. There are definitely times where you can have a discussion with the family. I see it more with other people, where folks will say, "So-and-so came in and talked to me about dialysis but didn't answer my questions. He didn't say this, or that." A lot of times, he did, but they just didn't hear it because they were distracted. That's understandable because it's a high anxiety time. They're not going to hear a lot. So, you just have to keep going back and make sure they've got all their questions answered.

Jennifer: Have you ever had an experience—and I've never thought of this question before—but, you mentioned patients being intubated in the ICU. They can't make decisions for themselves. Decisions are being made about them, and they're not aware of it. Have you ever had patients—when they finally do become aware—get angry at the way things have gone?

Dr. E: No—actually, not.

Jennifer: Good. I would think that they would just be happy to be alive.

Dr. E: They're surprised, and they're grateful that they don't remember any of it most of the time. Many times, they come back and thank you even if they, or the family members, didn't think that they would want x, y, or z. They usually come back and say, "I'm glad you kept me going."

Jennifer: Good. Alright. Were there any specific classes that you took in med school that dealt with doctor-patient communication? Were they required, or elective?

Dr. E: Yes. They were required. I went to, primarily, a primary care-oriented medical school, Michigan State University, and they're very focused on the psychosocial and patient care thing. So, we had a class that was just all about interviewing patients—facilitating the open-ended discussion: "How do you feel about this?" We were videotaped while we were doing it. So, we'd go back with the instructor and have to relive it. I have to be honest. It wasn't one of my favorite courses, but we did have required classes like that.

Jennifer: Okay, so interviewing patients. I have one more question, but before that—do you know what I mean by the term, "biomedicine, or biomedical model"? Have you heard of that at all?

Dr. E: I've heard "biomedical" before. I don't know, specifically, what you mean by biomedical model.

Jennifer: Well, just to give you an idea, I've talked to a few students at IUPUI. I've actually viewed the movie, *Wit*, with them. I hadn't ever heard of it until I took a particular class, and we watched it. It stars Emma Thompson. It came out in 2001, and it went directly to HBO. She, basically, plays a 17th century English Literature professor

who is diagnosed, in the opening frame, with Stage IV Ovarian Cancer. It's kind of an autobiography of the character's treatment, and she is treated at the academic hospital of the university where she had taught for years. One of the first doctors to examine her had been a student of hers. He was very research-oriented. They framed the movie in such a way as to get the point across that the academic physicians only cared about the cancer. Her body was, basically, an incubator to them. There was one scene, at the very end, where she is just shaking and writhing in pain. The doctor comes in and says, "Ms. Bearing, are you in any pain?" She looks at the camera and says, "I can't believe this." They, basically, put her in a morphine coma, essentially. When I talked to students about that movie, after we'd viewed it together, I had students who described physicians as parallel to auto mechanics, where they look at the body like a car. The biomedical model is, therefore, considered very mechanistic, very reductionistic, where the mindset is treating a disease that just happens to be inside a person. That's what they associate with physicians. At the other end, you have the biopsychosocial model where, as you might guess, all of the psychology and all the humanity of medicine is placed. They associate that with nurses. So, doctors and biomedicine over here [gesture]; nurses and biopsychosocial over here [gesture]. Having been a physician for a little while, do you see that as a fair assessment? Do you see that, in practice, as polarized as spectators see it, for lack of a better word?

Dr. E: I can see why they see it that way, for sure. It sounds like, especially after watching that movie, you'd see it that way if that was your only reference point. For many students, it probably is unless they've been on the receiving end of medical care and know, first-hand, what the interaction with their physician was like. I think there's

probably some truth to that. We've got to work to learn stuff from the nurses about how to better serve that part of patient care need. Try and spend a little more time doing that, but I think it's interesting.

Jennifer: So, that would be working with the nurses—you see that as a way to sort of integrate those two models?

Dr. E: Mm hmm.

Jennifer: So that they're not so polarized?

Dr. E: Mm hmm.

Jennifer: In my head, I sort of see it as biomedicine is the overarching, but psychosocial is a branch from that. I see humanity in medicine. So, I'm always thinking of ways to reframe that so that people can see the humanity in the medicine. I have also been given the idea to work with nurses more, and that it is a very team-oriented approach. I've also been given the feedback that there is a lot of discussion that goes on that the patient doesn't see—like we were talking about with the intubated guy. Even, say on 4 or 5 E, let's say if someone has acute renal failure because of their heart issue, the cardiologist and nephrologist are going to get together—not in the patient's room—but they're going to get together. They're going to discuss things to try to figure out what's best for that patient. Obviously, each doctor will see them separately, but it kind of occurred to me that there is an untold story there that the patient isn't always privy to. That might account, a little bit, for some of these—in my opinion—harsh judgments.

Dr. E: I think some of it's true. I also think the spectrum of family medicine, internal medicine, OB/GYN probably have developed the psychosocial model a little bit better than, for instance, surgeons because a lot of our interaction with the patient is when

they're asleep. During a lot of our one-on-one time, they're asleep, and we're doing surgery on them—something mechanical. We have to be really good at that because that's the key part of the teamwork that we provide. So, we haven't had as much time to develop the psychosocial skills, probably, than people who are doing it all day, everyday.

Jennifer: True. Yeah, I've even mentioned in a paper for a class that I'm best buds with my ENT, but when I went to get my tonsils taken out, I suspect he wasn't thinking about that! He was thinking about what was going on in, and around, the operative field. That's what I would want!

Dr. E: Right.

Jennifer: So, that's all the questions I have. Do you have anything else to add that you might have thought of as we've been sitting here, talking?

Dr. E: No, but if I think of anything, I'll give you a shout. If you have anything else to ask, feel free to email me or call me.

Jennifer: I appreciate that.

Dr. E: No problem. Good luck.

Jennifer: Thank you very much.

-- END --

APPENDIX F

Interview with Dr. F:

Jennifer: Some of the questions might seem like they're out of left field, but there is a purpose for them. The first few questions I have are actually media-based. I am interested to know how you feel physicians are portrayed by the media and whether, or not, you feel this is a fair, or accurate, portrayal.

Dr. F: Um…

Jennifer: I know everyone has different viewing habits.

Dr. F: I think, generally, the portrayal is probably positive, given a lot of the shows that they have on TV currently and in the past. It tends to be showing physicians in a favorable light. I guess some of the general feeling, in terms of abilities, sometimes, you almost get a caricature type of portrayal just because it's kind of beyond the ordinary. You see things more than what someone actually does. I think that's true of any profession that's dramatized on television, or in movies, but I think, generally, it's positive. I think, obviously, when news is reported, there are always going to be people who do bad things, including physicians. That definitely gets a lot of attention, and for good reason, because we don't want that to be prevalent, but I think, generally, it's positive.

Jennifer: When you talk about the types of shows that are on, are you talking more about the reality types of shows, like *The Doctors* or *Dr. Oz*? Or, are you talking about the shows like *Grey's Anatomy, House*, and things like that?

Dr. F: Yeah, I was actually referring to *Grey's Anatomy and House*—things like that. Actually, I hadn't even thought about it, but there are those shows like *The Doctors* and

Dr. Oz, and there are a bunch of other ones on Discovery Health, and so forth. I think a lot of people view that positively. There is a lot of good information that people might not process, or get, from their own physician. I think it's perceived as a good source of information.

Jennifer: Now, when you mentioned the exaggeration, that's what made me think of *House*.

Dr. F: Well, yeah.

Jennifer: I've watched that show for a long time. I always liked to try to beat him to the diagnosis, but it's so far out there now that I have no idea where they're going with it.

Both: [Laughter]

Jennifer: Have you ever had patients come to you and talk about something that they've seen on TV and question you about it, or expect your treatment of them to follow a certain pattern because of it?

Dr. F: Not so much from TV. I mean, I've never had someone come to me and say that they've seen something on *Grey's Anatomy* or *ER*—or not admitting it, anyway. Now, as far as *Dr. Oz* or *The Doctors*, I think people have referenced that they've seen things on there, but they haven't necessarily said, "I saw this, and I want to do this." It's just been more of kind of a remark but not necessarily wanting their care guided in that particular fashion. Now, looking at the Internet is a different thing. I think that people will look at the Internet and say, 'I read this on this site, and I'm interested in this medication.' They got this information, and they want to try it. That can be good and bad in some sense. Sometimes, there is a lot of information out there—and I think having an open mind helps—but it can also be that people are focusing on one area of medication, or

something, without understanding the breadth. They think, 'This is going to fix me. This is going to solve everything, and I won't have to do anything,' without understanding all the implications that it has. In other senses, when people look and investigate, it empowers them, and they take more responsibility for their care. It demonstrates a person who is a little bit more motivated as well.

Jennifer: That's interesting because I just finished a paper about patient non-compliance, particularly, with cardiac regimens. So—this all kind of ties together—do you think, or have you experienced, that the patients who do ask for a certain medication, and are given that medication, are more likely to comply with it? Or, do you think that if their request is explained away in such a fashion as to make them understand why it's not the better idea, are they less likely to comply with what you prescribe for them instead?

Dr. F: I think it probably varies with each individual. I think with most people who are open-minded and reasonable, if you explain to them why you're choosing to do things a certain way, they'll understand. I think in terms of what they may bring to the table is, "I saw this. Will this help me? Is this something that will apply to me?" Now, some people will say, "I want this. I've done the research. I know what it is. It's going to help me. I want it." That's the minority. Those individuals—no matter what you say, they won't be dissuaded.

Jennifer: Do you wind up giving them that medication?

Dr. F: If I don't believe it's appropriate, I won't give it to them. I say they're going to have to ask someone else to do it. I'm not going to do something that I think is wrong just to appease somebody. I think you're asking for trouble, especially if it's

inappropriate, and they get sick, or hurt. Then, the liability comes back on you for prescribing it.

Jennifer: That's true. Okay. This sort of relates to what we've been talking about, but how do you feel that the pervasiveness of contemporary media impacts your practice? We sort of touched on it a little bit. Now that I'm thinking about it, I feel that it might be a little bit repetitive because I think you answered it with the whole prescription thing where patients find drugs on the Internet. We've also talked, in one of my classes, about direct-to-consumer advertising from pharmaceutical companies. Do you think that impacts as well? Do you think they get more from an advertisement, or more from the Internet?

Dr. F: It's hard to quantify which is more. I think it probably depends on what someone uses more often. Some people can use both quite a lot. I think both can have an impact. I guess, in terms of media, you have media that we think of typically such as TV, movies, news, things like that. Now, you also have social media that's very prevalent—you know, Twitter, Facebook, things like that. So, I think people use all sorts of information for all kinds of things. One is trying to figure out what physician to go see—to determine which ones are good and bad. Then, trying to decide what hospital and how to direct their own care. I think they'll use all aspects. In terms of one having a greater impact, I'm not sure if I know the answer to that.

Jennifer: Well, the reason I ask is because when direct-to-consumer advertising came up, one of the students felt like maybe some of the drug companies were shooting themselves in the foot because they talk about all these side effects. So, they thought the pharmaceutical companies may be losing money because they had been so thorough in

their explanation. The professor explained that the pharmaceutical companies don't advertise to the doctors anymore. Those ads are kind of meant to mimic the Physicians' Desk Reference. The ad is supposed to tell you everything that the doctor would have had it been prescribed, initially, by him.

Dr. F: I think it's more prevalent and that the exposure to the average person will increase. People will become more aware of it and be more likely to inquire about it if it pertains to them than when it wasn't prevalent because people wouldn't know, or have the knowledge to ask. It's also different. Twenty years ago, you had to go find medical books and literature and try to understand it. Trying to find something that was written in lay terms was difficult. Now, people just go on WikiPedia or Google to get some sort of lay explanation for almost anything.

Jennifer: Now, do you have websites that you recommend to patients? Do they talk about their sources with you? Or, do you just refer them to Google?

Dr. F: Not all the time. Some people, if there are specific questions about diet, nutrition, things like that. I don't know all of them. I usually just tell them the sites that I've looked at and that I think are useful. Obviously, there are so many out there, it's hard to stay on top of all of them. If someone has a question, I'll try to answer it specifically.

Jennifer: Based on that, do you feel that patients are asking more questions now than they did in previous generations?

Dr. F: I would say, "Yes." I haven't been around long enough to know, but from being in medical school 15 some years ago and coming to now, I think patients are self-empowered and ask more questions. They're armed with more information. So, they're more knowledgeable coming in, and I think, also, the physician-patient relationship is

kind of evolving. Before, in my perception, it was more of an authoritarian type figure—whatever the doctor says goes, and you don't question it. That's how it was 30 – 50 years ago, but now, there is more of a working relationship as opposed to that.

Jennifer: I see that, too. A lot of times, in academia, it's talked about as if it's a tyranny situation.

Dr. F: Yeah, and I think if you continue to approach it that way...

Jennifer: It's just going to perpetuate…

Dr. F: It could perpetuate, or nowadays, people just go elsewhere because there *are* choices, and there *are* people who don't do it that way. I think if you don't evolve and change your ways, or change that approach, I think people will seek other choices. Now, you're kind of limited, in certain situations, based on your insurance and all those things, but there are still enough choices within most areas of medicine—unless you're looking for someone who is very specialized and detailed. Then, you may be stuck because there may be only one person in the entire city who provides that type of care. If they're that kind of person, then you would have to go out-of-state, or somewhere.

Jennifer: Do you think it's a good thing that patients are coming in with more questions?

Dr. F: I think so. I think, sometimes, it can be tough for physicians because you have tons of questions and can be bombarded with them. You're trying to answer and explain them. At the same time, I think, ultimately, it's a good thing because, obviously, they're trying to understand things. I think, sometimes, someone who has a better understanding and is more interested in what's going on, and in themselves, they're more likely to be compliant and follow through with instructions as opposed to someone who says, "Do whatever you think, Doc." They may follow blindly, but at the same time, they may not

always be willing to go the extra mile and do certain things. Or, they're apathetic to their own care and won't do a whole lot.

Jennifer: That's funny because I had a guy I was trying to consent this week, where the conversation went,

> Patient: "Oh, I'll do whatever you want."
>
> Me: "This is up to you. You're not going to hurt my feelings if you tell me, 'no.'"
>
> Patient: "Oh, I don't want to do it, then."

I thought, 'Yeah, you'll do whatever I want, but not really!'

Dr. F: Exactly. Sometimes, it's more frustrating communicating with someone like that because, let's say, he consented. Then, you're always, in the back of your mind, wondering if he is going to be compliant or drop out if it's a study, or be lost to follow-up, and those kinds of things.

Jennifer: Yeah, that is true. Okay. Actually, someone else brought this to my attention. Some of the older patients will say, "Doc, I trust you. Do whatever you want," but, then, some of the patients in the younger generation, who do have more access to information, are little bit more discerning. To them, it comes across as a bit more distrusting of doctors. Do you feel that way?

Dr. F: I think, in a general sense, that may be true—older vs. younger. In general, I think I'd say the better distinction is more vs. less educated. You have people who are younger who are like, 'Whatever,' and go with it. Then, you have people—who surprise me all the time—who are in their 70s and 80s and still are probably more knowledgeable about things and use the Internet more. They're more resourceful than people who are half their age.

Jennifer: So, age isn't really a determinant? It's an education level?

Dr. F: Yeah, and it doesn't necessarily have to be someone who has a Ph.D. is going to be better than someone who has a high school degree, but someone who is engaged and inquisitive, and you can pick up on that right off the bat. One person may be, 'I don't care. Whatever.' There's not much that stimulates them, but I think it also goes to what people talk about your mental disposition—your mental health, your adherence, and your non-adherence. There are people who are happier and more positive. They'll be the ones more likely to adhere as opposed to those who are not in that state of mind. It may be not due to their own faults, but they'll be less likely to adhere because they're absent-minded, can't concentrate as well, or are just less motivated to do something.

Jennifer: I see what you're saying. I read an article about that. It was talking about the depressed patients. Okay, so, I'm going to ask you some more communication-oriented questions now.

Dr. F: Okay.

Jennifer: The basis for this next question is kind of based on some research that I did with IUPUI students and showing them a particular movie, called *Wit*. I don't know if you've heard of it.

Dr. F: No.

Jennifer: I hadn't ever heard of it until I watched it in a class. Basically, Emma Thompson plays a 17th century English Literature professor who is diagnosed in the first frame with Advanced Ovarian Cancer. She's treated at the academic hospital of the university where she has taught for years. The way that they framed that film was to show that the academic physicians could not have cared less about the fact that she was a

person. They only cared about the cancer. So, they were treating the disease that just happened to be inside a person. She was basically the incubator. I watched that with about 6 – 11 students and gauged their experiences with physicians beforehand with some questions and questioned them again, afterward, to see if the movie had impacted them in the least. Unfortunately, what I found there, as well as in a lot of the articles that I've read, is that the majority of the public feels that physicians are bad communicators. It's kind of a blanket statement. How do you react when you hear that? Is that a fair assessment? What are your thoughts?

Dr. F: I guess I can't answer for every patient. I don't know how everything is communicated to each individual.

Jennifer: Oh, sure.

Dr. F: I'm not surprised by it because I hear that from many people. Now, sometimes, I think it's because physicians don't communicate well. They don't take the time, or they're in a rush. Sometimes, also, I know from my own personal experience—this was just yesterday or the day before—I communicated with a guy about a procedure and all of the risks and benefits. I spent a good 20 minutes talking to him. His son was in the room, and he understood. At the end of the conversation, the patient was nodding his head. His son asked him, "What do you think?" He said, "I don't know. I couldn't hear a damn thing."

Jennifer: Are you serious?!

Dr. F: Yeah! So, I think that's what happens sometimes. You can even sit down and draw pictures for people and try to explain things, pause, let them ask questions. Then, they'll just look at it and say, "I don't know. This is just too confusing." Ultimately,

there is physician-as-communicator fatigue because you're thinking, 'Oh, god, I can't spend a whole day here. Read this book and call me with some questions, or something.' There is that end of it as well.

Jennifer: Okay, personally, when do you feel that your communication with patients is successful? Are there specific things that you could point out?

Dr. F: I think, always, some positive reinforcement for me is when someone is asking questions because you know that, at least, they've heard something to be able to ask a question. I think that's the biggest. I don't always, necessarily, try to have them repeat back to me everything that I've said because of the jargon and terminology. I'll ask them, in general, if they understand and if it makes sense. If they can kind of give me the general gist of things—I don't expect they would be able to regurgitate everything I've said because it's a lot of new words, especially if they're not familiar with it. So, those are some of the cues that I look at, and I think a lot of it is also in layers. When you see someone, they probably will only grasp a small percentage of what it is you're communicating to them, especially if someone is introducing a new diagnosis to them. Something I was always taught is that you can tell somebody, "You have cancer." After that, you could be in the room for an hour talking to them about the type of cancer and how to do the staging, treatment options, and so forth. Most people, as soon as they hear that, they're going to be thinking about their entire life—their family, their friends, what's going to happen to them, and the voice of the physician, or whoever is communicating to them, is going to be in the background. So, I think if you're a patient, going to see a doctor about a condition that has already been established, and you're inquiring about treatment options and things, I think it's time for the physician to

communicate with that patient because they've had time to absorb and process the information. It's not the shock, or revelation, of what they have. So, they're not absorbing that aspect. I think, sometimes, it's the circumstances as well that dictate how someone comprehends.

Jennifer: You may not have that kind of time due to the circumstances like you said, but with a new diagnosis, do you introduce the concept in the hospital and then wait until a follow-up appointment to start explaining?

Dr. F: Well, you kind of have to—what I usually do is tell them what it is and try to explain to them what it is.

Jennifer: Knowing that you'll have to explain it again?

Dr. F: Yeah, sometimes you know you're going to have to explain it again. Sometimes, it's adding layers to it. One thing—when you're a medical student, they usually send the medical student in first to get the H & P. The student goes in. Then, the intern goes in, and then the resident goes in. Each person who goes in will get more information than the first person got. As people get asked questions, they start thinking about things more clearly. So, by the time the attending staff goes in there, they'll get all these other answers that no one else got before just because people are sort of primed, in some sense. So, when I see people, I'll try to explain things. I'll actually give them an outlook for how things may go. For example, if someone comes in with heart failure, a low EF, or something like that, I'll explain what's going on and what we're going to treat, given that I'm an electrophysiologist, and I put devices in. One of the things I know is that down the line, depending on how things go—this may be premature, and we may have to have discussions based on how you do in a few months—about things like defibrillators,

transplant, or something like that. That's what you can expect. You know, some people have this idea that if they "take this pill," they're cured, and it's all done. Some people think they only need these medications for about three months, and then they can be done. I had a lot of patients who were Russian when I did my residency. Apparently, people would tell me that they had high blood pressure in Russia. So, they were admitted to their hospital for two or three months, were on medications, and kind of calmed down—got the blood pressure down. Then, they left the hospital, didn't take any medicines, and they came in a couple times, or maybe once a year, or something. They expected that's how it would be here. I said, "No, because once you stop the medicine, you're back to square one again."

Jennifer: That's interesting that they would work it like that.

Dr. F: Yeah, I don't know how that came about, but it is surprising.

Jennifer: Yeah…now, we kind of talked a little bit about some of the unsuccessful communication with the patient not being able to hear. I wonder why that guy just didn't say, "I can't hear you."

Dr. F: I think he heard some of it, but I think it was a combination of not hearing and not comprehending.

Jennifer: Maybe, he was just depending on his kid to fill him in after you left.

Dr. F: Yeah, and that's always the hard part when you sit there and you think someone is hearing, or understanding, what you're saying. You go on for a long period of time, and at the end…

Jennifer: So, the nonverbal cues aren't matching the situation?

Dr. F: Exactly, yeah.

Jennifer: So, there is an imbalance there. Of course, the patients who come in and say, "Whatever, I don't care," is a problem.

Dr. F: You know, one of the issues in terms of communication is when patients are asking questions. Ultimately, it's still a fixed period of time all day long. So, if someone is coming in, and they have a page and a half full of questions, either you cut them off and tell them to pick the most important questions to ask because we can't address them all today when you come back. When I was in medicine, Primary Care, I think that worked a little better because we saw them more often. Sometimes, as a specialist, people can view it as that guy doesn't really care because I only see him once a year or twice a year. So, there is a fine line there; but you [as the patient] ask a bunch of questions. That takes 10 – 15 minutes, right there. By that point, the questions you need to ask, and the stuff that you need to do as a physician and the time it takes to explain the treatment plan—everything is going to be rushed because you're left with less time. You have someone else who is waiting, saying that I'm now 20 minutes behind schedule. They don't care why, but when you walk into their room, they want extra time as well, not realizing that other people want the same thing. So, there are a lot of factors that can influence communication, where it may not be consistent from person to person, or physician to physician just because of the circumstances and time.

Jennifer: So, for patients that you know, and you know they're going to bring out the laundry list of questions…

Dr. F: I usually have people start going through their questions, but sometimes, after a while, if it seems like you're going through *tons* of questions and it's taking a lot of time, then I'll say it's time to pick off the more important ones, here. Or, at least, I need to be

able to do what I need to do. So, we can talk while I do some other parts of the exam and things like that. Otherwise, we're not going to be able to get through anything. We'll have the patient's questions, but I won't have my questions answered, and I won't know what to do.

Jennifer: I'm guessing, most people would be amenable to that.

Dr. F: Yeah, yeah, most of the time, they're fine. Most people have pretty legitimate questions, and for that reason, you try to answer as much as you can. Occasionally, you get questions that have no relationship and are so far out of left field. You just say that I'm not the best person to ask about that. You need to ask so-and-so. I'll have someone come in, and usually, it's older patients. They're usually in with a family member, or someone, but they're coming to the cardiologist, and they'll say, "I have this rash," or "My knee is kind of sore." You try to be attentive and answer their questions, but sometimes, you just have to say I'm not the one that you want to be asking, or the one that you want to be managing because it looks like someone else is already managing that for you, and I don't want to step on any toes, or anything.

Jennifer: Well, and the other person can give more in-depth information.

Dr. F: Exactly.

Jennifer: I guess it would be like asking the orthopedist about an ICD, or something.

Dr. F: Yeah, yeah. Sometimes, you want to be helpful and give information. At the same time, misinformation is even worse. If you don't know, just say you don't know.

Jennifer: And, I've found in reading dictations that non-cardiologists don't know the difference between an ICD and a pacemaker. I'll see it both ways. I tend to have standing meetings with Dr. [A], and I'll bring it to him. He just shakes his head and says,

"A pacemaker is *not* an ICD; an ICD is *not* a pacemaker." Okay…were there specific courses that you took in med school that dealt with doctor-patient communication?

Dr. F: We had, in our first year, our school had a year dedicated to physician-patient interaction—empathy, understanding, breaking bad news, dealing with difficult patients. I had a course on that, and we did a lot of taped sessions, where you were graded. I forget what they called it at the time.

Jennifer: So, was it a required course?

Dr. F: Yeah, everyone took it. Yeah.

Jennifer: Okay.

Dr. F: I think it was a required course at the time. It was a pass/fail thing, and everyone had to take it. Sometimes, people can be a little subjective in terms of how they grade. So, it's not as though you would get a "C" and not pass just because they didn't like your style. You either met the requirements and did a good job, or you totally bombed and failed.

Jennifer: Was there feedback at all?

Dr. F: Oh, yeah, there was tons of feedback.

Jennifer: Okay. Initially, in terms of pass/fail, I'd be thinking, 'What did I do wrong?'

Dr. F: Oh, no. It was one of those things where if you really weren't getting the hang of it, they'd give you feedback early on so that you didn't find out, at the end of the term, that you were just way off the map.

Jennifer: Okay. Now, coming up on this last question, I first have to ask are you familiar with the term, "biomedicine" or with the biomedical model?

Dr. F: I'm familiar in the sense that I've heard of it. I guess I don't know the details.

Jennifer: Well, I'll just kind of explain. The biomedical model, or biomedicine—whichever you want to call it—is really associated with being purely scientific, reductionistic, mechanistic, kind of what the movie, *Wit*, was trying to drive home, if you will. People associate that model with physicians. At the other end of the spectrum is what is called the biospsychosocial model, which takes into account all of the humanity, the psychology, the sociology, the culture, etc. They [people] associate that model with nurses. Doctors are over here, and nurses are over here [gesturing]. Do you feel that is an accurate assessment of how medicine is practiced? In terms of the judgment—doctors and biomedicine at one end with no humanity attached, and nurses and biopsychosocial at the other end where all the humanity lies? Do you agree with that?

Dr. F: Not at all. I completely disagree.

Jennifer: I know this is probably a lot to think about off the top of the head, but can you foresee a way to bring those ideas together so that they're not so polarized? Can you think of a way to merge those? I see them as intertwined, but…

Dr. F: Yeah, I think that's the case. I think that some of it is because, a lot of times, in the hospital, for example, you come in, and physicians are there maybe once or twice a day—making assessments, providing factual information. I think people try to be empathetic, understanding, and so forth, to their patients and family members. I think each time a doctor comes in the room, people think, 'Here is some new data that I have to process—some new information to understand.' Then, the rest of the day is spent more one-on-one, frequently, with the nurse reinforcing concepts and answering questions. They're there more often. So, it's just a little bit more of a personal relationship. I think, inherently, one is going to end up looking one way, and the other is going to look another

way. Although the intent is probably not the same; probably, neither party is to that extreme. In terms of how to make the patients perceive that it's more intertwined, I don't know how to do it. From a functional standpoint, you can't necessarily have a doctor who is sitting there all day long because he has got tons of patients. Obviously, the nurses can provide more information, but I think they do that already. I think it's probably easier to bring the biopsychosocial toward the middle. It's harder to get this end [biomedical] to move toward the middle. I guess I don't know the answer to how to intertwine them.

Jennifer: Do you think it's a little bit different in the outpatient setting?

Dr. F: Probably, yeah, in the outpatient setting, you'll initially be seeing a patient for the first time, and it's a new interaction. After that, you have re-established patients with follow-up and things like that. I think each time that you see someone, a connection develops, and they trust you, get to know you, and you get to know them. There is a bond that's created. I think that schism is less noticeable in the outpatient setting. In the inpatient setting, if someone comes in, let's say you have one doctor one day and a different doctor the next day.

Jennifer: Like on the weekends?

Dr. F: Yeah, like the weekends—then, it's really hard to necessarily bring that closer. Now, once in a while, in certain circumstances, it may click with certain patients. It depends. With someone who is severely ill, and you're talking to family members who are sitting over a person in the ICU, then it's going to be very biomedical. Oppose that with someone who came in for something minor…elective surgery, or something like that. They're feeling better. They're getting to be toward the end of their hospitalization

and are more likely to want to smile and joke around. Whereas, someone who is very sick—that is going to be the last thing on their mind. They're probably still grieving and upset at the fact that they're in the hospital.

Jennifer: That makes sense. It does. Well, those are all the questions that I have. Unless anything has come to you while we've been sitting and talking that you'd like to say…

Dr. F: Not that I can think of.

Jennifer: Well, I appreciate this very much.

Dr. F: Sure, sure. I hope it's helpful.

Jennifer: It is. It is.

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APPENDIX G

Interview with Dr. G:

Jennifer: I would, first, like to know how you feel physicians are portrayed by media? Do you feel that this is a fair, or accurate, portrayal?

Dr. G: Well, I think, sometimes, the problem is that they're portrayed as all-knowing. The expectation, that the patients sometimes have, is that we can diagnose and solve every problem that we're presented with. I also think that, unfortunately, there is too much medical information out there, sometimes, about diseases that are not exactly common. So, that creates a greater demand for physicians' services even for healthy people who, maybe, don't have anything but are afraid they do. They think if it's caught early, they'll do fine. One of the problems is that representation of physicians in the media is more conducive to having people consume the media than it is to foster medical knowledge or to foster health, in general.

Jennifer: So, you basically think that media is looking at entertaining, right?

Dr. G: Entertaining and having people watch.

Jennifer: So, how do you feel that the pervasiveness of contemporary media impacts your practice? Does it help, hinder, or do you not see any noticeable effect?

Dr. G: I think it helps in some respects, but I think the biggest thing is that it creates false expectations, especially in what I do which is oncology. Every day, there is a news article about a new treatment that cures cancer, and it's not necessarily true.

Jennifer: Not only that, whether it be TV shows or movies—*a lot* of soap operas do this—whenever there is a cancer storyline, it comes down to the wire. Then, there is this miraculous cure and recovery. Do patients expect that?

Dr. G: Sort of—yeah, yeah.

Jennifer: Are those the hardest?

Dr. G: Well, I mean, sometimes, it is. I think, as far as cancer is concerned, the problem is that we all try to be proactive and positive-minded, but sometimes, that makes things worse. If you accept what the situation is, sometimes, it makes it easier for you to look toward your family members and really make sure everything will be okay for the time when you will no longer be able to care for yourself. If you just keep thinking something is going to come along and cure you, it doesn't allow you to prepare for what's going to eventually happen. So, in that sense, it's a hindrance.

Jennifer: Okay. You might've mentioned this a little bit, but with increased Internet access, do you think patients are actually asking more questions now than they used to?

Dr. G: I believe, definitely, that they ask more questions. I think the problem with the Internet is that it also gives access to sites that give false information and also to sites that are more advertising than anything else. In cancer, again, we'll go back to the hope. There are a lot of people who make money off of false hope. Now, fortunately, there are credible websites that oncologists believe in and have reviewed. So, I try to help the patients in finding those websites when they come with information and say, "What do you think of this tea? Or this vitamin treatment?" I'll say, "Well, that's not proven, but if you want some information, I can help you find some places, online, that you can get some up-to-date information about cancer and treatments."

Jennifer: Now, would you prefer that they, at least, come to you and ask you instead of just taking that stuff?

Dr. G: That's fine. I mean, people are very into taking their lives into their own hands, and I believe that that's the right thing to do. I think the problem is that, unfortunately, most people don't have the capability to do so. It's kind of like if I had a legal problem and then, myself, tried to solve it—I probably would mess it up because I just don't have the knowledge to do it. I think that's the problem. A lot of people think they can just figure things out by playing on the Internet, but if anything, at least it makes them more involved in their disease. It's a marker that they're really involved in their care. So, sometimes, it's helpful, too.

Jennifer: Okay. Now, I'm going to get into a little bit more communication-oriented questions. This is based on some of my own previous research along with some articles that I've read as part of the lit review. Basically, the bottom line is that the majority of the public, as far as I can tell, regards physicians as bad communicators. How do you respond when you hear that? Do you feel it's a fair assessment? What is your gut reaction?

Dr. G: I think it depends on the physician. Some physicians are better communicators than others.

Jennifer: True.

Dr. G: Also, it depends on the patients. Some patients aren't as good of listeners as others. Definitely, it's not something that can necessarily be taught. Although, modern day medical education is sort of trying to.

Jennifer: When do you personally feel that your communication with patients is successful? What are the successful components of that conversation, or series of conversations? Is there something specific that you can point out?

Dr. G: I guess when I ask the patient what they understood, they explain it to me, and I agree with it. One of the things that they've shown—they do medical questionnaires for doctors and patients after a medical interview. It's usually completely different what the patient heard than what the doctor thinks he told them. So, that's where the disconnect is. So, I think that if I agree with what the patient tells me back, then I've done a good job of communicating with that patient.

Jennifer: By the same token, when do you feel it's unsuccessful? Is there something outside of hearing you completely wrong? Sometimes, it's easier for people to point out their successful communication, and other people go straight to the unsuccessful. So, I try to ask it both ways.

Dr. G: When the patient doesn't seem to understand what is specific to what I do in oncology—what their disease status is, what their options are. The problem is that, in my particular field, the barriers are not just the physicians' communication, but there are all sorts of defense mechanisms that patients put up. As they say, they hear, but they don't listen. So, we have to try to break through that sometimes. I think that's the biggest thing we see.

Jennifer: Now, is it hardest in the beginning, or is it harder down the road when chemotherapy is working…

Dr. G: Or not most of the time…

Jennifer: Oh, what a comforting thought. At the same time, there are patients that you cure, though, right?

Dr. G: Mm hmm. Yeah, there are.

Jennifer: So, is it hardest to communicate with patients in the beginning then? Is that when their defenses are the strongest?

Dr. G: Depends because, sometimes, if things start not going well, sometimes, their defenses pop back up again. So, obviously, the more time you spend with a patient, the better you get at reading them, and the better they get at reading you. So, you understand each other a little bit better.

Jennifer: Is it—and it may be the only thing—but is it easier in oncology because you do tend to have such a long run with the patients?

Dr. G: I think it might be. I think oncologists are probably better than other physicians at communicating. Surgeons are the ones who are notoriously bad. ER physicians—they don't really have a lot of time. So, their communication is pretty basic. Either you get admitted to the hospital, or you can go home. That's about the extent of their communication. So, I think different specialties work on communication a little bit better. If you're a psychiatrist—well, maybe not a psychiatrist because psychiatrists deal with a lot of people who are impaired anyway—but I think that they, obviously, would tend to be better communicators than, say, an orthopedic surgeon.

Jennifer: Well, and I definitely would consider cancer a chronic illness. So, in the chronic illness specialties…

Dr. G: Right. Typically, most oncologists are good communicators because, in the end, most of what we do is not only prescribe a treatment, but we have to convince the patient to go through it. We have to come up with a plan and explain it to the patient. So, in the end, of all the doctors that a cancer patient will meet, probably, the oncologist is one they have the most communication with.

Jennifer: Makes sense. I see heart failure in kind of the same way.

Dr. G: Yeah, they do have to be very involved with their doctor.

Jennifer: Couple more questions—were there any specific courses you took in med school that dealt with doctor-patient communication?

Dr. G: Yeah, I took some psychology and philosophy courses. Those, I think, helped.

Jennifer: Were there any that you had to do any role-playing in, or anything?

Dr. G: Well, in residency, there were a few of those?

Jennifer: Required?

Dr. G: Mm hmm.

Jennifer: So, were they just kind of mock set-ups where you had to go in with a pretend patient? Were you graded on how you delivered the news? Is that, basically,…

Dr. G: Yeah, they taught some basic things—always sit down, establish eye contact. At the end, ask if the patient has any questions or if there is anything else they want to talk about. How to pick up on certain cues—for example, if a patient says, "I'm going to be okay. I'm not going to die," those are certain things that you don't want to ignore. The natural tendency is to try to ignore those things, but that's the patient trying to communicate with you and is a specific emotional need. So, those are the sorts of things you need to pick up on. Then, obviously, transcultural communication and how to deal with that.

Jennifer: Now, I had a physician tell me that he wished there had been more intercultural communication in med school because there is a much more diversified patient population than there used to be. That was one shortcoming he felt on his own. Do

you—I know that you have a pretty solid cultural background, yourself, but do you see a growing need for that?

Dr. G: I think so, but I think it has been incorporated more and more in medical training. So, I think it's something that the newer physicians, maybe, have a little bit more of.

Jennifer: I do have one last question, but before I get to it, I have to ask. Do you know what I mean by biomedicine, or biomedical model? Do you know what I mean when I say those terms?

Dr. G: Mm hmm.

Jennifer: Okay. Good! So, you're familiar with the way in which the biomedical model is framed…

Dr. G: Well, I don't know. It depends because there are different things you can consider "biomedical." So, what exactly are you referring to?

Jennifer: Well, a lot of the articles that I read—actually, most of the articles that I read—they characterize the biomedical model as being a very mechanistic, reductionistic, and very scientific-oriented. At the polar opposite end, is the biopsychosocial model, wherein you have the humanity and all of the psychosocial elements to dealing with medicine.

Dr. G: Mm hmm.

Jennifer: Well, the biomedical model is associated with physicians. Whereas, the biopsychosocial model is associated with nurses. These ideas are very polarized. Do you think that's an accurate assessment?

Dr. G: Again, I think modern physicians have a better training in dealing with it, and it all depends where people are coming from. In the past, recruitment for physicians was focused more on people with a basic science background. Increasingly, more physicians

with a humanistic background are being recruited, and that's being valued, especially in the areas of clinical practice. I do think that a lot more people are putting an emphasis into that. Even if you look at our clinical trials, quality of life assessments are being used more often. So, it's not a question of 'how long did somebody live?' but 'how well did they live?' I do think that is something that is progressively getting integrated into medical practice.

Jennifer: So, do you see them as naturally becoming more integrated?

Dr. G: Mm hmm. Well, we know that the way that people feel, or the way that they interact with others, makes their course of disease change, or at least, how they perceive the course of their disease. I don't believe that if you're happier, you do better with chemotherapy, but you may have a better outlook. So, you may not live longer, but at least, you'll have a better outlook on things and, maybe, enjoy the life that you have. I do think those are things that we try to address with our patients.

Jennifer: Cancer just seems to be that, altogether, different animal. Now, I've told all the cardiology doctors about this one, but you will actually benefit from me talking about this movie. Have you ever heard of the movie, *Wit*?

Dr. G: No.

Jennifer: I hadn't either until I watched it in a class. It was direct-to-HBO; it didn't go to the theater. Basically, Emma Thompson plays—

Dr. G: Actually, sorry, I did see it in a class.

Jennifer: Yes, yes, where Emma Thompson is—

Dr. G: A terminal patient, and she has some sort of resident. She feels that he treats her inhumanely, I guess. Yeah, I'd seen the movie. Actually, it was part of residency. We had to all sit down and watch the movie.

Jennifer: Okay. I actually watched that movie with some random students at IUPUI. I had questions for them about how much experience they had had with physicians and with the cancer treatment process before we watched the movie. Then, we watched it, and I asked them additional questions because I saw it as pretty powerful, and I wanted to see if it changed…

Dr. G: It's powerful, but it's stereotyped.

Jennifer: I agree!

Dr. G: It's a little bit exaggerated. It's exaggeration to make a point but still exaggeration.

Jennifer: And, that was my point. You know, a lot of times, people, especially—and there are media studies that show this—that if people do not have a personal experience in their life—they don't have any relatives who have ever had cancer, they don't have any idea what's involved with it. Let's say they watch this movie, and that has the potential of becoming their reference point for it. They replace their lack of personal experience with the vicarious experience, if you will, of that film. So, I just felt like that had such potential to perpetuate negative stereotypes against doctors. So, I was talking to people. Appalling as it was to me, this movie wasn't changing good opinions to bad, it was confirming the bad opinions they had to begin with. Then, I decided I needed to start talking to doctors about how they feel about communication. Anyway, those are all my questions. Unless you have anything else that occurred to you as we were talking?

Dr. G: No, but if you need to ask any other questions, that's fine.

Jennifer: Okay. Thank you.

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APPENDIX H

Interview with Dr. H:

Jennifer: Some of these questions may seem like they come out of left field, but I have a purpose for every one of them. I'm going to start out by asking you some media-oriented questions. Then, we'll move into more communication-oriented questions. First of all, I would like to know how you feel physicians are portrayed by the media and whether you feel this is fair, or accurate.

Dr. H: I think, in general, it kind of depends on what kind of media; but, in general, there is kind of a deference by the media to physicians. In that sense, there tends to be, in general, kind of positive portrayals. It varies across the spectrum of whether you're talking about objective news versus newspapers or in-depth reporting versus TV shows. I think, in general, it tends to be deferential treatment, I would say.

Jennifer: Now, it's funny that you say, "objective news reporting." In communication and rhetoric, in particular, which is where I tend to navigate, there is a saying that 'objectivity is a myth' because there is always a slant, or angle. Do you find that?

Dr. H: Absolutely, I think so. I think, similarly, there tends to be that kind of slant as well. You seldom will see—a lot of times when it's objective reporting, you see the physician giving their impression of something. It's almost equated to being the truth. So, it kind of brings a weight to the conversation. I think it's kind of a general societal view of physicians that is translated into the media's reflection.

Jennifer: Now, have you ever had patients come to you with the expectation of their disease progressing somewhat like they've seen on some of the TV shows?

Dr. H: I think that probably does impact, to some extent, how people view the medical profession. There are always these kind of medical miracles—something that is beyond what the realistic expectations may be. So, I certainly think that does inform that.

Jennifer: There are media studies that do speak to the fact that if someone doesn't have personal experience with an illness, like heart failure, and they watch something on TV, they use that. That becomes their frame of reference, and they use that in lieu of any personal experience.

Dr. H: Absolutely.

Jennifer: That becomes their knowledge base.

Dr. H: I agree 100%.

Jennifer: Just to piggyback on that, how do you feel that the pervasiveness of the contemporary media impacts your practice? Have you seen that at all? Does it help, or hinder?

Dr. H: I think it helps, actually, particularly with new media—the Internet. I think it's more of a positive force than a negative force. Sometimes, you'll kind of be warned about people getting on the Internet and just reading 'whatever' and having unrealistic expectations; but I think, in general, patients are pretty savvy users of new media. As for kind of older media—print media, television—patients don't really refer to it as much. I certainly do encourage people to look things up on the Internet and get more details about things that we may be talking about in the future, and they can start to get out in front of. I think, in general, it's had a positive impact, actually.

Jennifer: Do you have specific websites, or do just send them to Google?

Dr. H: Well, often, I'll just send them to Google. I don't really use specific websites.

Jennifer: Then, do they bring back to you specific questions about what they find?

Dr. H: I've not really had anybody. People will, sometimes, say, "You started me on this medication, and I went on the Internet and read about these side effects." Then, they may start imagining some of those side effects, but they probably bring that kind of stuff in more indirectly in terms of how they've educated themselves as opposed to specific questions about something. I've definitely gotten questions that have been more informed by their detailed research.

Jennifer: Do you find that patients are asking more questions now than they did in previous generations?

Dr. H: Well, I have a limited practice time period [laughs], but—

Jennifer: I'm trying to think of schooling and everything. I'm not trying to age you [laughs].

Dr. H: I think, in general, certain segments of patients clearly have a higher degree of sophistication about things that they've researched in more detail. At the same time, there are times that I'm surprised when patients aren't asking certain questions, or aren't as informed as they could be.

Jennifer: Now, are the older patients the ones that tend not to ask more questions?

Dr. H: Yes, certainly older patients—younger patients are more plugged in—but even younger patients…I think it has to do with, number one, their interest. I think patients who are detail-oriented are the ones who tend to look into things and bring back questions, or who are in the hospital looking up stuff to ask you the next day. 'Why are you doing this, or that?' At the same time, there is a good number of patients, that are young even, that just aren't interested, or they have a certain level of trust in you that

you're going to do the right thing. So, they don't want to use up that mental space to be thinking about their illness. They try to do everything else that they do that's not related to their illness. I think, sometimes, people just don't want to be the one. They expect you to be the one who has the answers. They have more trust in you—and maybe, it's not even trust—they just don't want to have that task upon them.

Jennifer: I can see that. Okay. We're going to get into some of the more communication-oriented questions.

Dr. H: Mm hmm.

Jennifer: Now, this is based on some of my own previous research that I did with some students on the IUPUI campus. What I did was I showed them a film called *Wit*. I had never heard of it until I had to watch it in a class. Have you heard of this movie?

Dr. H: Was this a play, originally?

Jennifer: Yes, it was.

Dr. H: Then, it was turned into a movie?

Jennifer: Yes, it went straight to HBO.

Dr. H: Well, I can't say that I've ever watched it.

Jennifer: Well, the nutshell—it came out in 2001. Emma Thompson plays this English Literature professor who was diagnosed in the opening frame with Stage IV Ovarian Cancer. So, she was treated at the academic hospital of the university where she had taught for all these years. It was approached from the direction that the academic physicians saw her as incubator for her cancer. It was "full dose, full dose, full dose," and they weren't really paying attention to her as a person. So, I watched this film with students, and I asked them questions about how much experience they had with doctors

before I even showed it to them—and afterward just to gauge any change in their perception of physicians. What I found was that their responses, along with a hefty literature review that I've done for this, it would seem that a lot of people regard physicians as bad communicators. So, I'm kind of interested in how you respond when you hear that—just to think that a lot of people—that's their impression of physicians, that they're bad communicators. What would you say about that?

Dr. H: I think it's hard to generalize, certainly. I think there are some physicians that are very good communicators. Part of it is that it's an art form in terms of distilling down into the nuts and bolts—the big picture—just being clear about, number one, what's going on and what the plan of care is, getting the patient's insight into that, and providing additional emotional/social direction/support the patient needs. So, there are a few different elements to the patient encounter—a sense that you kind of have to pick up and tailor it every time you see the patient. One encounter may be focused on one thing, and the next may be focused on something different. It's definitely an art, and I think some people have mastered that art more than others. Certainly, in my case, it's kind of an evolving thing. It really is something where the more you're communicating with patients, the better you'll get at it. There's also kind of a personal style and the ability to slow down and communicate that's important. I wouldn't say that's a fair statement to generalize and say that all physicians are poor communicators, but I think that communication makes a big difference between a really great physician and a physician who may have all the technical know-how, and may know how to get people doing better, but doesn't have that component. I think there's a huge difference between the two. So, I think it's an art that has to be honed for physicians.

Jennifer: I've heard it said that you can't really teach a bedside manner. Do you agree with that?

Dr. H: I don't know. I think, certainly, people have different personalities. Your personality is hard to, necessarily, change—how you react to stress and those kinds of things; but that said, I think to some extent, bedside manner can be taught. It takes some work and investment, but I'd say it can be taught. I wouldn't agree with that statement.

Jennifer: Okay. Now, you kind of touched on this a little bit, and I'm just going to ask you this to see if there is anything else you can think of. When do you feel your communication is successful? What are the successful components of that conversation?

Dr. H: I think, number one, at the end of the encounter, when I can tell the patient, or their family—which is often just as important a part if the patient is in ICU—are satisfied with what you've told them, that they feel informed about what's going on, what the plan of care is, and how they play into it. I think just getting that sense at the end of the conversation is good, positive feedback. As far as information that you've provided—obviously the important things are updating since the last time you've seen the patient; what the plan for each of their problems is; and also what the longer term plan for that patient is going to be so there are no surprises; gauging what the expectations are; addressing those expectations whether they're appropriate expectations or inappropriate. At the end of the day, you're judged by how satisfied the patient, family, or caregivers are at the end of that conversation.

Jennifer: So, do you go more on non-verbal cues? Or, do you just ask if anyone has any more questions?

Dr. H: Well, there certainly are a lot of nonverbal cues. There is a big nonverbal part to what we do, and you can certainly sense whether the patient is hesitant, holding back something, or if something is simmering that they're not communicating. Part of being a good communicator with that patient is being able to elicit those things and help address them—being able to come up with a remedy for those feelings. So, I think that there is a lot of nonverbal. I think nonverbal is very key—something you should be thinking about trying to address instead of just kind of, 'Hey,' but I didn't really say anything, and let's move on. I think nonverbal is important, and at the same time, the tenor of the conversation. It definitely has to be a two-way conversation. You *have* to give them space to say, number one, how they're feeling, and then any other issues they may have. So, it's a two-way communication with a large part being nonverbal.

Jennifer: By the same token, can you point to the unsuccessful experiences? Are there things you can point to where you know that conversation just didn't go well?

Dr. H: I think that my approach in all those situations is the same. So, I will try to do all those techniques I just talked about. A lot of the times, when it's unsuccessful, it's just because, number one, there is still a kind of wall, and it may be too soon for the patient, or family, to recognize what you're telling them. It's often surrounding a situation where a prognosis may be not good, and we do this a lot—dealing with situations where continuing aggressive care may not be the best thing for the patient. A lot of times, it's resistance from families. Sometimes, it's resistance from patients. To some extent, you need to respect that. So, if things are not going well, that's kind of a cue that you just need to take a step back. Nothing needs to be decided in any given second. I think that just means that you need to strengthen that rapport with that patient or that family, and

keep chipping away at it. Those tend to be the situations where the communication doesn't go well—somebody's not receptive to hearing what you have to say. If there's even a little bit of an opening of receptiveness, then I think a skilled physician ought to be able to get through that opening, and open up the conversation a little bit. I think if I had to count the number of times that has happened in the last year—where it was just a very negative interaction, it would probably be less than three. So, it's not a common thing by any stretch.

Jennifer: Okay. That's good.

Dr. H: Right, exactly. That's good. We try to keep it that way.

Jennifer: Were there specific courses that you took in med school that dealt with doctor-patient communication?

Dr. H: Well, there was not a specific communication-related course. We had, in our pre-clinical years, we did a Practice of Medicine course, where we talked about not only some of the clinical skills but, also, a lot of the interactional skills—visiting with patients. We had kind of a mock patient set-up for practicing interviewing and physical exam.

Jennifer: Were they recorded?

Dr. H: We did have recorded ones, and we got to watch our interaction played back, yeah. So, we had a fair amount of practice as far as that goes. It's still not a substitute for being the actual guy on the spot, but…

Jennifer: Is it kind of a deer-in-headlights feeling the first time you go live?

Dr. H: Yeah, well, I think, certainly, as you start clinicals and you're going live, it's an interesting experience. Fortunately, it's kind of a graded experience, and you're not following more than one or two patients. So, you can take the time to get to know the

patients. That's how most medical schools work, but you just don't get good at it until you've done it thousands of times, really. It really needs to become second-nature. It's something you learn, and therefore, you apply it in another environment. It really becomes part of your demeanor, over all. I think, while we do make efforts to train people in patient communication, it's really something that's acquired over many, many interactions.

Jennifer: I just have one more question, but before that, I actually have to ask you—have you heard the terms, biomedicine, or biomedical model? Are you familiar with those terms, or how they're used?

Dr. H: You'll have to refresh my memory. I probably did at some point.

Jennifer: Well, biomedicine, or the biomedical model—however you want to term it—according to literature and the students that I talked to at IUPUI—biomedicine is seen as very reductionistic, very scientific. The approach to the human body is paralleled to a mechanic approaching a car. Okay? On the other end of the spectrum is the biopsychosocial model, where you find all the psychosocial stuff. Well, the biomedical model is associated with physicians, and the biopsychosocial model is associated with nurses. Do you feel that that framing is accurate?

Dr. H: Oh, boy.

Jennifer: I know that's a lot!

Dr. H: Yeah, I don't know. I had actually heard those terms before. I didn't really draw the line between associating one with physicians and one with nurses. If anything, I would think that both would be associated with biomedicine.

Jennifer: The problem is that they're so polarized—the ideas.

Dr. H: Yep.

Jennifer: Do you find that, in practice, they are, in fact, polarized?

Dr. H: I think, clearly, it's a lot easier to identify a medical problem and treat it—prescribe whatever the treatment is for it and monitor the quantitative and calculated stuff that we do. The other stuff is a lot more amorphous. It's a little bit harder to pin down. That's probably why, to some extent, we don't do more and why it's often obfuscating our plans because it's not something that we do very well. It's integral and, obviously, plays a major role in the morbidity that our patients suffer within their relationship network. So, just from our meetings, you can see, that's something we're constantly and, predominantly, wrestling with. Medically, something happens. There is some pathway, or things we may try, or we may get to a point where nothing else can be done. The other stuff is a lot harder to direct. It has to do with things that are often—or seem like they're often out of our control. So, I think that there is some tension between the two. Obviously, when being effective in treating a patient, you need both. I think, in general, we're better at addressing the biomedical. Biopsychosocial just gives us headaches to some extent, but I would agree with the statement that you need to address both when treating the patient and the whole person.

Jennifer: Is there a way to alleviate the tension between those two?

Dr. H: We certainly struggle. We have our social workers, our psychologists. We try and be psychotherapists, sometimes, and try to address these problems in the scant time that we have. At the same time, do patients want us to be taking over that much? Maybe, some of it is just recognizing those things, trying to do what we can. I don't think we'll ever totally be—we're not going to be addressing all of the psychosocial needs that our

patients have 100% of the time, but, certainly, I think it's worth making that an important part of the treatment plan. I think we recognize more and more it's pivotal. At the end of the day, our goal is to have people at home, having a reasonable quality of life and doing the things that they want to do with the rest of their life. So, to the extent that we can do that, I think we recognize more and more that it's an important part of the picture.

Jennifer: I hear a couple of things—address what is expressed. You can't address it if they don't express it, right?

Dr. H: Absolutely.

Jennifer: Also, the teamwork—everybody is at the table to discuss *that* patient. I've kind of gotten the sense in talking to people along and along, that they emphasize the teamwork. Timing is an issue because you only have so much of it, but I've also heard that—and I kind of got it from what you were saying, too—that no matter how little or how much time you have, you can make the most of what you've got. Then, the patient doesn't even realize that it was only 'so many minutes' because it felt like half an hour.

Dr. H: Right, right. So, there is some disconnect with that, but…[phone call derailed conversation].

Jennifer: Those are all the questions I have unless you have anything you want to add based on what we've talked about.

Dr. H: No, I think it was a good discussion. Hopefully, it was helpful.

Jennifer: It was, and I thank you very much.

Dr. H: Absolutely no problem.

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APPENDIX I

Interview with Dr. I:

Jennifer: What I'm going to do is, basically, ask you some opinion questions, okay?

Dr. I: Okay.

Jennifer: I'm going to start out asking you some media-oriented questions, and then we'll move in to more doctor-patient communication. Is that okay?

Dr. Okay.

Jennifer: Recognizing that people have different viewing habits when it comes to the media, I would, first, like to know how you feel physicians are portrayed by the media, and whether you feel this is fair, or accurate.

Dr. I: That's a difficult question to answer because, I think, many times, the media portray us in a very good light and, other times, I feel we're not portrayed as, maybe, we might be. If something is good and the patient is benefitting from it, then, I think the physicians are portrayed well. On the other hand, when there is a bad outcome, or a questionable outcome, then I think physicians may not be portrayed in a very good light at all. So, I think we have both good and bad, *and* we *do* have good and bad physicians just as you have in any occupation; but I think when there are bad outcomes, or when something doesn't go right, I think the media is very quick to challenge the physician or think it's a physician's fault if something bad happened.

Jennifer: I know what you're saying because I've read premature study findings that were positive and, later, turned out not to be.

Dr. I: Right.

Jennifer: And, I've also had physicians tell me about investigations into previous trials—like with stents—and media just take it and run with it, and they're broadcasting every bad thing they can think of.

Dr. I: Right. There's so much competition now, in the news media. We've never had 24-hour a day news. Now, we've got 24-hour a day weather. I mean everybody is looking for something fresh and new to put on the air, or on the TV. I think the problem with that is that they'll take information, that is very preliminary, and make huge leaps as to its applicability. For years, we wondered how did the media know that the New England Journal article for this coming week says, 'this.' They wanted you to make a comment on it, and we didn't have a copy of it. Then, we learned that they were on the early mailing list—or early communication list—to receive those articles before we did. Then, they'd want to know our opinion about them, and we'd have to scrounge around, or have that media person send it to us because our subscription didn't come as early as theirs did.

Jennifer: That's almost like a set-up.

Both: [Laughter]

Dr. I: It is. It is. We found out there's an early notification list. Then, our media people got on the early notification list so that when those things came up, they'd be able to get us the information.

Jennifer: That makes sense.

Dr. I: I think that tends to cause problems between people—not just physicians—but people in certain professions and the media.

Jennifer: Mm hmm.

Dr. I: They're getting the information first and wanting us to comment on it when we haven't even had time to read it or even contemplate on it—was this a good study; analyze whether the study was any good, or the study set-up was any good; or the questions they were asking. Is that exactly what the results say? So, really analyzing the study, and how it was written, is very important. You can't do that in 10 minutes to come up with an answer for the media.

Jennifer: Right. On my homepage—it had to be about a month ago—there was a story. They were dropping names like American Stroke Association. I think it was their annual meeting. Anyway, the end result was that diet coke increased risk of heart attacks, and I'm scanning this real quick, wondering why! Well, it turned out, the very next day, there was a doctor on *Good Morning America*, who was saying, "Okay. Look. They just assumed that none of the subjects' beverage habits had changed within 10 years. All they did was look at diet coke. You can't do that." I thought, okay, that makes sense now.

Dr. I: Right. There almost need to be courses offered in how to analyze a study. What type of a study was it? Was it randomized? What is double-blind? Was there cross-over, or no cross-over? What patient population are you looking at? All those sorts of things are very important in analyzing the results of any study. So, I know the media gets really agitated with the medical community. They think we want to be closed, not tell them anything, and not give an opinion. I think part of our reticence is that we want to be sure that when we comment on a study, that we've really analyzed that study and are sure of what it found. You can't do that by just reading the abstract.

Jennifer: Yeah, that's true. So, how do you feel that the pervasiveness of the contemporary media impacts your practice? Do you notice it at all? Does it help, or hinder?

Dr. I: Oh, I think it does both. You know, everything is a double-edged sword. Patients are very informed nowadays. They advertise drugs on TV; they're in magazines; they're in throw-away articles, and so forth, at the beauty shop. The Internet is a big issue. Patients get on, look up their symptoms, get a print-out of all the things that could be causing those symptoms. They want to bring them in and have you go over that with them. In some ways, I think it does help because I think it does explain certain things to patients that, maybe, I didn't take the time to do—or didn't have the time to do. On the other hand, I think it's a source of getting too generalized of a situation to explain somebody's personal complaints and problems. Fatigue and shortness of breath—there are so many things that can cause those symptoms, and it may not be this one diagnosis. My mother does this all the time. She's on the Internet; she reads all these articles; she looks at TV. Everybody thinks there's a fast and easy cure for whatever it is that you have. "Go ask your doctor…" It's, "Ask for it by Name."

Jennifer: Yep.

Dr. I: So, it is a problem because it's just a snapshot in time. For the physician to have to sit down and say, "Yes, Lipitor is a good drug, but you're already on a medicine that does the same thing as Lipitor. And, it's a generic drug. So, it's not going to cost you as much." It takes a lot of time to read what the patient brought in, explain it back to them, and why it may, or may not, be what they need.

Jennifer: Yeah…so, would you agree that patients are asking more questions now than they did in previous generations?

Dr. I: Absolutely, and that's good. That's good. I think the paternalism we fostered, as a medical community, that, 'Oh, don't you worry about anything. I'll tell you what you need to know.' I think it's very outdated, and it was very wrong to treat the patients that way. Patients need to be very much a partner in their healthcare. So, I encourage people to read stuff, but I try to guide them to things that are relevant for them. That, way, they don't just go and type something in a search engine because, a lot of times, they're not going to find exactly what it is they need to read about. The stuff they need to be reading, they're not interested in—losing weight, controlling the salt in their diet, and that kind of stuff.

Jennifer: Quitting smoking?

Dr. I: Quitting smoking, exactly.

Jennifer: Yep, yep. Okay. Now, we're going to move into more of the communication-oriented questions. Before I do that, this was kind of based on some of my own previous research that I did with some students on the IUPUI campus. With about half a dozen, or so, students, I watched the film, *Wit*. I don't know if you've heard of it.

Dr. I: Shaking head "No."

Jennifer: Well, I hadn't either until I had to watch it in a class. It came out in 2001 and went straight to HBO. There was no theater time. Basically, Emma Thompson plays an English Literature professor, who is diagnosed, in the opening frame, with Stage IV Ovarian Cancer.

Dr. I: Oh!

Jennifer: So, she's treated at the academic hospital of the university where she has taught for years. They approached it in such a way that the academic physicians she saw didn't see *her*. They only saw her cancer. It is shot as if it's a documentary. There's a part, toward the end, where she is just writhing in pain. The doctor comes in and says, "Are you in any pain today?" she says, "I can't believe *this*!" So, I asked the students a few questions about how much experience they had had with physicians, themselves, and with the cancer treatment process. I was trying to gauge reactions with the questions I asked after watching the film. Did it confirm perceptions that they had about physicians? Or, did they change in any way? What I got from that, in addition to *a lot* of literature, it seems, to me, to be the consensus that physicians are bad communicators. I would like to know how you feel when you hear that that's what people think.

Dr. I: Right. I think they're right.

Jennifer: That's, largely, the answer that I'm getting.

Dr. I: I think they're right. I go with my mom and take her to many doctors. They talk around her. They talk over her. The new computer-medical-records systems that we have are another excuse for someone not to look at you because they're busy entering data, or looking up data, rather than looking at you in the eye—or watching your mannerisms like writhing in pain.

Jennifer: Mm hmm.

Dr. I: So, I think a lot of times, we are very poor communicators.

Jennifer: It's got to be interesting for you, as a physician, to take your mom to different doctors.

Dr. I: Mm hmm.

Jennifer: I'm guessing they have to know what you do.

Dr. I: Mm hmm. Most of them do, yeah.

Jennifer: Does it change the way they interact with her, do you think?

Dr. I: Maybe, some of them—the people that I know closely, or have worked with closely—they tend to be more careful; but ones that I don't work with, or that don't know me well, I think I see the way they treat her in the way that they must be treating their other patients—which is, for the most part, not listening. I think to be a good communicator, you need to be able to listen. So, they don't listen to what they're being told. They're busy telling the *patient* what it is *they* want to tell them, and I think that's a real problem. A lot of people will say, "Well, we don't have enough time to really sit and listen to what they have to say," and I say, "We have to have the time to sit and listen to what they say because, most of the time, they'll tell you what's wrong."

Jennifer: Mm hmm. Yeah.

Dr. I: My practice is different because I'm not really hampered by a time clock as some physicians are. Some are paid in a way that they have to see so many patients in so many minutes and have to get in and get out. I have the luxury of not having to do that. I can spend as much time, and I schedule as much time with a patient as I need to.

Jennifer: That's good.

Dr. I: So, that suits me to a tee. I wouldn't do well if I just had five minutes to get in and get out. That's how a lot of practices are being run, and in those instances, they're not listening to what the patients are telling them.

Jennifer: I've always heard people complain about waiting in the waiting room for x amount of time, and I tell them, "You want that because that means they're taking the time!"

Both: [Laughter]

Dr. I: That's true! Then, you'll get the time. That's right.

Jennifer: Yes, you'll get just as much. So, you can't please everybody, but I've also heard it said that there are steps that you can take and things that you can do even if you *don't* have a lot of time, per se, if you have to play beat the clock.

Dr. I: Right. Exactly.

Jennifer: There are things that you can do to make that patient feel like you're not rushing. Some of the things that you talked about—making eye contact, sitting down and talking to the patient—it is an interesting addition with the electronic medical record.

Dr. I: What you can do, if there really isn't a lot of time, is say, "As I understand it, you're here today so that we can do your physical exam, and you've brought up a lot of things that we need to discuss. It's going to take more time than what we've allotted for today, and I'd like to make another appointment with you to come back and address those issues." So, that's one way you can deal with it is to tell them that there isn't enough time that day, but have them come back because "I am interested, and we do need to get those concerns figured out."

Jennifer: With chronic illness, it's probably easier to do that, right?

Dr. I: Mm hmm. Mm hmm.

Jennifer: I'm guessing a lot of these patients are seen, at least, on a monthly basis, if not, every three months or so.

Dr. I: With our heart patients, they are.

Jennifer: I've just been in GI, but I've been a monthly patient! So, I know how that is.

Dr. I: Right, and the patient needs to take some of the responsibility, too, because my mother, for example, will go in and start talking to them about stuff that's absolutely irrelevant, "Oh, I like your shirt," or "How are your kids?" or whatever. I try to redirect her, "Mom, we need to talk about what it is that we're here for." So, a lot of patients want to do social hour, or minutes, and that really detracts from the amount of time that you have to spend talking about their physical problems. So, being able to redirect them back to talking about their high blood pressure problem, and patients should come in with a written list of their questions. They should come in with a written list of their medications so you're not spending all that time.

Patient: "This is what I'm taking."

Dr. I: "Great. Let me copy this, or is this my copy?"

Then, I can work on that later and focus on the questions. I think them having the medications and questions written out is very helpful. Preparation, on both parts, is very important.

Jennifer: I'm a list maker.

Dr. I: That's good.

Jennifer: My endocrinologist will say, "Take out your list. Let's hit the high notes."

Dr. I: That's right.

Jennifer: I just brought a few notes. He'll say, "You brought a book. Let's hit the chapter titles."

Both: [Laughter]

Jennifer: There are some things that I think are important, but when I get there, I'm like, "Eh."

Dr. I: That's right, but at least you've got them written down, and you've got the choice of being able to talk about them, or not.

Jennifer: Yep…okay. Well, when do you, personally, feel like your communication with patients is successful? In other words, what are the successful components of that conversation, or series of conversations?

Dr. I: Well, one thing would be is when they partner with me. They're going to take their blood pressure at home. They're going to call me and report what their blood pressures are to see if we need to increase their medication, or not. A lot of times, I don't want to increase it right there on the spot because they say,

> Patient: "Well, my blood pressures have been fine at home."
>
> Dr. I: "Well, do you have them with you?"
>
> Patient: "No."
>
> Dr. I: "Alright. Well, let's have you take your blood pressures."

Then, if they have a fax machine, they can fax them to me. Or, they can email them to me. Or, they can call and read them out to us. So, when I see that they're partnering with me; when I see that they're really willing to take a role in their own healthcare—to start exercising, to start cutting back on their calories, to stop smoking—then I feel like my communication has been heard and acted upon. Some people don't make their appointments. So, when they come back for their appointments, I think that's a victory. Some people don't take their medications or get them refilled. So, again, I take that as a victory if we're doing that.

Jennifer: Yeah, I actually just finished a paper on noncompliance with cardiac regimens. Basically, because, of all of the charts that I read every day, 'Oh, he didn't get his Plavix filled, and here he is again, two weeks later.'

Dr. I: Mm hmm.

Jennifer: I'm like, "But, why??"

Dr. I: I know. I know.

Jennifer: So, when I made my presentation, I knew they were going to say it was cost. So, I nipped that up front and talked about the social workers who work with the patients to get samples; they work with the insurance; they work with pharmaceutical assistance programs. So, all that said, "Why?"

Dr. I: Exactly.

Jennifer: So, I don't get it. I guess I'm in a unique position because I work in this.

Dr. I: Well, I think it's our job to make sure the patients know what they have—know what their diagnoses are—and what that means for them. A number of patients that I've had—I'll say something about smoking. I'll ask them,

Dr. I: "Did anybody ever tell you that you need to stop smoking?"

Patient: "No, they told me I needed to cut back."

You know, at first, I thought maybe they were lying, but I think that's probably true. I think people—physicians being people—are loath to look at somebody and say,

Physician: "You must stop this."

Patient: "Well, I'll try and cut down."

Physician: "No. You must stop smoking."

It's just like when you go talk to a family and say, "Well, they're doing poorly. I don't even know if they'll make it through the night. I just don't think it's going well." Then, you come back and say, "Well, I'm sorry. Your loved one died," and they say, "Well, you never said they could die." So, I think it tells you that people *have to hear* the bottom line. So, I make it a point now that I've had that happen to me—"Well, you never told me they could die,"—is that when I tell them, "Your loved one is not doing well. They may not make it through the night. The likelihood is they are going to die." You *have* to say those words whether it's to get their attention or to let them know you're serious. You have to, unfortunately, be almost in their face with it. So, I think the same thing has to be done with the cigarette smoking. The same thing has to be done with the weight and with the exercising. You have to be very plain, very blunt, and not have a prepositional phrase ahead of it or after it. Then, I know I have done my part to inform them. Then, the next part is to try to get help for them. "Who can help you with this? Do you need to go to a cigarette, or tobacco, cessation thing? Will you go to this? Will you try that? Will you try a medicine?" Then, once you've done that, then, I think it almost has to be repeated. Then, after that, they're on their own, but you tried.

Jennifer: Yeah, I was in the room for a smoking cessation deal. I was trying to consent a patient, and he said "no" the first time. Dr. [A] called me and told me that the patient he thinks he was a little loopy the first time. He wondered if I could scoot over and talk to him again. I was like, "Let's go!" I was starved for a "yes" because I had been turned down so many times!

Dr. I: I know.

Jennifer: So, I went in there, and he told him, "You've got to stop it." This guy—50-some years old, sitting on the edge of the bed—he said, "But I love smoking!" He's like, "I made my peace with the Man upstairs when I was in the ambulance. I love smoking!"

Dr. I: I know. [Shaking head "no"].

Jennifer: I thought, 'Well, it's a good thing you made your peace because if you don't stop, you're going to be seeing Him pretty soon!"

Dr. I: It's going to get you!

Jennifer: I just couldn't believe…

Dr. I: You have to have the partnership. They have to be willing partners. If they're not willing partners, and you've explained the risks of them continuing with that behavior, I think that's all you can do—and tell them you're here if they change their mind. To continue beating ourselves up because we can't get people to stop bad behaviors just puts us in a tizzy. Then, we get in a confrontational relationship with the patients, and I think that's bad. I don't want to take care of you anymore because you don't listen to what I say, and it's hard not to feel that way sometimes; *but* we're not doing either one of us any good. Maybe, with some time and continued talking about smoking cessation—or, if they have to have another angioplasty, or something—maybe, the light will come on, and they'll be willing to do it. I hit them hard and heavy the first two times. After that, I tell them,

> Dr. I: "I'm here. I'll talk about it. Are you still smoking?"
>
> Patient: "Yes."
>
> Dr. I: "You must quit."
>
> Patient: "I know. You told me."

Dr. I: “Is there something we can do to help you?”

Patient: “No.”

Dr. I: “Okay.”

I don’t get all embroiled in it anymore. It’s too hard. We go through it with so many patients.

Jennifer: Yeah, I was reading in a chart not too long ago that the patient couldn’t afford their medications but didn’t have any problem affording their cigarettes, and that was another thing that I pull out in my paper. I went to a website that lists cigarette prices. I’m like, ‘Okay. This is the range that a 2-pack-a-day smoker is spending in a week to support the habit.’ Come on!

Dr. I: Exactly.

Jennifer: Well, I went to another website that talked about the thousands of dollars that could be saved by quitting—spend money on life instead of death! My professor is going to get a kick out of my paper!

Both: [Laughter]

Dr. I: Does he smoke?

Jennifer: Well, I would hope not. He’s got a couple of stents.

Dr. I: Oh!

Jennifer: I don’t know. I digress.

Dr. I: No. People make choices, and they’re not all good choices.

Jennifer: This was a sociology class, and I was coming at it from a completely different angle. I’m a communication major, and sociology is all about the system. That’s why I

knew they were going to harp on cost and talk about the extraneous problems that people have, and that's true, but still…

Dr. I: Everybody makes choices.

Jennifer: Exactly.

Dr. I: We now have the ability for patients to get their medications for $4 a prescription, or $9 or $10 for a 90-day supply. That is just dirt cheap!

Jennifer: Yeah, there was a lady I was trying to consent for a study—it didn't work—but she said, "You know it's the doctors' fault that these medications are so expensive." I don't know the strength of my own facial expressions, but I must've given her a look because she started being a lot nicer after that.

Both: [Laughter]

Jennifer: I was trying to give her options like the $4 Walmart medications. She had a reason she couldn't do everything I suggested.

Dr. I: Right.

Jennifer: I thought, "Well, I can't help you, lady."

Dr. I: No. They're not ready to be helped.

Jennifer: Okay…I know that we talked about successful communication, and I can understand unsuccessful communication in ways that they're [patients] just not complying; but is there anything else that you can think of that you've experienced where you knew a conversation had not gone well? Is there anything specific that you could point to?

Dr. I: Well, I think you have to be careful about being judgmental with people. I have to admit that, in order to get from them their bad habits, I've learned that you have to ask

the question as though everybody is drinking everyday. "How much do you drink a day? What kind of recreational drugs do you use? Do you use marijuana? Do you use this? Do you use that?" I try to make it so that I'm not judgmental with them. Very frequently, they'll be very honest with you about what they do. I ask people, particularly the ones we're working up for transplant, "Have you ever been in jail?" I'm surprised by the number of people that have been in jail. I ask them why. Have they been in the military? If they have, what kind of discharge did they get? There's an honorable discharge, a general discharge, and a dishonorable discharge. If they get a general discharge—if they get a dishonorable discharge, that means they did something really, really bad. One guy got it, and I said, "Why did you get a dishonorable discharge?" Well, he had shot his commanding officer. OH! Okay. Somebody else got a general discharge because he was caught stealing something. Rather than putting him through a trial—and he didn't want to be in the service—they just gave him a general discharge. A general discharge doesn't allow you to access the VA system, and a dishonorable discharge does not. So, almost everybody can get through their military career with an honorable discharge. So, that gives an idea that there are underlying problems with patients. So, trying not to be too judgmental when you're taking a history or talking with them. Again, I think letting them lead the conversation and trying to redirect it where it's necessary…let's see. I'm trying to think about what you asked—disagreeable. Well, the gentleman that has a VAD in who lost communication with us.

Jennifer: Oh, I know who you're talking about.

Dr. I: Yeah, FB—I went in and talked to him because the nurses told me that he brought a knife to clinic. So, I went in and talked to him and his wife, and asked him how things

were going. I said, "I understand you had a knife with you in clinic last week." He said, "Yes." I said, "Well, that won't be allowed anymore. You are not to bring any kind of weapon—knife, gun, whatever—to this clinic." That didn't go well, but that's just how it had to be. I told him we'd call security if he did and have him shown out. Anyway, that didn't go well. He was on the defensive about that because he knew that that was wrong, but he did it anyway. Otherwise, I've always thought that my communication skills with the patients have been good. If I see that I'm not getting through to them, or if I see they're not accepting of what I'm talking, or saying, then, I try to back off and try another tactic. Some of them—if you try to tell them what's going on after the testing, and they disagree with you, then I usually ask them, "What do you think is going on? What do you think you have? What other kinds of tests do you think you should have that you haven't had?" Sometimes, I'll say, "I would really recommend that you get another opinion, and I would help you find someone to see. Or, if you know someone else to see, that would be fine. I'll be happy to send your records to them." That usually diffuses a lot of issues.

Jennifer: Were there any specific courses that you took in med school…

Dr. I: *No*, they didn't have any of that stuff. Now, they're doing it, and they're doing faculty education courses. They happen after hours, and they're having them about once a month.

Jennifer: Okay.

Dr. I: I think the one that is coming up soon is called "Dealing with the Difficult Patient." Others are being able to give bad news to patients and their families, etc. So, the School of Medicine is trying to educate faculty about communication with patients and families. No, there *were* no courses, but there *are* now. I think that some of the

clinical skills that they're teaching the students—again, how to deliver bad news, how to deal with a difficult alcoholic patient, or somebody that's on drugs—so, I think that they're trying. I think they finally recognize we've gone from this paternalistic attitude where 'I'm the physician, and if I tell you something, that's how it is. You won't ask me any questions, and you won't question me about that decision. I'll tell you what you need to know. You don't have to worry about it. I'll take care of it.' From that paternalistic attitude to one where the patient is a willing partner in their medical care.

Jennifer: So, none of the courses even broached the subject at all?

Dr. I: No! Not back then.

Jennifer: Okay. I actually just have one more question for you, but before I ask it, I guess I need to know if you've heard of the terms, "biomedicine" and "biomedical model"?

Dr. I: Kind of, yeah.

Jennifer: Well, going back to the literature review and the students that I talked with and what not, biomedicine, or biomedical model—however you want to term it—is considered to be very reductionistic, very mechanistic, all science. I've read that it parallels the doctor working on the body to a mechanic working on a car.

Dr. I: Oh! Uh huh.

Jennifer: At the opposite end of the spectrum, we've got the biopsychosocial model, which is the ensemble. All of the levels are there—whole person centered—biological, psychological, and social.

Dr. I: Okay.

Jennifer: Well, biomedical is associated with physicians. Biopsychosocial is associated with nurses. Do you see that as a fair assessment as it falls out in practice?

Dr. I: Well, let me think about that…well, let's do this first. Let's realize that most nurses are women, and most physicians—at least, around here—are men. There are basic differences in personalities, I think, between men and women. Nurses, I think, have always been pictured as being the comforting, almost a mothering kind of an individual who recognizes the wife who just came in to see the husband has got a bruise on her cheek. Maybe, she got whopped around by somebody, and they point that out, and say, "Maybe, we should bring social services in to do a history and see if there are any signs of abuse." They're with the patient more than we are, too. Typically, having been in a predominantly men's field—although, that's changing. Now, a little over 50% of the medical students are women, but from the time I entered medical school, the physicians were men with some women. Men, I think, typically are not the mothering, 'How was your day, is there anything else we can get you?' type of a person. Indeed, it probably was more, "Okay. You've got a broken arm. We're going to fix it. Now, your arm is all better. You can go home. Oh, you don't have a home. Well, I don't know what to tell you." So, but, I think now, with more women entering the field, and with more of the emphasis changing from that paternalistic model to looking at more holistic methods of treating patients, I do think that's starting to change—maybe not as much as it should, but it is starting to change. And, we don't spend that much time with patients, particularly, the ones in the hospital, for example. We go in, we make rounds—and we might make rounds twice a day—but the first time around, we'll take the most time. The second time around is just to make sure things we initiated that morning are being taken care of.

Nurses, on the other hand, will have that patient for anywhere from 8 to 12, and sometimes, 16 hours. So, there is a much greater opportunity for the nurses to get to know the patient *as a person* and their families than there is for the physicians to do that. So, there probably is some truth to that, but I think the medical schools and the training facilities are really trying to instill in the physician that they need to be more of a person and not just a mechanic, as you pointed out.

Jennifer: I think some of that, and you went through this so maybe you can help me bridge that gap, but I was reading an article about getting through medical school. One of the scenarios was about going in to Gross Anatomy Lab for the first time and actually having to dissect a cadaver. The fact that "this person was my age; this was somebody's grandma; etc,"—the students that were interviewed in this particular article actually had to replace that individual with an appliance, let's say, just to get themselves through it and be able to remove themselves so that they didn't fall apart and could learn. Do you think that might represent some of that mentality or method?

Dr. I: I hadn't thought about that, but it's true. You know, you're exposed to such shocking things like the cadaver lab—the place smelled. IU has such huge classes. So, half of our class would have Gross Anatomy one day, and the other half would have it the next day, but we all ended up in the lecture hall afterward. You could smell who had been in Gross Anatomy because that formaldehyde smell just clung to your hair, your clothes. Yeah, you wore those white coats over it, but that didn't do anything. Nobody wanted to take their white coats home to wash them. You just hung it up. Nobody wanted to take them home and wash them with their own clothes, or take them to a Laundromat and have someone else smell it. It was gross! That's why they call it *Gross*

Anatomy. There is—you have to detach yourself. There has to be an emotional detachment from a lot of things. When you're coding a patient or when you're doing procedures to a patient. If you stand there and think, 'Oh my gosh, this poor person. I'm going to hurt them if I do this,' you'll never get it done. So, there has to be some detachment…compartmentalization…I don't know what it is so that you're not continually paralyzed by the feelings that could overcome you about what you're doing. There's no doubt that some of the stuff that you see in the operating room or emergency room can be just really gross, but you have to put it behind you and just keep going. So, I don't know. I guess you just don't think about it anymore after that, but you have to be careful that you don't turn into some kind of automaton and that you don't turn into some sort of unfeeling, unemotional robot taking care of patients. You know, we were always told that it would be absolutely unprofessional to cry in front of a patient or their family. Yet, when you go and talk to families, and the patient's not doing well, or the patient has died, it's hard to keep from crying with them. I've learned, over the years, that I think they appreciate if the tears are true. They are touched by the fact that you're touched by the death of their loved one in some fashion. Yet, you can't get so emotionally involved with every patient because it takes a piece of you every time one of them dies, especially if you've taken care of them for a while. It's…I don't know…I cry with my patients when their family members die. They send me notes, thanking me for taking care of them. I try to send a sympathy card if I know one of them has passed away, and the families really appreciate that. How much of a human being to be is, I think, what everybody has to figure out and how close to get to patients and their families. If you're not—that's part of the thing I've always thought has made it worthwhile is when you did

become an important part of that patient's life, or their family, and to be able to know that they've got kids and grandkids, or to know that they like this or that. Now, I'm giving up my regular patients to concentrate on transplant, and it has been very difficult. I've had patients who stood out in the hall and said, "Dr. [I] dumped me!" I'll tell them that I'll meet with them one more time, but due to constraints in my schedule—and I'd been preparing them for this—I'm going to have to turn you over to one of my colleagues, but I'll make sure everything is okay. It has been very touching. Most of them have been very understanding, but it has been one of the hardest things I've ever had to do because I've been taking care of some of them since 1980. So, a lot of them have been a very long affiliation, and they are sort of like family.

Jennifer: That's my whole life. I was born in 1980.

Dr. I: Yeah, tell me! Everybody has to learn how far they can go and how much they're willing to expose themselves. That's just part of life. You get out of it what you put in. It's a lot of stuff that is really hard to teach.

Jennifer: Yeah, I've heard it said that you can't really teach a bedside manner.

Dr. I: No, people either have it, or they don't have it. Or, they've been mentored, "Watch this." I've had students, or house staff, tell me, "I really like the way you did *this* or *that*." A lot of what I learned, obviously, I watched my mentors and liked the way the patient looked at them when they [doctors] took their [patient's] hand or weren't afraid to touch them in an appropriate way. They weren't afraid to shake the patient's hand or the husband's hand. There needs to be—humans want touching, and a lot of people aren't comfortable with touching. I don't know how they got in to medical school that way, but patients do well with touching—even patients on ventilators. You can go in the room and

talk to them softly and say, "It's Dr. [I]. You're doing fine." If you stand there long enough, you can even watch the heart rate go down. So, you know they're hearing you, or at least, there is some recognition that you're there, and they're responding to it. We need a lot more mentors to do that with our students and our house staff so they can see them interact with the patients.

Jennifer: Well, this has been very helpful.

Dr. I: Oh, I'll bet. [Laughs].

Jennifer: No, it really has! Thank you so much!

-- END--

APPENDIX J

Interview with Dr. J:

Jennifer: First of all, thank you so much for doing this.

Dr. J: My pleasure.

Jennifer: They're opinion-type questions.

Dr. J: Oh, okay.

Jennifer: I'll start out by asking you some media-oriented questions, and then we'll move on to more communication-oriented questions. Some of the questions may seem like they come out of left field, but I have a reason for asking every one of them.

Dr. J: Alrighty.

Jennifer: I would, first, like to know how you feel that physicians are portrayed by the media and whether you feel it's a fair portrayal, and why.

Dr. J: I think that in some media, it's very fair, and when we talk about media, I think there are several avenues. When you look at shows, particularly, on TV—if we call that one form of media—I think that there are some inaccuracies with that.

Jennifer: Entertainment-based, you mean?

Dr. J: I think there is some entertainment to it, but the bottom line is it's fairly good. When we talk about professional interviews, I think they do very good. When I talk about that, it's the written media, the television, and radio media. I think they get not enough background, but it's acceptable. I think, sometimes, with the written media, there's probably an opportunity to have it better explained, but I think they have a very limited amount of time, or space, in which to publicize it. I would say, on a scale of 1 to

10, I would say that physicians in the media are about an 8.5 to 9 if you would rate them at how accurately they are portrayed.

Jennifer: Okay. Now, how do you feel that the pervasiveness of contemporary media impacts your practice? Do you see it at all? Does it help, or hinder?

Dr. J: Run that question by me again.

Jennifer: With the pervasiveness of contemporary media, do you see that it impacts your practice at all? If you do, how so? Is it positive or negative?

Dr. J: Well, I can see it both ways. I think it predominantly gives a positive effect. Where I see it the most positively is with the Internet. Most of my patients come to me pretty much unprepared. They haven't researched what they're coming to see me about. Then, there is another group of patients who comes over-prepared. They've researched and read things that they really don't understand, but I like when patients have researched what their problem is, particularly, by looking at the Internet. At least, they have an idea about what they're seeing me about. I think that's very helpful. I also think that it needs to be, as I tell my patients, when you look at how to take care of things, medically, on the Internet, and you're not a medical professional, you need to read that and have your professional interpret it for you. Just like when I read something about investing, or banking, or real estate, that's not my cup of tea for lack of better words, I probably need to have a professional help with that as well. I think it's good for background material, and I think it's very helpful.

Jennifer: Do you have a particular website that you refer patients to, or do you just send them to Google?

Dr. J: No, I don't have any website. I don't use that as part of the mainstream of my practice. The way I usually tell them, it's based on what I do, particularly, and there may be someone, somewhere else, who does it differently. There are really no right or wrong reasons to do either of those. It's just what a particular physician is comfortable with and feels is best for that particular patient.

Jennifer: Now, do you find that patients who are coming in prepared, or over-prepared, are younger?

Dr. J: Yes, most of the time. Usually, it's the daughter or the son of an older patient who comes in prepared. It's not the patient. It's probably their family.

Jennifer: Okay. That makes sense. So, with that increased Internet access, would it be fair to say that patients of more recent generations are asking more questions?

Dr. J: Mm hmm. They usually come very prepared. I wouldn't say prepared like they're interrogating, but more prepared in the sense that when you tell them, "This is why we're doing this," the light goes on. 'Oh, yeah, I've read about that,' or 'I've heard about that.' It's not a foreign concept. I think that is helpful to them because, at least, then, for lack of better words, their nervousness of being around a physician—a lot of the concepts are foreign to most people—so, it gives them a comfort zone. Sometimes, it *makes* them a little bit nervous because if they've read one thing and are expecting one thing, and you tell them something completely different based on the clinical findings in their exam, it confuses them a little bit. I'd rather be able to explain those things to them and have them feel like they're *a part* of the decision process.

Jennifer: Yeah, because you have to know something about something in order to ask questions about it.

Dr. J: Right. Exactly.

Jennifer: Okay, I'm going to ask you a bit more communication-oriented questions now based on your own personal experience. The first question I have is actually based on some previous research that I did with some students at IUPUI. I don't know if you've heard of the movie, *Wit*, at all…

Dr. J: Mm mm.

Jennifer: I hadn't, either, until we watched in a class. The gist of it is Emma Thompson plays an English Literature Professor, who is diagnosed in the opening frame with Advanced Ovarian Cancer—Stage IV. She is treated at the university hospital of the institution where she has taught for years. The way that they approached this film—first of all, they filmed as if it was a documentary. So, she is talking to the camera as a character who goes through all this stuff. The academic doctors, who are treating her, can't see *her*. They just see her cancer and are treating her cancer. So, I watched this film with a handful of IUPUI students. I asked them how much experience they had, personally, with physicians in general—before we even watched the film—with the cancer treatment process, and I also asked them some additional questions afterward. I was trying to gauge perceptions. I was trying to see if this movie changed their perceptions about physicians, in any way, just based on the way this movie portrayed them. What I found was that it wasn't changing perceptions from positive to negative. It was actually confirming negative. So, that, coupled with *a lot* of the academic literature that I've read, the consensus seems to be that people feel physicians are bad communicators. So, I would just like to know how you respond to that.

Dr. J: Well, I think, in general, we have a tendency is to look at the patient as a disease process, and I've known that for a number of years because, I think—and it's not been something that I've brought to the mainstream in my practice because patients come and see me because they have a specific problem. You know, because you've got this problem, this problem, this problem. What I try to do is to, in my experience, and why I have my patients come to a different kind of office—I don't have them sitting on a table, in a cold exam room. I have them come in here [consultation room], where we're all sitting around, talking about things. I feel, very strongly, that that gets missed. That is something—communication is so vital to the patient, and I've heard this comment many, many times. "Well, I'm just a lung cancer," or, "I'm just a gallbladder." Even during my residency and medical school, "Oh, that patient we did the gallbladder on the other day." You become your disease process. Well, I take that personally because I think, "Well, I wouldn't want to be somebody's gallbladder. I wouldn't want to be somebody's heart surgery. I wouldn't want to be somebody's lung transplant or heart transplant." I'd want to be that person who needed that particular procedure. So, the way I see it—and I may be unique in that respect—I like talking to patient about all aspects of their life, and I tell them, "Well, you brought this issue. Here is what we've got, and here is how we deal with it," as opposed to, "Well, you've got lung cancer, and here is how we're going to take care of it." So, right away, it gives you the opportunity for the patient to feel relaxed. I don't start the conversation with the patient by saying, "Tell me about your lung cancer," or, "Tell me about your aortic valve problem." I usually say, "Well, what brought you here to see me today?" So, what I do is I let the patient communicate to me, and it's very interesting how the answers come. "I've got this valve problem; I've got

this spot on my lung; I don't know—Dr. So-and-So said to come see you; well, it started three months ago." They can tell you a story. So, I try, in my own practice, to avoid using that doctor-type term, 'she's a lung cancer; he's a heart patient; she's this; he's that' because, yes, that's the disease process they have; but it's not the way you should think about your patients. I may be unique in that respect, but I do know there are a lot of physicians who will not remember someone's name, specifically, and the way that we communicate with each other—"You know, the patient in bed such-and-such that's got the lung cancer?" "Oh, yes," and that's how we communicate to each other because that's how we remember them. The part I like to do is I like to go that extra step and realize they are people with feelings. If you take them away from their disease process, you can delve into so much more about them, and they will open up to you. If you're just a spot on the lung, or a valve problem, it's one-dimensional; but if you say, "How did you get to come see me today? What brings you here? How are you doing?" You know, one of the things is if you let them communicate to you, the process is so much better.

Jennifer: I know what you're saying. In communication, it comes down to what they call 'labeling.' I've done some papers in regard to mental illness, too. One of the points I made in one of the papers was that if you *have* something, then, you feel like you can control it. You can *have* schizophrenia; whereas, if you *are* schizophrenic, what can you do?

Dr. J: Right.

Jennifer: It becomes your identity.

Dr. J: Exactly. Precisely.

Jennifer: We're on the same page, here.

Dr. J: We are. Exactly.

Jennifer: Okay. Well, personally, when is it that you feel that your communication with patients is successful? By that, I mean what are the successful components of that conversation, or series of conversations?

Dr. J: I think, for me, it's when the patient is given an open-ended question, and they express themselves. That's one. It gives me, 'Okay, this person knows what is going on, is very logical, and very sequential.' Two—when, after we've done all of the exam, and I've reviewed everything with them and explained things to them, from a medical perspective. What I like to do is I like to talk in common terms, and then, I usually tell them specific terms. For example, "You're going to have this procedure," or, "This is what you have, and it's one of the types of this problem." The reason I do that is to allow them—and I usually say in a relaxed manner, "Well, I wanted to let you know that I know how to use big words, and I graduated from medical school," because I usually try to put it in terms that they can understand and try not to talk down to them. Right away, I think I get a communication going. When I *know* I've communicated well to them is at the end of our interaction, I'll say, "Now, tell me what questions do you have for me?" That's the time for them to ask. Usually, they're very appropriate, very insightful. You know, "What if you find this?" Sometimes, I have to repeat, and it's because they're overwhelmed.

Jennifer: Right.

Dr. J: As a surgeon, the thing that I see as when the patients are most receptive is when they leave my office, after our consultation, and they have this sense of understanding.

'We have to do A, B, C, D, E, F, and G. Then, we're going to have surgery on this day. This is what he's planning.' When they can repeat the process back to me,

Patient: "Now, let me get this straight doc. This is what we're going to do?"

Dr. J: "Yes."

That's how I communicate with the patient and with their family. I always will communicate with the patient first and directly. Then, with the direct next person in line, which may be a spouse; then, with the next person in line, which could be a child. When I tell people about their office appointment, I like other family members to be here because that gives me feedback—that, yeah, I've communicated that well to them. So, those are the parameters that I see—*and* if the patient asks me questions that are kind of really direct like what kind of car I drive, well, that's just them trying to relax themselves in a situation in which they're uncomfortable. So, I don't view that as inappropriate.

Jennifer: Okay. Well, that's good. Now, by the same token, are there times when you have felt your communication with patients is unsuccessful? Is there something specific about that you could pinpoint?

Dr. J: Mm hmm. The way I look at it is when I get what I call, "You have to drag it out of them." Every single question—"When did this start?" "I don't know." "*How* did it start?" "I don't know." Then, I usually have to say, "Now, wait a minute. This has all been going on." So, when there is hesitancy on the part of the patient; and they may really not plainly know. Or, they think I'm asking for a date, 'It happened 3 weeks ago, Tuesday, at 2:00 in the afternoon.' All I need is 'about 3 weeks ago.' It's relative. The one I get concerned about is when, after I've completed my discussion with the patient, they either have no questions, or they give me this nonverbal communication like they

don't understand. Or, there is not an affirmation from them. How I deal with that is I usually go,

Dr. J: "You're pretty clear about this? What we're going to do?" I usually ask them another question.

Patient: "Oh, yeah."

Then, they walk out and forget what they're supposed to do. A lot of times, when I see that particular type of response, I usually say, "I'm going to have you come back and see me after these tests that I want done, and we're going to go over those again with you. Make sure that you bring your questions with you, and if there's any other family that wants to be with you." Maybe, what I'm seeing is only one person, and he's not going to tell the wife, or the sister, or the daughter, or the brother, or anybody else about what's going on. When I tell them, "I'll see you again," it gives me another opportunity to make that impact because it may be a bad day for the patient. Who knows, he might have had a fender bender on the way in. It may be a way in which I'm talking and communicating with them, and the third thing, if they have questions, I'd rather them be asked before we do a procedure than afterward. So, it's a way I kind of check that. It's amazing the next time they come back in, they bring a significant other, one or two children, a neighbor, or somebody else who is much more verbal in asking questions. It may just be the patient's *nature* not to communicate.

Jennifer: That's true. Alright. Now, were there specific courses that you took, in med school, that dealt with doctor-patient communication?

Dr. J: No. We took one course on doing history and physical during our second year of medical school. That was the first time that we had interaction with patients. For some

medical students, it's very uncomfortable. You have to ask very detailed questions about everybody's system known to man, and if you're asking a female about certain female conditions, that may be very uncomfortable for you. If you're a female asking a male…it really breaks down that barrier. From the standpoint of communication, there weren't any that said, "Here are the best techniques that work." It really leaves you open for your own style. To answer that, no, there's not really something that tells you how to ask questions. They kind of help you, but still, you're given a card with all these questions to ask. Some people just go down through the check-list of 100 questions, and ask you, "Do you have any problems swallowing liquids? Do you have any problems swallowing solids?" It's a very rigid approach to it, without being flexible. Most of the things that we learn about communication with patients is having done it over and over and over.

Jennifer: Trial by fire?

Dr. J: Mm hmm. Exactly.

Jennifer: Did you have situations where you had mock patients?

Dr. J: No, these were real patients that were in the hospital. They said, "Yeah, I'll talk with a medical student." So, you'd go in there and sit down with them, and they'd tell you their life history because they're waiting to get a procedure done, or testing, or something like that.

Jennifer: Okay. Were you supervised doing that, or was somebody just grading the responses you were able to get?

Dr. J: They were a combination. They would come in and listen to you for 5, 10, or 15 minutes—or however long. Usually, you had an hour with the patient. There were usually four of us in a group, and one staff doctor assigned. So, they would start out with

different ones of us to see how we opened and closed the conversation. Sometimes, they would just walk in in the middle and sit down. It was pretty free-flowing.

Jennifer: So—and I've heard different scenarios explained to me—so, did the staff doctor do their own interview as well?

Dr. J: No.

Jennifer: Oh, okay, because I've heard situations in which the first person who goes in gets a little information. The second person who goes in gets a little *more* information. By the time the attending is in there, he's got it all.

Dr. J: Right, and that's how it's done when you get further in to the clinical aspects of it; but from the initial interviews that we did as second-year medical students, it was the way you approached. When you're a junior, you learn how to ask questions in a more succinct manner, and more focused, because they [patients] were complaining about something, and you were trying to rule out, and figure out, that particular symptom that brought them to the hospital. And, you're right. A senior staff doctor can usually decipher that pretty quickly.

Jennifer: Okay. So, you learn techniques later on to get the patient back on track.

Dr. J: Mm hmm.

Jennifer: I know how conversations can go.

Dr. J: One of the best things that I learned—that I didn't learn in medical school—was advice that I received from a very elderly physician when I was young. He said, "Listen to your patients, and they will tell you 85% of what's going on with them. The rest of it, you'll pick up with an exam or with a diagnostic study." Most people will tell you, and the real *key* is to get the patient to communicate and tell you what's going on.

Jennifer: Okay. Yeah. We're down to the bottom. Before I ask you this last question, I kind of have to know have you heard the term, "biomedicine," or have you heard about the biomedical model in any way?

Dr. J: No.

Jennifer: Okay. Well, a lot of—again, this is media—public and even a lot of the literature that I've read. They discuss the biomedical model, or biomedicine—however you want to think of it—and they talk about that in terms of it being very mechanistic, reductionistic, scientific-oriented only. I've seen the parallel that the physician approaches the body as the mechanic would to a car.

Dr. J: Mm hmm.

Jennifer: On the other end of the spectrum is the biopsychosocial model which is basically everything—the biology, the psychology—the humanistic side of medicine, basically.

Dr. J: Okay.

Jennifer: Well, physicians are the ones associated with biomedicine on this end, and nurses are the ones associated with biopsychosocial on this end [gesture]. Do you see that as a fair assessment, or as the way that it actually plays out in practice?

Dr. J: I think it does. I think, when we look at the way patients are viewed, it's most of the time, on the biomedical end of it over here. What symptoms do you have? What diagnostic study do we order? What do we do with the tests? It's very logical-sequential. The nursing model—they [nurses] want to know what disease process they [patients] have. Part of what they [nurses] do is they look at, 'Gee, how does this impact the patient as a whole?' When you have someone with a diagnosis of cancer, there is a part of this

that has to be empathetic. The other part that you have to realize is the physician spends a period of time with the patient. The nurses spend a much larger period of time with them, doing their vital signs check and seeing the patient by responding to call lights—more of the "Can I get you something?" They are more nurturing, if you want to use that word. Then, when physicians come in, we say, "Okay, this is post op day # 2. We need to do this, this, this, and this. Is there anything we can get for you, or do?" Then, the patient lays there, in bed, afraid because I think, a lot of times, the patient is afraid to voice something. They may be either afraid of the response, don't know *how* to communicate with somebody like that, and for goodness sake, they're not in awe of us. We're just regular people. One of the things that I see, and how I've modeled my practice, is really different than most people. I'll tell you why. I think that the worst way to communicate to a patient is to put the patient a defensive posture. They're in a gown; they're on a cold table; they're in an examining room. The physician walks in—white coat, suit coat—dressed. So, there is constantly—for lack of better words, you have the naked person vs. the fully-clothed person. So, what I like to do is I have the patient come to a consult room and sit down. We're both on the same level. They're not sitting on a table, and I'm not standing up, looking over them. We communicate. Then, we go to an exam room, where I examine them. Then, when, they get dressed, we come back and sit down, and we go over *all* the information and outline what I think we should do. What it does is it gives you the ability to take away this white coat image that people clam up to sometimes. They're afraid to talk to us sometimes. "Oh, my god. This is a doctor." The other part of it is that being a specialist is different than being a family doctor. A family doctor is someone that, over time, has grown to know you, and the communication skills

might be different because you see him at soccer practice, at baseball, at church, at the PTA, at the grocery store out in their local community. It has kind of taken away that mystique of "that's the doctor." Even to this point, when I go home, to my hometown, there are many, many people who just don't know how to speak with me because I'm some "big Indianapolis heart surgeon." To me, I'm just a regular old guy. So, that's what I do and feel is important to portray that. When you have the ability to say, "This is what we're going to do. This is why we're going to do it, and this is how it's done," and put on the heavy-handed doctor thing, people respond to it. They understand. Suddenly, we're not goofing around. When you can have a conversation with them, and learn a little bit about them, and make them feel at ease, I think you get a lot further with them. That's why, when I see patients, I have to figure out—when you're in a specialty situation—how you can better communicate with the patient, get the responses that you want, gain their confidence in you. They *love* their family doctor! They *love* that doctor who has been treating them for 50 years, or 30 years, or however long. Suddenly, you're seeing somebody who, when you walk in for the first time, they're telling you you need a major operation. That puts a lot of people into a spin. So, the way I look at it is the first time I see them is the "get over it." They learn what we're doing and that we have to take care of this problem. You have to give them the confidence that they're making the right decision by having something done. The second time I see them, before their operation, is to answer questions—anything that has come up because what happens, a lot of times, is people leave your office. They go home. They talk to a neighbor; they talk to a friend; they talk to a son or daughter; they get on the Internet. They check things out, and then, they want to come in and ask questions. So, instead of—trying to avoid the telephone

conversations—I just have them come in for 10, 15, 20 minutes, sometimes a half hour. We sit and talk about anything that's on their mind. So, it gives them the confidence and the ease in which we're going to take care of them. That's just the communication skills that I've developed over the years. I have to admit, I think a lot about this because I see the mistakes that physicians make in dealing with the patient. When I sit here, and I listen to people, you find out about all your colleagues' mistakes. "Well, he doesn't talk to you like this. I want to come to you as my doctor," because somebody doesn't talk to them in a certain way. It's interesting.

Jennifer: Okay. So, they just feel that they get better information from you?

Dr. J: Mm hmm.

Jennifer: In a more understandable fashion, I guess?

Dr. J: And, I think, just taking it away from that very sterile, "I'm the doctor. You're the patient," environment to, "Hi, I'm just a regular guy, here. This is what I do. This is why Dr. So-and-So sent you to me. Here's how we're going to take care of it." It gives them a bit more relaxed attitude, maybe, and they ask questions.

Jennifer: I would think that it would be different inpatient vs. outpatient.

Dr. J: Mm hmm.

Jennifer: I know that one nurse has to take care of three patients; whereas, one doctor may have to take care of three times as many, right?

Dr. J: Well, when you're inpatient, there are—when you assess inpatient, and it's very interesting—because this is something I've looked at. Every day, when you make rounds, every patient has a different need. Some patients never need anything. "I'm doing fine. Thank you very much. See ya. When are these tubes coming out? When is

this happening?" They don't need the coddling, as I call it. There are some that, every day, you need to sit down and just spend 15 minutes with them, and they ask you the *same* question. After a while, I'll say, "Well, now for the seventh time that you've asked me this question…" I point it out to them that I realize they're asking the same question, but I think it's their nervousness about interacting with a physician.

Jennifer: I was going to say, is that medication-induced, or what?

Dr. J: No, no. This is usually family that asks the questions, but I learned a long time ago, when you make rounds, there are always going to be one or two patients a day that need special attention. It may not be the same patient every day. Part of my routine in dealing with patients in the hospital is some days, you just go in, and it's all doctor business—what I call directing the daily nuts and bolts care. "Take this catheter out; do this; check this; order this." Sometimes, it's very succinct. It's that biomedical model. Then, during that hospitalization, one day, I'm going to walk in and have more time to communicate about other things that are going on with them. I find that communication to the patient, in the hospital, if you sit down in a chair, or on the bedside, and you talk to them, they will think you've been there for an hour talking to them if you've been there for five minutes.

Jennifer: I've heard that.

Dr. J: So, what I do is I try to make a point that, in my mind, I know which one is going to have the 20 minute conversation about what's going on at home, and what their appetite is like. You kind of make it your visit for them. There are others, where you just need to be the doctor, and say, "This is what we're going to do A, B, C, D, E, F, G," and that's all they need. So, that's something I learned very early in my medical school

career because I watched another physician who had that same pattern. I like that pattern. If you *sit down* to talk to the patient, they'll think you've been there *all* day. If you're standing by the door, and you never put your hand on the door handle, and you always walk completely into the room. For example, here at Methodist, what I'll do when I walk in, if they're sitting in the chair, I'll sit on the edge of the bed and talk to them. Or, I'll sit in the chair across from them, but always, if I'm going to have a conversation, it's going to be the more time spent with them—what I call the communication time—I sit down. It's amazing the response you get from that.

Jennifer: All in the perception, right?

Dr. J: Yep. That's all it is.

Jennifer: Well, thank you for this.

Dr. J: You're welcome.

Jennifer: Is there anything else that has come to your mind that you want to say?

Dr. J: No. I hope this helps you.

Jennifer: It does.

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APPENDIX K

Interview with Dr. K:

Jennifer: Thank you very much for doing this.

Dr. K: You're welcome, Jennifer Marks.

Jennifer: Some of these questions might seem like they come from left field, but there really is a reason for each one of them. I'm going to start out by asking you media-based questions. Then, I'm going to move on to more communication-oriented questions. I would, first, like to know how you feel physicians are portrayed by the media and whether, or not, you feel this is a fair portrayal. I do understand that people have different forms of media that they watch.

Dr. K: I think it is not physicians being portrayed. Media is after stories. So, if there is a hot story, whether it is good or bad, they'll portray it. So, if that hot story turns out to be demeaning to a physician, or physician group, then, they will run with that story. That physician group might argue, 'Okay, they are not portraying us appropriately.' At the same time, if they have a good story to run with, that is a hot story, they'll run with it. That might portray physician in a good light. For example, if you look at overuse of stent by Maryland physician, it was all over the newspaper that that physician placed nearly 30 stents on a particular patient. So, that was a hot story—overuse of stent—they picked up; they ran with it. A lot of discussion in various media outlet—newspapers, television, and everything on that; and that portrays physicians as a greedy group of people trying to make money doing unnecessary procedures on poor victims.

Jennifer: Right.

Dr. K: At the same time, you also get stories like how the lady, mauled by a chimpanzee, and lost all of her face, got a new face transplant. She got a second look at life. Now, that also was in the media, and if you look at that, then you will think the doctors are miracle workers. So, media doesn't run with physicians. Media runs with a story. If that particular story highlights physicians in a good way, then that will turn out to be a positive thing for the physician. If that particular story highlights a particular physician, or physician group, in a bad way, then that story—you know, you can argue that it puts a negative light on physicians. So, my feeling is that media doesn't run with physicians, or portray physicians. They portray stories, and those stories—depending on what kind of story it is—will reflect on physicians—good or bad.

Jennifer: Okay. I can see that. Now, I'm curious. Have you ever had a patient come to you and expect their medical course to take a certain path because they've seen it portrayed that way on one of the medical shows, like *House* or *Grey's Anatomy*?

Dr. K: Yes. We will have few patients who have heard few things on the Internet, or they'll have a certain expectation they come up with and see if we can do it. Yes, by all means, they pick me out on the Internet because I specialize in few things, and certain devices I use. So, they come down, expecting exactly what was given out on that particular website on the Internet. So, yes, patients do come to me, expecting a certain kind of outcome or certain kind of things, which they have seen.

Jennifer: Okay. Is there any other way that you feel the pervasiveness of contemporary media impacts your practice? Does it help, or does it hinder?

Dr. K: Media is how we use it.

Jennifer: So, you feel like you're in control of media?

Dr. K: No, no, media is how you use it if you want control. For example, for a long time, physicians never were in the media for any reason, mainly, because it was considered to be a noble profession—not a business. So, physicians never were allowed to advertise themselves. Physicians never were allowed to portray themselves as the best, so on, so forth. So, for decades, physicians never were involved, directly, with any advertisement or media. The hospitals might if they do a fancy procedure, but the physicians as individuals, or groups, never portrayed themselves. It's usually the hospitals if there is a major, important new procedure done—the first of its kind—they will, then, give it to the news media. The news media, then, will probably introduce to you the physician, but the physician portraying themselves as the best—that's never happened and still doesn't. Whether that's good, or bad, I don't know. The way medicine is going on, it's moving into being run more as a business enterprise. So, if that is the way we're going to go, then, involving the media—taking advantage of media—is essential. I don't think we put media to its best use. Hospitals might, but physicians don't put media to its best use at all.

Jennifer: So, how would you change the physicians' use of media? How would you make it better?

Dr. K: Are we going in the direction, is the first question we have to ask ourselves. In other words, are we going to go and say, "I'm the best physician to do this,"? Like how Ford runs its car, or a hospital claims it's the best hospital. Is a physician going to go and say, "I'm the best interventional cardiologist,"? I don't think that we are currently in a situation, where we are going to be like that because we are not God. We all have a basic level of education that, I think, speaks for itself, and we don't go and portray ourselves

like lawyers and other people. I don't think that those days are here yet. So, the way I say physicians should take care of the media is to advertise what they do.

Jennifer: Mm hmm.

Dr. K: My feeling is, for example, a patient needs to know who the physician is. Many times, you don't know your physician, okay?

Jennifer: Mm hmm.

Dr. K: You probably can pull up his picture to see how he looks, or you have word of mouth. You never seen him, or heard his voice, or anything like that. So, I came up with an idea to tell people, how about if we have a 30 second introduction by the physician about himself and put it on YouTube for a patient to go and look at. It becomes part of their business card—just like your office address, phone number, email. Then, you have this YouTube site address. So, Jennifer Marks, then, goes and sees who Dr. [K] is. He says who he is, what his philosophy is, where he trained, so on, so forth. So, those things might be important for a patient to look at and see. When they come to the office, they do not get much time with the physician. They get lot time with other office personnel. Then, with the physician, they get about 15 minutes. They might have so many things they want to ask, but they only get 15 – 20 minutes. Then, they're gone. On that particular day, that poor physician was busy, running around. He/she happens to have added on a 15th or 16th patient he has to see. He may not be very patient in those 15 minutes on that particular day. Or, maybe, he has a headache, or his child is sick. So, that is the 15 minutes in which, on the physician, they [patients] make a judgment. So, having a place where they can go to, where they can look up and see him speak, hear his accent, let him tell about himself, so on, so forth—I thought would be beneficial. So,

physicians can take advantage of media like that. Physicians can highlight the importance of certain things they do, using media outlets. For example, they can have patient-related story, or take 1 – 2 page newspaper patient-related story about something they [physicians] have done which is important and impacts a lot of people. To help people understand—'okay, that patient had this; she underwent this; maybe, I have the same thing; maybe, I should go talk to him as well.' That, they [patients] can do. I think there are so many other ways, like this, that physicians can take advantage of the media. It doesn't mean they have to advertise *themselves*, saying, "I'm a better doctor than the other guy," so on, so forth. I don't think we'll ever go in that direction. I may be surprised. I may be wrong, but I don't think we will ever go in that direction. Physicians *should* take advantage of the media in these ways.

Jennifer: Mm hmm. Okay, yeah. I haven't heard anybody say that before. So, that's different. Now, with increased Internet access, have you noticed that patients ask more questions now than they used to, in previous generations?

Dr. K: Yes—good and bad. Some of them are legitimate, relevant information, but Internet has a lot of—for lack of better word—junk in it. You can never really find a source. So, I have people who have strong beliefs that statins are harmful, and they come in and say, "I read about this, here. I don't want to take a statin." You know, statins are cholesterol medications.

Jennifer: Yeah.

Dr. K: They have a proven beneficial effect. At the same time, they [patients] won't take this; but if you look at the medical list, they'll be taking about 15 herbal medications, or vitamins, or ancillary medications, which have not been shown to have any value. If any,

they might have a negative effect, but they [patients] are more comfortable taking those pills. They don't want to take a statin. That kind of information, patients print down, and come to me. Some of them will come up with relevant things to read. They'll say, "Doc, when I read about this, it says I can take this pill vs. this pill. What do you think of it?" So, the availability of information on the Internet has increased the level of questioning by the patients.

Jennifer: Mm hmm.

Dr. K: But, I would say, normally, the educated ones.

Jennifer: Okay.

Dr. K: The other group, who don't tap into this, they probably don't ask any questions at all, but the people who are educated, who are Internet-savvy, who have access to the Internet, or access to the media will read about these things. They will come up with questions about that.

Jennifer: Now, this is regardless of age?

Dr. K: Yes.

Jennifer: Okay. Do you have specific websites that you give to people? Or, do you just defer them to Google?

Dr. K: I just say, "Go Google it."

Jennifer: Okay. Then, to bring further questions back to you?

Dr. K: Mm—what I'll say is—I'll be the primary educator of the patient. So, I won't say, "Go read about it, and tell me if you have questions." No, I will educate them, but then, I'll say, "If you have still more questions, or if you really want to know about it more, you can always go look it up on the Internet." I'll tell them that *after* I educate

them. So, I am the primary educator of them. I'm the primary source of information for them, but I tell them to go look it up if they want more. If I'm doing procedure, like PFO Closure, or a new procedure I'm doing on them, I'll explain procedure to them in entirety. I'll be the primary source of information for them. I'll tell them the pro's and cons—everything. I'll also say, "You have Internet, right? Why don't you go look up what device it is? Do that, and if you have more questions, I'll be happy to answer them." *Then*, I say that, but I always put myself as the primary source of information for the patients.

Jennifer: Okay. So, we're going to move on to some more communication-oriented questions, now. Okay?

Dr. K: Okay.

Jennifer: Now, this next question is based on some of my own research that I did with students at IUPUI. I showed about 6 – 12 students the movie, *Wit*. Have you ever heard of that movie?

Dr. K: What is that? Remind me.

Jennifer: I hadn't heard of it, either, until I had to watch it in a class. It came out in 2001 and went straight to HBO. So, it wasn't in theaters, or anything. Emma Thompson plays a 17th century English Literature Professor, who is diagnosed in the very first scene with Advanced Ovarian Cancer. She is treated at the academic hospital of the university, where she has taught for years. The way that they approached that film—first of all, they filmed it as though it was a documentary. So, you had her character basically explaining everything that she was going through, and the way that they approached it was that the academic physicians saw her as an incubator. They were just really concerned about the

cancer. They weren't really acknowledging her as a person. So, I asked students how much experience they had, personally, with physicians or with the cancer treatment process via themselves, or loved ones, before we even watched the movie. Then, after we watched the movie, I asked them if their perceptions had changed based on what they saw and how it was presented to them. I did not find that perceptions were changing from positive to negative. What I found was that the preconceived negative notions were being confirmed.

Dr. K: Give me an example.

Jennifer: They weren't surprised by how the doctors treated her—that they were just concerned with the disease and not the person. I had students tell me that doctors, and medicine, are very mechanistic, reductionistic, and scientific, basically. They weren't surprised by what they saw in the movie.

Dr. K: These are medical students?

Jennifer: No, no.

Dr. K: What kind of students are they?

Jennifer: Actually, most of them were undergraduate communication students. One guy in that group wanted to be a doctor, and he had various doctors in his family. So, that, coupled with a lot of the literature review that I've done for this, it would seem that a lot of people regard physicians as bad communicators. I wanted your perspective on that. How do you react when you hear that people feel that way?

Dr. K: Well, several things, you know. There is an element of truth to it, but not in its entirety. That's how I'll answer the question. They're not bad communicators. They communicate bad news many times. Now, they also have to remain impartial, emotion-

free when they are dealing with a person who is dying, or has dangerous things. They have to find a way to be emotion-free, or impartial. That is how they are all trained. That is why you don't see a doctor crying when a patient is dying, or anything like that, because you're [as a medical student] being taught right from the beginning to handle this in a very impartial, detached sort of fashion so that you can still make relevant medical decisions on them. For example, let's say you're my friend. I shouldn't say you. Let's say somebody else is my close friend, and then I have to do a procedure on that particular person. If I am too emotionally connected, or too emotionally attached, because I know them 6 – 10 years, in my office, I won't be able to perform as efficiently as I would [otherwise]. That's why you don't see many doctors do procedures on their own family members. They usually give it to their colleagues or somebody else, because when they're attached, there are several things that might influence what they're trying to do. If something goes wrong, they'll never forgive themselves. They're trying to remain above this so that they can do this in a detached fashion, objectively, understanding that they are humans, and there is small percentage of chance that bad things might happen despite *best* efforts. They don't get too much emotionally caught up with that which can, actually, destroy their personal career. Let me give you an example. So, not you as a friend, but somebody else I give procedure to [do procedure on], and something bad happens on the table, and the patient dies on the table, or something like that. Then, what happens is that I won't be able to do my next one if I remain there because I will have to show the same thing again. So, what happens is that they're trained to be detached. Now, can they show little bit more emotion rather than remain straight-faced, like you see in the television shows of *ER*? They can be little bit more, but remember, physicians are

to some extent, taught to be like that throughout their 13 years of post-high school education. So, they are going to be like that because they feel that that is how they handle these situations and still go home and play with their kids and their wives—have a personal life—because they don't allow this beyond a certain barrier in their mind. Otherwise, they won't be able to live a lot because, everyday—let's take example of oncologist. *Every* day, he is going to see a person who is dying, or who has a bad cancer. *Every* day, that's what he's going to treat.

Jennifer: Mm hmm.

Dr. K: Now, if he carries that emotional burden home, he'll be a personal wreck. So, somewhere, he has to put a barrier where this doesn't penetrate. That is what they are doing. So, yeah, you would like your doctor to hold your hand and cry with you when he delivers the news that somebody has a cancer somewhere; but the problem is, he cannot. So, he is going to be as impartial, detached as possible, and he's going to deliver the news and say the scientific rationale behind how he's going to treat it. You cannot hold that against him. Now, if they are *rude,* and they come out as not caring, that is a different story.

Jennifer: Okay.

Dr. K: But, when you say, "bad communicators,"—say, it was major news for you. Say, you're telling someone they're HIV-positive, and you walk in and say, "You tested positive. Here, take this and go." No, that is being rude and ridiculous. So, you can expect the doctor to sit down and tell you, "Okay. The test came back positive. These are the ramifications of that. These are things we are going to do. This is the medical treatment I'm going to start. This is what you can look for." You can expect that, but

don't expect them to say this to you with emotions attached to it, or with a sad face, or cry with you because you're not the only person they're dealing with. They deal with people like you every day, and they have to go back to their lives, too. So, they have to have a barrier beyond which these scars don't penetrate. So, not truly bad communicators because you expect a chaplain there, and they [doctors] are not that.

Jennifer: Right.

Dr. K: They're not because they have to go back to their lives, too, and this is something they have to do day in and day out. If they are attached emotionally, too much, it becomes hard for them to function at a good, high level.

Jennifer: Yeah. Now, have you ever been in a situation where your facial expressions are saying more than you're feeling on the inside? Like, if you have to deliver bad news—so, at least, maybe the patient feels like you're experiencing it with them even if you're not? Does that make sense?

Dr. K: No, come again.

Jennifer. Okay. So, you have to deliver bad news. Obviously, you're not going to do that with a smile on your face, right? So, you have a sad expression on your face, even though you—I guess what I'm trying to ask is have you ever had your facial expressions convey more emotion than you actually feel?

Dr. K: Yes. We don't have a sad expression, but we have a concerned expression.

Jennifer: Right.

Dr. K: A serious face when we deliver news. So, yeah, patients do pick up on that.

Jennifer: So, the patients may feel a little more emotionally connected on their end than you do?

Dr. K: Yes, it could be. All I'm trying to say is that—you used the word, "bad communicators," and I was just trying to take issue with a global statement like that.

Jennifer: Oh, no, I understand.

Dr. K: Because, there is a much more accurate way. Everybody can communicate better. There is no doubt about that, but all I'm trying to say is that there is a reason they come off like this—with serious face and little bit detached feeling.

Jennifer: Oh, yeah.

Dr. K: Many physicians do have emotional feelings about patients, especially ones they've been following for long time. So, there is some emotional betrayal, if you will, on their faces sometimes. It does happen, yes. So, the patient may connect to that, especially if they have longstanding relationship.

Jennifer: Okay. I'm glad that you explained it the way that you did. You're putting a different spin on things. That's why I like to talk to different people because everybody comes from a different perspective.

Dr. K: I told you I'm expensive, Jennifer.

Jennifer: [Laughs]. I think I told you, "I'm sorry." So, personally, when do you feel like your communication with patients is successful? In other words, what are the successful components of that conversation, or series of conversations? Is there anything specific that sticks out in your mind?

Dr. K: Well, the key to success is that you have to understand what you are telling them. Number two, they have to have a certain level of trust in what you say. So, if you use simplistic language, and you paint realistic picture about what you are capable of, and

what you're not capable of, and you explain to them in a language they can understand, and there is mutual trust in relationship, usually the communications go well.

Jennifer: Mm hmm.

Dr. K: So, it is not the amount of time you sit and spend. It is these characteristics that I think is important.

Jennifer: Because you can make five minutes feel like half an hour.

Dr. K: Yeah, you can—you have to—those are the things: simplicity in language so they understand; painting a realistic picture of what can be expected and what cannot be. These are the important characteristics of how you communicate and how you get through. They also have a class II. Class II is based on your mannerisms—the confidence you inspire in them. Nowadays, many people talk to others before they come in. So, they do have a general idea of what they are dealing with and who they are dealing with—the expertise of the person. They have so many avenues to get that information before they actually come down. So, those are the three things that I think are important based on my experience.

Jennifer: Now, by the same token, have you ever had experiences where you felt your communication with patients was unsuccessful? Is there something specific you could point to there?

Dr. K: Yes. So, if they don't trust you, or if they are upset at something with you, or something like that—there may have been a delay in you seeing them, or something. Then, there is a barrier which you have to break through.

Jennifer: How do you go about breaking that barrier?

Dr. K: You just apologize for being delayed if you are delayed. If you are late, you are late, and you just say, "I'm sorry, but I had to do certain things," and, then, go on. If you ignore it, it would be like ignoring elephant in the room. If you're one hour late for your appointment, then, you can't expect them to carry on a conversation with you without saying anything about it. No, they would like to hear that and, then, go on. Usually, I give them a free parking or meal coupon, or something to ease their discomfort, if you will, of having to wait long. So, I tell my office personnel to do that. If there was a person that I couldn't do [a procedure on], and I have to send them home, I tell the Cath Lab to send them flowers—something, a token. That's all you can do because you cannot foresee the emergencies that come in, and they [previously scheduled patients] get thrown to next day, there is nothing anybody can do about it. If they [same individual patients] happen to come in as emergency, the same thing would happen to them as well. They get moved to as an earlier case than these people [previously scheduled patients]. There is not a lot you can do about it, but you can apologize for making them wait. I think that is perfectly human etiquette. Just because you apologize doesn't mean you are demeaning yourself, or anything like that.

Jennifer: Oh, no.

Dr. K: You just say, "Look I'm sorry, but this took my time," so on, so forth. I do not say *that*. Usually, I just tell my office staff to send them flowers, and that usually makes up for it. The next time they come in, they are usually apologizing for their bad behavior. We can all have bad times. Sometimes, when there is a lack of trust in what they see you as, and there is lack of relationship there, then, yes. There is not a lot you can do about that.

Jennifer: Does it just come down to personality?

Dr. K: Yeah, and you have to realize that, sometimes, the communication will become difficult. Or, some of them [patients] will have pre-conceived ideas about not wanting to take a pill; not wanting to get procedure done; telling, "I don't know why I'm here, doc. I really don't know." There are patients like that, and there, they have already have a veil that you're not going to pierce. It may not work. You try your best. I usually say, in that situation, "There should be a reason why you say 'no' for this particular procedure. In your particular case, it certainly looks like it would be beneficial. Is there any reason you don't want this to happen, or is there anything else that can help you to make this decision?" I will put an open-ended question, like that. Then, sometimes, things will be—I won't say 'silly'—but it will be pure emotional reason, like, their mom had the procedure and died from the procedure. Or, the brother had the same procedure and died from the procedure. It may be a reason as simple as that for them to say, "Absolutely not," and you're not going to pierce that. So, it's worthwhile delving on that, for some time, trying to figure out, but sometimes, it's just impossible. You can't do much about it.

Jennifer: Okay. Were there any specific courses that you took, in med school, that dealt with doctor-patient communication?

Dr. K: No.

Jennifer: No, none? Okay.

Dr. K: There are some when you do your residency. There are some courses, where they will tell you, predominantly; but, usually, medicine is not about classroom. It's about

you watching the physicians you train under interact, on a day-to-day basis, with various patients. So, it's an educational experience, but you're observing them.

Jennifer: So, would you—

Dr. K: But, to sit down and talk about relation, and have them direct you, "This is the best--" in residency, maybe, we had one class, or something, but not in medical school.

Jennifer: Now, when you were a resident, you said you did the mock-up?

Dr. K: There was some of it. I forget the name of that course, where you have a light rotation, and it was part of that. That's also, mainly, because I trained in New York. We had a very multicultural patient population. So, some of these things were physicians learning to respect individual patients' wishes, so on, so forth—even if it was completely contradictory to their belief. It's just like Jehovah's Witness refusing blood transfusion. Now, that is not incompetent behavior or incapable of thinking. It is just that is what their belief is. It's the same with other cultures, and everything. So, in order for that, we had these courses. Other than that, in medical school, per se, no.

Jennifer: Okay. Okay. Now, I've just got—you know, you almost actually answered this one when you were discussing the bad communicators because when you asked me for an example of what the students, who watched the movie, were responding to, and what their negative perceptions were. When I talked about how the students explained to me that physicians were mechanistic, reductionistic, and scientific, that's basically how biomedicine, or the biomedical model is described. Have you heard of biomedicine, or the biomedical model?

Dr. K: No, explain that to me.

Jennifer: Okay. Well, essentially, when they talk about medicine, they basically break it down into healthcare models in the literature. So, on the one end, you do have the biomedicine, or biomedical model. On the opposite end of the spectrum, is the biopsychosocial model. Biomedicine is really concerned with the science. Biopsychosocial, as you might guess, is concerned with the humanities, and the sociology involved in dealing with medicine. Well, not only in the literature, but also from the students I talked to, physicians are associated with biomedicine; whereas, nurses are associated with biopsychosocial. Okay? So, the two models are presented as very polarized: biomedicine over here and biopsychosocial over here [gesture]. Basically, science is over here, and all of the caring is over here [gesture]. Do you see that as accurate?

Dr. K: Not at all.

Jennifer: How do you feel that it comes across, in practice?

Dr. K: I don't know who came up with this model, or how they got it—that nurses are caring and sympathetic, and these other people are scientific. No, the problem is the roles are very different. For nurses, during a 12-hour shift, will have their own 3 – 4 patients. That's all they do—answer the phones, bring them food and a smiley face, probably give them a sponge bath, or feed them, so on, so forth. They sit down with the patient. That's what the roles are. So, naturally, they come across as people who are listeners. They have empathy, so on, so forth. A physician has about 100 patients. He comes in the morning, discuss for about 10 – 15 minutes with them, and he's gone. So, their time with them is limited, but these roles are what they are. So, to use that as—I can understand why their comments—but there is not a lot of truth to it because physicians can be, and

are, usually, as sympathetic and as caring as others as well. In their limited time that is available, that is all they can do. You see why it comes up. For instance, look at this gentleman. You saw him sitting down—you can turn around and look now—so this person is going to take this gentleman from the Cath Lab region all the way to the car, and he's going to wait for it to load up. On the way, he's going to have a pleasant conversation. They're going to talk about soccer, football, baseball, NBA, tennis—whatever—they'll do that.

Jennifer: Mm hmm.

Dr. K: Because they have nothing else to do. That is all in that 15 minutes he's going to spend. So, naturally, if the guy is a nice, chatty person like that, it will leave impression on the patient. You know, this guy was a nice guy, so on, so forth.

Jennifer: Mm hmm.

Dr. K: But, the physician, in the 15 minutes he has to give you—you don't want your physician talking about baseball, football, everything else—he [patient] wants you [physician] because he [physician] is only with you [patient] for this length of time. He [physician] better focus on you [patient]. That's the way he should see it. So, in that 15 minutes, he'll [physician] tell you what he has to tell you and do it to the best of his capability. So, the roles are different. To ask them who is who is very different. If you take 100 doctors and 100 other people, with the patients, doing the same thing for at least 12 hours. *Then*, you ask them who came out better. Then, if they say, "These guys came out better," I'll accept that. No, here, you are taking a biased opinion because physicians spend about 10 minutes; whereas, the other person spends 12 hours for 3 days, but this guy [physician] only sees them 5 – 10 minutes a day for 3 days. It's natural for others to

communicate that these people [nurses] are more caring. That is what they are expected to do. So, you want your doctor to be not only caring but also to treat you, and so forth. So, there is an additional expectation out of physician. It's different.

Jennifer: No, I agree. I, actually, *don't* agree with the way it's framed, but I couldn't just come out and tell you that. I wanted to know what you think.

Dr. K: That is why the difference is. That is why I say it has got to be a teamwork. For example, if you come to my office, you will like my coordinator better than me. My patients like my coordinator better than me. They will say, 'hello,' and everything like that because she's the face of my practice. She'll spend 20 minutes on the phone with them about the dog that died last week, the medications, and the boat trip that's coming up and the fishing trip they're going to take. She talks about all those things politely. She sits and listens to them, so they establish a rapport with her. The 20 minutes with me is all about how they're going to stop smoking, start exercising, do this, do that, what I'm going to do, so on, so forth.

Jennifer: Now, do you have patients who try to small talk with you?

Dr. K: Yes, and I *do* small talk with them, definitely, but I cannot do like her [coordinator] with everybody because, then, I will not have time to do the rest of my job. Right? What do you like me to do? Small talk with you, or take care of your dad? You tell me. So, I understand why they feel that way. I think it's natural for them to feel that way. That is why I feel it has got to be a teamwork. So, it is a circle. The physician directs it, but what I cannot do, I will outsource it to other members of my team who have the time and ability to do that. So, I have my Physician's Assistant doing certain things, my nurse doing certain things, my secretary doing certain things. So, as a team, you have

the entire package for the patient so the patient feels, "I have somebody when I call, I talk to. I know that person will communicate with my physician, and my physician will communicate with her. Then, she will talk to me." That is why I like that. So, my feeling is there should be a team presenting themselves as a package, where people, who have time, will spend more small talk with the patients. They will establish a rapport, so on, so forth, and you have an efficient physician team doing many things for them as well. So, imagine if you put that as a team, then, you have a very successful combination. Now, that is what I have believed in, and I pick and choose my team carefully. So, you will find some of the people who work on my team have different qualities and characteristics because I do outsource some responsibilities to them, and I don't feel bad about it. For example, if somebody likes my coordinator, I am more happy.

Jennifer: [Laughs]. One less thing you have to do, right?

Dr. K: Exactly.

Jennifer: Can you see a difference, or foresee a difference in patient perception, from inpatient to outpatient, as far as time with you?

Dr. K: You've got to expand on the question. I don't understand.

Jennifer: Okay, well, if someone is an inpatient, they're probably going to see you for fewer minutes at a time than if they come to their appointment with you in the office, correct?

Dr. K: As an inpatient? It can happen both ways. I have more time if they're here. They are sitting down, doing nothing all day, and I can go there. It may not be the same, but yes, to some extent, but go on, finish your question.

Jennifer: No, I was just—in a lot of other interviews that I've done, people seem to think that patients have more time in the outpatient setting rather than the inpatient setting. So, I just wondered if you saw it in the same way.

Dr. K: True. So, you're saying they'll have more one-on-one time as an outpatient rather than as an inpatient.

Jennifer: Yeah.

Dr. K: Depending on the nature of the problem or the situation. If a person is over here, and they come down with gas-related chest pain, and I know it's nothing to do with heart that is going on; then, the next day, when I round on them, I say, "Mrs. Jones, you're doing very well. You have no issues with the heart. I'll see you in my office in 4-weeks' time." That's all they're going to get. Whereas, as an outpatient, if they come in, they're going to get that 10, 15, 20 minutes. So, that is true, but there are certain procedures I do where I sit down with the patient and the family for nearly an hour, sometimes, answering questions. And, then, I come and see them*, again*, the next day to answer questions, so on, so forth. So, it's hard to generalize. For simple elements, the answer is true, but as the complexity of what I'm going to do increases, I'm obliged to sit with the patient and family to get them all on the same page before I do anything on them. So, I do spend a lot of time with them, then.

Jennifer: Those are, actually, all the question that I do have, and it has been very helpful for me.

Dr. K: You're welcome.

Jennifer: Now, is there anything else that you would like to add that has come to your mind as we've been sitting here, talking?

Dr. K: Not really. So, what are going to do with this? What is this for? What is your thesis title?

Jennifer: Well, really, it kind of started as a way to kind of change the frame of biomedicine because you heard how it's portrayed in the literature. I see biomedicine as overarching and biopsychosocial as a branch of that. I see them as more integrated than the literature explains them to be. So, I decided that, instead of, talking to more patients and asking them how they feel about doctors, and why—the literature is filled with patient perspective. It's not quite as filled with physicians' perspective. Now, granted, I'm not going to change the world with the few interviews that I'm doing—laughs.

Dr. K: It all starts with a village.

Jennifer: But, it's just my small part to offer the perception of people—physicians, who are on the front lines of medicine every day. Instead of people, sitting around in classrooms, talking about doctors—I work with them, so I decided to talk to them.

Dr. K: Good idea. What are you doing with it?

Jennifer: I'm typing up all the transcripts right now. Basically, I'm going to analyze it using Walter Fisher's Narrative Paradigm—rhetoric, narrative criticism.

Dr. K: Then, what will you do with it when you analyze it?

Jennifer: Then, I will have to defend my thesis.

Dr. K: Does your thesis have a hypothesis?

Jennifer: Well, it's qualitative. I don't do numbers.

Dr. K: What is the purpose behind doing this?

Jennifer: To begin to reshape the way in which medicine is discussed and biomedicine, in particular. I'm trying to show that there is humanity in medicine. It's not all just

hardcore science. It's not just 'doctors don't care; nurses do.' It's all nuanced. It's not black and white, and I'm trying to expose the gray area. Did I answer your question?

Dr. K: Yes.

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APPENDIX L

Interview with Dr. L:

Jennifer: Thank you for doing this.

Dr. L: No problem.

Jennifer: Okay, I'm going to start out just by asking you some media-oriented questions. Then, we're going to move into more communication-oriented questions.

Dr. L: Okay.

Jennifer: Now, some of the questions may seem like they come from left field, but there is a reason for every one of them.

Dr. L: Okay.

Jennifer: I, first, would like to know how you feel that physicians are portrayed by the media and whether you feel this is a fair and accurate portrayal—understanding that everyone has their own viewing habits.

Dr. L: Right. I think—when you say media, are you talking public television, or are you talking public news, or what?

Jennifer: Whichever you have the most experience with and can speak to.

Dr. L: Honestly, news-wise, I think we're portrayed fairly. In terms of prime time television, I think the portrayal is often sort of skewed such that it builds in more drama. Take, for instance, *ER* or *Grey's Anatomy*—it's really not about medicine. It's mostly about drama and the social interactions. No doubt, some of that probably does exist, especially when it comes to all the melodrama in *Grey's Anatomy*, but I think it's oversimplified and hyped. It might take 100 hospitals in the U.S. to build up as much BS as they build up in one day on that show.

Jennifer: [Laughs]. Right.

Dr. L: So, I think it's kind of unfair, but it exists in all cultures and all occupations. It's nothing unique to medicine.

Jennifer: So, overall, you'd say it's positive?

Dr. L: I think it's positive to some degree, yeah.

Jennifer: Okay. How do you feel that the pervasiveness of contemporary media—well, I would say, impacts your practice, but you're in a unique position in the ER. It may still impact in your area. Do you see it at all? Does it help? Does it hinder?

Dr. L: I think, in some ways, it has provided an average audience an outlet to become more informed. So, in some ways, media has provided more information to people in the public. However, sometimes, that information is not always very accurate or can be misinterpreted. So, sometimes, it makes the job harder. Patients come with expectations, or wants, that you can't meet. They don't jive with what their diagnoses is or what their needs might be. For instance, drug advertisements often suggest that x, y, or z drug ought to be used or not be used. I think that can be harmful in some ways because patients want these things but don't really understand why they can't have them, or what not. You spend a lot of extra time, trying to work around that piece.

Jennifer: Does that happen more with patients who tend to use the ER as their primary?

Dr. L: It can be both, honestly. I've seen it on both sides of the aisle. Unfortunately, a lot of the patients who use the ER as their primary tend to be less informed. Their problem is—and I'm not saying all—but the majority of their problem is non-compliance to some degree, inability to purchase what they need for basic necessities. Sometimes, it's no desire to do those things either.

Jennifer: Mm hmm.

Dr. L: So, it's a mixed bag, honestly. I've seen it on both sides. Sometimes, the more fluent, informed can be some of the more difficult patients to take care of.

Jennifer: Yeah, I can see that.

Dr. L: [Laughs]

Jennifer: Because they have their own ideas, and they must be right.

Dr. L: Right. Exactly, and often times, half-informed. You have to work around that, or what their friends got or thought about. They use those perceptions, sometimes, to guide their needs, and that's not really the most accurate.

Jennifer: Now, I don't know if you've ever seen some of the reality ER shows that have been on TV. I know some of them have been on TLC or Discovery Health Channel, where sometimes, they'll only focus on the trauma. I think one I used to watch was called *The Critical Hour*. Have you ever watched any of those shows?

Dr. L: Um—a little bit in the past. They're not on as much now. They used to be kind of a fad back in the early 2000s.

Jennifer: I know it's reality, but I also know that reality can be scripted when it's shown on TV. So, do you find that it's pretty well an accurate portrayal?

Dr. L: Um—yeah, it's the same thing. The reason they target the trauma is because it builds better drama. They don't go to the STD Clinic and shoot film because that's just not very interesting. I was around, actually, when they shot—like at Charity, when I was a med student—I was around when they shot a lot of that early media stuff. It's obviously—not scripted per se; some of it is. They'll follow the patient around, get a lead on a story, and try to drive the physicians to say certain things and do certain things

at times. They divert away from the patient at times. A lot of it is very edited. So, if it takes three days to occur, they'll try to snap it into what may seem like 60 minutes.

Jennifer: Exactly. This is a little bit off topic, outside the realm of healthcare, but when I watch *Kitchen Nightmares*, Gordon Ramsay is not only putting their business back together. A lot of times, he is mending fractured families. I know he is there for like four days. I want to know who he is working with that makes that happen in four days.

Dr. L: Right.

Jennifer: Because I know that's not happening in that amount of time, let alone the 37 minutes they cut it down to and put on TV. So, it's the same kind of thing. It speaks to a lot of the technology they use in media—how they take individual shots and put them together, in a seamless flow. It's what they call continuity editing. Nobody watching it is even aware. They just think it's happening from A to Z.

Dr. L: So, the expectation is, well, this should happen in an hour. I should get all this done. It's not how it is. This does unfold over many, many hours—days, sometimes.

Jennifer: Yeah, and I can see how in the ER, that would be tough to deal with in reality because things that take six hours to happen, and they're [viewers] watching it happen in an hour on TV—I wonder if that does underlie some of those complaints.

Dr. L: Mm hmm. It does, sometimes.

Jennifer: Compounding human impatience, anyway.

Dr. L: Right.

Jennifer: It does make me wonder that. Okay. I know we've talked about the pervasiveness of all contemporary media, but do you specifically notice that with

increased Internet access, patients are asking more questions now than they used to, in previous generations?

Dr. L: Mm hmm. Absolutely, and a lot of them do look things up on the Internet and will come back to you with questions regarding what they've seen. It's the same thing. It's a mixed blessing because a lot of the information on the Internet is, to some degree, accurate. A lot of it is inaccurate. There are no editorials there. There's no, I guess, guard against what information is what, and it depends where they go for that information. There's no police. You can publish anything you want out there, and it can be completely false. There's no one to tell you you're right or wrong, and worse—no one to guide the public on which information is more correct.

Jennifer: That's true.

Dr. L: A lot of it comes to what I call quasi-science, where you start talking about nutrition and oddball supplementation—things like that, where we really don't have a lot of evidence behind some of those things. We have a lot of problems re-guiding misconceptions in regards to that.

Jennifer: Yeah, because I know a lot of people will look at homeopathic remedies that are constructed, or marketed, as 'natural.' So, they [the public] automatically think it's safer than what the FDA has approved. I'd rather go with what the FDA has approved. My dentist told me that there could be peanut butter in a product, and the label can tell you whatever it wants because nobody is overseeing that. Now, the people that come in, asking questions—obviously, for an actual emergent situation like a trauma, or someone comes in unconscious—is it family members who are asking questions on their behalf in that situation?

Dr. L: Sometimes. Sometimes, it is family, or loved ones that have more questions. When I'm on the inpatient side, I see a lot more of that—people who are injured for a long period of time, obviously, family have a lot of questions about a number of things from their average care to predictions of recovery. So, it's not uncommon.

Jennifer: You follow inpatients?

Dr. L: Mm hmm. I do Critical Care as well, and I follow the trauma patients on the inpatient side. So, I do a little bit of both.

Jennifer: Oh, okay. I had this image of just ER in my head.

Dr. L: Right, right. Well, we're a little different—me, X, and Y are a little different. We do a little bit of both. A lot of my time is spent in the ER, but half of my time is also spent on the inpatient side.

Jennifer: Okay. Alright. We're going to move into some more communication-oriented stuff now, and this next question is actually based on a little bit of research I did with students on the IUPUI campus. I don't know if you've ever heard of the movie, *Wit*?

Dr. L: No.

Jennifer: I hadn't, either, until I had to watch it in a class. The gist of it is that Emma Thompson plays a 17th century English Literature Professor, who is diagnosed, in the opening frame, with Stage IV Ovarian Cancer. She is treated at the academic hospital of the university where she has taught for years. The way that they approached that film was from the point of view that the academic doctors didn't see her. They just saw her cancer, and they were concerned with full dose, full dose, full dose of this new chemotherapy drug—or, the trial drug. I actually watched this film with a handful of undergraduate students at IUPUI. I, first, asked them how much experience they had

with physicians and how familiar they were with the cancer treatment process before we even watched the film. Then, we watched the film. Afterward, I asked them additional questions to gauge either changes in perceptions of how they saw doctors or any confirmations of previously held notions. What I found was, luckily, the film wasn't changing positive perceptions to negative, but, unfortunately, what it was doing was confirming the negative perceptions held from the beginning. So, that coupled with a lot of the literature that I've looked at regarding patients' perceptions of physicians—it seems to be that a lot of people perceive doctors to be bad communicators. I would like to know how you respond when you hear that.

Dr. L: In some ways, I'd agree. There was a generation of physicians trained, in the 70s and 80s, that were very scientifically-oriented. These people were very intelligent, but as you know, very intelligent people in any social circle sometimes aren't the best socializers. They, often, are introverted, sometimes outcasted. These individuals made their way into mainstream medicine, and got into clinical medicine, with very little social skills. In my own experience, interacting with physicians as I came through the high school ranks, and what not, you find kind of a change. So, the new focus, really, is on communication. For a long time, the focus was on science and being the best scientist/physician—not realizing that medicine is more than just diagnosing, understanding, and being a scientist. It's delving into human emotion, bridging the gap between therapy and diagnosis, and interpreting that for a human—making sure that they're addressed in all those ways. Nursing, and other fields, really focused on that. Medicine really laxed in those years. Now, it is completely different in that communication is a component of the educational model. We, actually, are tested on

communication style. Students have to, actually, go in and speak with people. They have to go in and give bad news. They get feedback as to how they interacted and how they could do it better. They go in and tell patients that they're going to have to have a procedure and explain things to them in a way that is simple for the patients to understand. They get, again, feedback on how the interaction goes. So, communication has become a big component of it when we start talking about core elements. Communication and socialization skills are a big point of that check mark. Not only is it knowledge-based, but interpersonal skills are one of the things that we evaluate, training physicians and medical students with regard to it. So, I think it probably did suffer for a long time. We, unfortunately, are repairing the repercussions of that narrow-mindedness.

Jennifer: When do you think it started changing for the better?

Dr. L: Um, I don't know if I could put a finger on it. I know in the 80s and 90s, there was a big focus on communication. People very clearly realized that there was a lapse. I think it was a surge in medicine. During the 30s and 40s, when physicians were in medicine, it wasn't lucrative. It was feasible. Physicians were there with pharmacists and other folks, but it was a lot of good-minded people who really worked hard. It was like the average farmer. You went in early in the morning and came home late at night. You provided for your family, and you helped other people. So, you had that Norman Rockwell image of the physician. Then, medicine became kind of a financially lucrative field. Suddenly, you had this shift of people who really sought that for themselves. There might have been some selfishness in that drive as well, with interest in the career but very limited interest in the interaction and that nurturing the community type of attitude.

Jennifer: So, was that when administrators began taking over hospitals?

Dr. L: To some degree, and unfortunately, just at the time when medicine realized we have to be more socially responsible, and responsible for communication, the financial forces in power started moving things toward the more numbers-driven side of medicine. For the first time, all of the public really saw medicine as an opportunity; whereas, in some situations, back in the 30s and 40s, it was limited to those who had means. So, now, everyone has the same expectations, which is appropriate. The sheer volume of people seeking medical attention has grown visibly. The population has grown as well, but the sheer volume of people all wanting the same sort of attention has dramatically changed.

Jennifer: Mm hmm.

Dr. L: We see people come in for things that we never would've seen in years past. 'I stubbed my toe.' How many times would you go to the Emergency Department for a stubbed toe? 'I have a runny nose.' You know, that was cared for by grandparents and parents. You just didn't seek medical attention for that because it was, quite frankly, unnecessary. You don't need it. With, or without, a physician's assistance, you're going to probably do what you do. But, I know, at least, from the point of my training—and that was early 90s—there really was a focus on communication. Now, it's quality, and patient perceptions are now driving the economic dollar; that is really being pushed hard. So, now, we have the Studer Initiative and all those other things really driving physician communication and pushing them toward better engagement with the families and patients which is good, I think, to some degree.

Jennifer: Okay. Now, from a personal perspective, when do you feel your communication with patients is successful? In other words, what are the successful components of that conversation, or series of conversations?

Dr. L: Um, successful—I try to be successful every time I engage, but I kind of take a simpleton approach to the initial communication—the 'Hey, there. How are you doing?' sort of approach. I sort of engage some basic components and try to address the non-medical issues, initially. I try to talk about the day, or something like that, just to get them engaged from that perspective and then drive in to what they are here for; what their needs might be. From an emergency perspective, we have kind of limited time frames because there is such a volume of people. So, I try to communicate as I do—I'll be examining and talking the whole time so that I'm not wasting their time. We're getting things done. Then, at the end, I try to tell them what I think is going on and try to give them a list of possibilities because it's never as simple as 'Well, I know exactly what you have.' Sometimes, it is. Then, I talk about what tests might need to be done to help us verify those things. I give them an idea about what I *really think* is going on; describe what we would be doing from that point on; tell how much time I think it might take; a little bit about the next phases. I, often, will say that I'll try to come back by to explain things a bit more. At the end, they'll go home with more information. So, I try to wrap things up and try to engage them for questions in that initial interval so that we get so much done because I can never predict the next 10 minutes. If all hell breaks loose, the chances of me getting back may be limited. So, I try to make sure they feel like they've got my full attention and that they've gotten as much accomplished in that short interval

as possible—with the hopes that I can get back and do more. If things change, I feel like I've gotten it all sort of accomplished in that short period of time. That's my approach.

Jennifer: For complicated cases, do people just kind of stand around? Are they overwhelmed by what may, or may not, be going on?

Dr. L: No, I think a lot of people understand. If it involves some disaster diagnosis, or what not, obviously, we go back in and spend time explaining. We do also involve chaplaincy and social work. So, we utilize a lot of our affiliate care providers with those conversations because they have more time to spend; to sit and listen, which is often all these patients and families need. Sometimes, it's a little bit of shock and awe. So, the questions you drive often aren't there in the first 10 minutes. They come 30 minutes later. So, we try to address those things, but often times, it's just, 'We think you have pharyngitis. It might be Strep…guess what, you have Strep. You're going to get an antibiotic.' It's as simple as that. It doesn't require a whole lot of explanation. They'll ask sometimes, 'Well, is this a bug I caught?' 'No, it's something you've lived with all your life. At times, you just have a weakness in your defense, and these bugs become injurious. Now, our job is to try to help you fight that back.'

Jennifer: But, it's so contagious!

Dr. L: It *is* contagious—very.

Jennifer: I lived with Strep for 10 years. My tonsils are now gone, but I didn't get them removed until a couple of years ago.

Dr. L: Boy, it's much harder as an adult.

Jennifer: Yeah, it knocked me on my can. I was on pain meds for 10 days. Okay. We talked about your successful communication. By the same token, have you ever felt like

your communication with patients was unsuccessful? Does a scenario stick out in your mind, where you can point to that and say, "Well, if I had just said this or not said that?"

Dr. L: Yeah, there are various situations where family members, or even patients, come in, already marred with anger from other interactions. That makes the next interaction much more difficult because you're trying to overcome those biases. So, no matter what you say, it seems like there is always some sort of frustration in the next reaction. Then, there are other circumstances where, maybe, you address someone in the room as 'mom,' and they're not. They're 'sister," or something like that. So, then, they're upset, 'My gosh. They think I'm the mother,' or something like that. 'Do I look that old?' type of an issue. It's a simple faux pas, but it may mar the communication from that point on. Most of the time, you can kind of get around that. There are some situations, where you walk in the room and know, at the end of the conversation they're not going to be happy. No matter what I do, they're not going to be happy. It's not me. It's probably nothing I will say, do, or otherwise. It is the disease or their frustration with the issues. You'll deploy as much as you can to try to smooth things over, but at some point, you have to say, 'Okay.'

Jennifer: Does that tend to happen more with patients who wind up being diagnosed with a chronic illness, and they're just in that *process*?

Dr. L: Yeah, or frustrating illnesses that have no great cures, and they're struggling with the information. Sometimes, they're struggling with the follow-up, and the Emergency Department is not a great place for therapy for that. We can mandate things, but we can't give them the diagnosis that they want. Sometimes, they can be very frustrated by that. They want the answer. I'm like, you've been to five different specialists and have spent 6

months doing this. Saturday morning, at 7 AM, it's probably not going to happen.' Number one, I'm not the specialist for the weird disease that you have. I can help provide you some relief and comfort for that, but to give you an answer is not reasonable. You've had more invasive tests than I can offer. You know they're going to leave frustrated, and that's okay. They came in frustrated.

Jennifer: Yeah, I know with some things, you have to catch it in the flare, and nobody can ever predict when that next flare is going to happen.

Dr. L: You can always explain that to them, too. I give the analogy of the squeaky car that you drive to the mechanic, and as you turn in to the parking lot, the noise stops. That happens a lot in medicine. There's nothing we can do about it. We do our best to try to give you information with what you provide us, but if it's not there, it's not there. Cardiac stuff can, sometimes, do that. We'll put them [patients] on monitoring devices at home because it's a moment in time. If they happen to have something that we can observe, then we can give them a little more reassurance as to what it is. If not, I can't tell them.

Jennifer: Yeah…you were talking about the core communication courses in med. school. Were those something you encountered as a med. student as well?

Dr. L: No, I didn't encounter them as a student. I was a nursing student before. When I did undergrad, I did both nursing and biology.

Jennifer: Okay.

Dr. L: I did a lot more communication in nursing, which was probably a benefit. It obviously helped me as I moved through the ranks. I found kind of a lack of that in medical school. Now, in recent years, however, that has become a bigger part of the

curriculum in terms of addressing, engaging, and—do you have a background in communication?

Jennifer: Yeah, it was my bachelor's degree and is my master's.

Dr. L: Okay. So, you know the whole point of observation and looking at both verbal and nonverbal cues.

Jennifer: Eighty percent is nonverbal.

Dr. L: Right, but that's something that's taught. Unless you were taught it, or just have a gift for gab, that's something that can escape a lot of people. For me, it was never taught to me in medical school. I didn't learn it in medical school. I learned it in prior studies or just from being around, dealing with people. That's something that I think is now being taught more in terms of being able to communicate, address, and affirm, and do those things. So, 'I understand you said *this*. This is how I interpreted,'—that feedback issue. I took several communication classes in nursing school, and I find that's helpful in terms of being able to address the frustrated patient and all those other things. I think that lacked when I did medical school. We didn't have that. I think, now, the future students are getting those communication skills. Those are being taught as part of it.

Jennifer: So, what kind, if any, communication exposure did med. school give you?

Dr. L: It was mostly like an apprenticeship model. You watch me go talk and interact so you'll understand how that works. It wasn't a very formal, 'Here's some of the science and technique behind it.' So, it was mostly watch, observe, and learn. I think, while that's good, you need some formal component as well. 'Here's how we address these things; here's how you address feelings; affirm that they are feeling *this*," which often

helps them [students] overcome the negativity that can be pent-up in that interaction. I think they're [med. schools] doing more of that now.

Jennifer: So, it almost sounds like you're describing that technique called active listening.

Dr. L: Yeah, I can't remember all the verbiage that goes behind the stuff any longer, but the act of doing it and understanding it is still there.

Jennifer: I *think* that one is a little bit more psychologically-oriented, but from my perspective, I've always felt like communication and psychology go hand-in-hand.

Dr. L: Mm hmm.

Jennifer: But, I do think communication is a little bit different in the fact that it does a little bit more acknowledging of other disciplines. It's kind of a combination. You *have* to assess all these other factors: the social; the psychological; and on larger scales, the political and the economic to really understand why something is coming across as it is—and then, how to address it.

Dr. L: Mm hmm. Well, we tell the students a lot of times—and this comes with experience. This is really where you get good at your job is in those early encounters—those early, first minutes—you discover what it is they [patients] want. What are they here for? And, sometimes, it is for a medical, scientific reason. Sometimes, it's just for affirmation or concern. So, they know that they have a sore throat. They want to know that it's not something worse. Honestly, it's just coaching and counseling. That's what your job is at that point. It's not to be a scientist. Anybody could've done that. Grandma could've told you you had a sore throat. It's just to be able to affirm and sort of counsel them [patients]. The new parent, who doesn't have a lot of resources—to tell them that

their baby is going to be fine; the baby looks good. These are the things we look for. This is how you be a better parent. So, I'm being a lifecoach at times. Anybody could've done that, but they sought my attention with the white coat. Sometimes, it's just understanding that. 'I don't think you need a CAT scan, but this is something you're really worried about. Why are you worried about that?' 'Well, I think I have cancer.' 'Why do you think that?' 'Well, my great-grandmother had it.' So, now, you understand. You've uncovered why they have this weird, convoluted story that you can't really put a finger on. It's like, 'Why didn't you just tell me that that's what you're worried about? You went around in circles with a headache, back pain, and weakness, and…Oh! You're worried you have cancer. Why is that?' So, sometimes, it's just delving into the clues that they give you and trying to figure out what it is. It's not as simple as you'd think when people say, 'I've got a headache. Can you tell me what it is?' They, sometimes, come in with the most off-the-wall stories and backdoor into the real problem for no good reason.

Jennifer: It's wild that someone would come to the ER for a runny nose.

Dr. L: It is what it is. They're there because they needed a work excuse, you know. You find out the underlying issue. 'Why are you here at 7:00, at night, with a runny nose?' 'Well, because I felt like crap all day and couldn't go to work. If I don't have a physician's excuse, I'll get docked pay for that day, or worse, it goes on my record, and I may get fired for it.' So, now you realize, aha!

Jennifer: Oh, so they go to the ER instead of going to Immediate Care.

Dr. L: Or, they couldn't get in to their doctor. There are many, many reasons. We beat up on Primary Care. There just aren't enough of them. If I try to get somebody an

appointment with their doctor, sometimes, it's two months before they can get in. The public sees us [in the ER] as an Immediate Care, and that's okay; but you're right. A lot of times, that [runny nose] could've been solved by a much cheaper, Immediate Care sort of interaction.

Jennifer: I did see an episode of *ER* where this little old lady—she had to be 80-something years old—comes in and says, "I've got a hang nail." The doctor told her if he cut the nail for her, it would cost like $3500. "Are you sure you want me to cut this hang nail for you?" "Oh, yeah." So, he did it.

Dr. L: That's right. Okay.

Jennifer: Wow, alright. You actually did touch on this a little bit, and I think you're probably in a better position to answer this question because you came from nursing and went on to med. school. Are you familiar with the terms, "biomedicine" or "biomedical model", in any way?

Dr. L: Little bit. It depends on what aspect you apply it to because there's biomedical science, which is a different beast vs. a communicative model. So, it depends on what you're…

Jennifer: Okay. Well, in a lot of the literature that I've read, when they [academicians] talk about healthcare models—mostly in communication and sociological medical journals—you've got biomedical model on one end. That is looked at as very reductionistic, scientific, and mechanistic. On the other end of the spectrum, you have what's called the biopsychosocial model which is, basically, where all the humanity lies, if you will. It would also seem—going back to the students that I watched the movie, *Wit*, with—I had students tell me that they associate physicians with the biomedical

model, and they associate nurses with the biopsychosocial model. From your standpoint, is that an accurate assessment in practice? Is that how you see it falling out?

Dr. L: For years, that's the way it was taught. The physicians were geared toward the biomedical aspects. Whereas, nurses were geared toward the "meeting the patients' needs/communicative model." So, the product of the schism was driven by the educational structure. That's sort of the division of labor, if you will, when it came to healthcare. The nurses were at the bedside with the patients. They [nurses] were dealing with those social issues. The physicians really weren't. I mean, they were segregated from that. 'This is what you've got. This is what you take to get better.' They walked away from the emotion of the interaction. Now, the consumer wants somebody that is better versed to walk the path between the two.

Jennifer: Mm hmm.

Dr. L: They want someone to be the guidance counselor. Again, I think it has to do with education and how those two models are now being met on an education level, such that trainees are being taught components of both. It's the same thing for nursing. It's not just communication. You're there to be an investigator. You're there to understand the situation and be able to uncover those things. You need to understand the science more and bridge the gap between those things. So, both sides of the aisle have sort of moved toward the midline.

Jennifer: I think you're the first person that's actually seen that merge actively happening because most people I've talked to can understand why physicians are associated with one way and nurses are associated with another just because of the roles that they play and the division of labor—like you said.

Dr. L: Right.

Jennifer: But, it's nice to hear that there is actually a merge that is actively taking place. I wonder how long it'll take it becomes apparent to more people than just the ones on the inside track.

Dr. L: Are you talking about to the average public?

Jennifer: Yeah.

Dr. L: I mean, I think it'll become more apparent as more of this next generation are interacting. You have to have an overwhelming number of people who—if the public sees a million doctors, and 999,000 of them come from this model, and only one comes from the other model—then, still, the public opinion is driven by the 999,000. So, as more of the new generation—who probably has more middle ground—will start to interact more and more patients, you're going to see that opinion start to sway in more of a positive direction. Again, it's being driven. It's something that even the older physicians are being taught now. We're being pushed toward patient communication satisfaction because we realize that science is a big part of it, but, unfortunately, a lot of it is overshadowed by the communication. You can be the best physician and have patients who absolutely think the care is horrible because of the way that you communicated with them. Or, the gruff nurse in the middle of the night told them [patients] something ugly. You know, they [patients] got a curative surgery that saved their life, but they walk away from the encounter with a negative vision because of some poor interaction in the middle of the night. You're like, 'Hmm, that's not good.' Unfortunately, the bottom line is going to be tied to that opinion.

Jennifer: Mm hmm.

Dr. L: So, not only is it good enough to deliver quality of care, but you're also going to be judged on all of the touchy-feely aspects of it as well. You know, too noisy, and all these other things which are going to be a big driver for consumer advocacy. You have a public now that is really choosing this place over the next based on other factors beyond just the physicians. So, that, alone, is going to start driving physician behaviors toward a middle ground. You're going to have the individuals who are, unfortunately, far left, who are the poorest of communicators. They're not going to have jobs in 10 years. They'll either be retired or won't be making money because the dollar—your paycheck—will be tied to how well you do. Some of those individuals are probably going to have to have professional communicators with them because some of them do not have the life skills to be able to do it.

Jennifer: The *Big Bang Theory* types.

Dr. L: Exactly. They just don't. The other thing is setting up perceptions. We do a poor job of explaining what to expect. You go in for a tonsil surgery. Say, "These things can be somewhat painful." It sets you up to say, 'Well, I'm going to have pain, but they're going to give me pain medicine to deal with it."

Jennifer: Well, he told me I was going to have pain. I already knew that. What surprised me was that I thought I was going to have pain right away. It was the delayed onset that threw me.

Dr. L: Right. This is a miracle! Oh, no, here it comes.

Jennifer: Seriously—I thought I was going to be dying from day one. We had talked all about what to expect, and everything…

Dr. L: I think the future in a lot of healthcare is going to be professional communicators. I've argued before the administration here. Wal-Mart gets this. They put a greeter at the door. They spend money, up front, on these individuals who are designed to engage the public right away and steer perceptions. It's the same thing for automotive companies. You walk into a car dealership, how many people tell you hello? Sometimes, that's to your own detriment. You're like, "Oh my gosh. Get away from me," but people engage you and ask if they can help you. So, you walk away going, "Wow, people were really willing to help me." Now, if you go to the same auto dealership, and nobody pays attention to you, how often are you going to buy a car there? You walk out thinking, 'Nobody cares. I'm definitely not coming back here.' I think that's a big part of it. I think we're going to reset expectations and form them early on as to what they [patients] are getting involved with. The more we do that, I think the better off, or more improved, will be our outcomes.

Jennifer: Those are all my questions.

Dr. L: Oh, okay.

Jennifer: So, unless you have anything else to add?

Dr. L: No, I'm good.

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CURRICULUM VITAE

Jennifer Lynn Marks

Education
MA, Applied Communication Studies
Indiana University
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BA, Communication Studies
Indiana University
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Conferences Attended
Central States Communication Association Honors Conference
Presenter
April 2006

Training Experience
Contributed to a group project which involved creating a fresh image for the local Hawthorne Community Center
December 2009

Contributed to a group project which involved creating a media plan focused on informing the public about the Community Health Engagement Program (CHEP) as part of the Indiana Clinical Translational Sciences Institute (CTSI)
July 2009

Professional Experience
Includes communicating with patients, recruiting them for cardiovascular and trauma research studies as well as communicating with clinicians, surgeons, and study sponsor personnel on a daily basis.