

Communication Theory and Health Communication Practice: The More Things Change, the More They Stay the Same¹

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This article considers one of the most fundamental concerns of health communication scholars, educators, and professionals—the relationship between communication theory and health communication practice. Assertions about the important role of communication in health care—as both problem and potential solution—have become increasingly common, as have discussions of theoretical advances in communication and health communication. That said, the fundamental challenge of improving provider–patient communication, and health communication outcomes more generally, persists—and, indeed, appears to be resistant to change. Inadequacies in the articulation and translation of communication theory for health care practice represent a substantial part of the problem. Scholars of communication embrace the complexity and nuanced nature of the process. However, when communication concepts are appropriated within health care discourse and practice, the complexity and nuance are often glossed over, favoring instead simpler, information-exchange perspectives. The changing health care and wellness landscape, with its growing range of health information services, sources, and settings, is unlikely to alleviate the consequences of this translation problem; rather, it threatens to exacerbate it. This article examines these issues, provides illustrations of situations that are emblematic of the translational gap, and highlights concepts that may help to enrich the contribution of communication theory in health care, health education, and professional practice.

¹My own interest in health communication dates to the late 1970s and the discovery of a medical problem with one of my children. The diagnosis and treatment required numerous health care encounters in local, regional, and highly ranked metropolitan health centers with a variety of providers ranging from family practitioners to national leaders in their specialty area. As a young communication scholar, I was struck by the fact that a very large percentage of the encounters that we experienced provided rich case studies highlighting the failure of professionals to understand and effectively apply communication theory to the practice of patient and family care.

This past year thrust me, again, into a participant-observer role that provided an extensive and diverse sampling of health care encounters in a number of provider settings in a different part of the country. This time, my role was that of a family member helping to coordinate the care of my 97-year-old father. I was dismayed to discover that, with a few notable exceptions, little appeared to have changed relative to the quality of communication in the intervening 40 years. Despite the presence of new medical technology, improved facilities, and new information systems, the same lingering shortcomings in the application of fundamental communication concepts in provider–patient/family encounters were apparent.

I now serve as a member of the faculty of our medical school, in addition to my primary affiliation in communication, and am aware that communication is widely regarded as important to health care by professionals across specialties. Paradoxically, though, my colleagues in the medical school report that they experience the same insufficiencies in communication when they deal with the health care system in settings where their identity as physicians is not known.

Though these accounts are anecdotal in nature and certainly not a random sample, I don't believe they are unique. Rather, they appear to be symptoms of a fundamental and enduring problem; for all we have written and know about health communication, the gap between theory and practice remains a most pressing challenge, and one worthy of attention from both health communication scholars, educators, and professionals.

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THE CONSUMER PERSPECTIVE IN HEALTH CARE

In the past several decades, across multiple sectors and settings, the emphasis on the role of consumers has increased, and the current focus on the patient's role reflects this broader trend in organizational study and practice. In contrast to earlier views, contemporary perspectives envision consumers as active agents with preferences that significantly influence not only organizational economics, but also conceptions of the quality of products and services, and of organizational effectiveness. In a structural sense, of course, consumers are external to organizations. However, the influence of their collective needs, expectations, satisfactions, and dissatisfactions—and the decisions that emanate from these—have led to system-oriented conceptualizations that situate consumers as internal components of organizations.² In these frameworks, producers and consumers are viewed as interacting and mutually influential. Because of this codependency, the perceptions and behaviors of consumers and producers are considered critical for assessing and advancing organizational excellence and quality.

The impact of “consumerism” has been particularly notable in health care, where this way of thinking amplified traditional concerns about patients' needs. Clinical dimensions of patient care have always been a central concern in medicine; the consumerism movement underscored the importance of patient focus from an economic and organizational effectiveness perspective (Reeder, 1972). The new conceptualization promoted a shift away from a view of patients as passive, detached, dependent, and powerless consumers of the services provided by expert and controlling health care providers. In its place, the framework offered a vision of patients as thoughtful, engaged, and influential health care decision makers and potential partners.

COMMUNICATION: PROBLEM AND SOLUTION

Consumerism brought the beginning of intensified efforts to listen to and better understand “the voice of the consumer” and with that, attention to communication as both a problem and potential solution (e.g., Bertakis, 1977; Omachonu, 1990; Parrott, 2004; Pascoe, 1983; Waitzkin,

1984, 1986; Ware & Davies, 1983). My own research (Ruben, 1990, 1992), for example, focused on what some 4,000 patients said they most remembered from their hospital stays and visits to health centers. The findings rather dramatically underscored the importance of communication from the patient perspective. By a substantial margin across all health care settings, the most frequently remembered events were those associated with “personal treatment/interpersonal communication by caregivers.” Contrary to expectations, most patients did not report that their most memorable experiences were related to the clinical or technical quality of the care they received. Overall, “clinical/technical” aspects of care accounted for only 27.0% (304/1125) of reported experiences. The “personal treatment/interpersonal communication by caregivers” theme accounted for 46.7% (525/1125) of all responses. “Policies/procedures” accounted for 9.4%. Facilities followed at 7.3%. “Quality/quantity of information provided” ranked fifth, at 5.8%, and “Other”—which included factors like cost and convenience—ranked sixth, at 3.9%.

Research has also shown that communication processes are essential to more accurate patient reporting and disclosure, reduced uncertainty, greater engagement in decision making, increased social support, more effective utilization of health care options and facilities, better adherence to treatment regimens, improved clinical outcomes, and enhanced prevention and wellness (Arora, 2003; DiMatteo & DiNicola, 1982; Greenfield, Kaplan, & Ware, 1985, 1986; Hulka, Kupper, Cassel, & Mayo, 1975; Kaplan, Greenfield, & Ware, 1989; Thompson, Robinson, & Brashers, 2011; Zolnieriek & DiMatteo, 2009).

In its 2011 report, the Picker Institute reported its conclusion that communication and care transitions were the two overarching themes that patients, families, providers, and experts all agreed were essential to quality patient-centered care. Consistent with this conclusion have been the numerous training programs, curricula, and certification requirements that emphasized patient-centered communication (Cegala & Lenzmeier, 2002; Like, 2011). These have included educational programs that focused on improved patient relations and consumer service (e.g., Bowman & Ruben, 1986; Leebov, 1988; Ruben, 1985; Ruben & Bowman, 1986), patient and family satisfaction surveys, the creation of “Patient's Bills of Rights,” and the publication of guides and lists of recommended practices (Jeppson & Thomas, 1994).

Beginning in 1999, six competency areas, three of which included communication skills, were introduced by the Accreditation Council for Graduate Medical Education (ACGME), and since 2004, medical students have been required to participate and be evaluated based on a clinical interaction with a fictionalized patient as a part of Step 2 of the U.S. Medical Licensing Examination (USMLE) (Brown & Bylund, 2008). This requirement was designed

²Among the other dimensions of organizational behavior to receive additional attention have been leadership strategy and development, clarity of purposes and plans, effective and efficient work processes, workforce well-being and satisfaction, outcomes measurement, benchmarking, tracking, and continuous improvement. These and other elements have been the focus of attention in organizational quality literature and practice, and are highlighted in the Malcolm Baldrige organizational assessment and recognition framework, developed in 1987 and arguably one of the most influential models of its kind. Customer focus is one of the seven categories identified in the Baldrige organizational systems framework. See <http://www.nist.gov/baldrige>

to promote patient focus and to address public expectations that physicians would be able to effectively demonstrate communication competencies in interactions with patients. Since its implementation, deficiencies have been identified in approximately 3,400 medical students (First, 2013; Lehman & Guercio, 2013). The examination is also credited with promoting changes in clinical skills curricula and education (Gilliland et al., 2008). In addition, accredited postgraduate training programs now must demonstrate that patient-centered skills—including communication—are taught and assessed (Brown & Bylund, 2008).

THE CHALLENGE OF TRANSLATION

Although the emphasis on communication has increased substantially over the years, according to the Picker Institute and others, the troubling conclusion is that these efforts have not led to the desired improvements in patient satisfaction and other patient-focus outcomes.

Where does this leave us? We know that there is broad consensus on the importance of communication as both a source of problems and a potential solution for improved patient care (Parrott, 2004). We also know that the dynamics of communication in health care contexts have been widely studied, and substantial efforts to improve provider communication skills have been implemented in a variety of settings. And yet, what is perhaps the most fundamental challenge in the translation of communication theory for improving health care remains.³ It is the author's contention that this persistent gap is, at least in part, a consequence of the way in which communication theory has been appropriated and integrated into health care discourse and practice. To the extent that this observation is correct, it becomes important to reexamine the way in which core concepts have been translated for use in health care, identify situations that are emblematic of the translational gap, and highlight concepts that may enrich the contribution of communication theory in health care, health education, and professional practice.

Sending and Receiving Messages: MS ≠ MR

In discussing the critical role of communication, the Picker Institute report describes the process this way:

Communication encompasses the exchange and sharing of information among several key players of the healthcare team, including communications between patients/families and providers, as well as among providers collectively

responsible for a patient's care. Communication is a foundation of effective patient-provider partnerships. It is a theme constant in any interaction a patient may have with the healthcare system. (Picker Institute, 2011, pp. 6–7)

Another important document, the Pew–Fetzer Task Force Report (1994, p. 9), used the same language—"exchange of information"—in describing the critical dynamics between practitioner and patient. It is likely that the "information exchange and sharing" conceptualization is attractive within health care, as it has been in many other contexts, because of its simplicity and commonsensical formulation and its strategic implications. From the perspective of communication scholars, however, notions of "exchange" or "sharing" of information present a very restrictive view of the process and inappropriately commodify "information"—both of which lead in directions that are of little help in explaining the intricacies of human communication.

Images of information being handily exchanged between provider and patient in a mechanistic and rational way, in an environment free from significant distractions, problems of multiple and often conflicting goals, preoccupying anxieties, and stress-impaired information processing, where message-sent = message-received, are simply very far off the mark. Such characterizations miss subtleties that are particularly vital for understanding health message-sending/message-receiving situations. They fail to acknowledge the extent to which each party brings his or her own personalized "maps" and "personal luggage"⁴—each reflecting the person's unique needs, values, attitudes, styles, education, cultures, physical and emotional abilities and disabilities, life history, present life circumstances, goals, and aspirations. These "belongings" travel with an individual, providing a communication scaffold that influences every aspect of the way messages are created, sensed (or not), made sense of, and reacted to (or not).

Clearly, the "information exchange and sharing" perspective is at odds with more nuanced, contemporary communication theory, which emphasizes the way people create, convey, select, and interpret the messages that inform and shape their lives (Ruben & Stewart, 2006). Of central concern are decisions associated with whether and how individuals sense, make sense of, and react to the messages in their environment, through a process that is not mechanical, tangible, or visible, and often not particularly rational, such that at any moment an individual is being bombarded with various messages that compete for that individual's attention. When applied to health communication, this means that communication outcomes are not easily shaped or controlled by message senders, but rather are more fundamentally

³In many ways, questions regarding the impact of communication theory on health and health communication practices parallel the concern raised by Thompson, Parrott, and Nussbaum (2010) about the impact of health communication research.

⁴The terms "maps," "luggage," and "belongings" are used to capture, in simple language, the complex system of physical, cognitive, emotional, experiential, and behavioral elements that interact to constitute unique individual identities at any moment in time. Thanks to Bob Like for suggesting the term "maps" for use in this context.

guided by the predispositions and the “susceptibilities and take-into-accountabilities” of the receivers (Thayer, 1968).

While there is nothing particularly new in the foregoing discussion from the perspective of leading scholarship in the communication field, these conceptualizations often fail to inform health communication discourse and practice. A compelling example of the value of a more discerning view of communication is provided by the efforts undertaken in the United States to bring about smoking cessation. Beginning in 1965, packages of cigarettes prominently displayed a warning message cautioning consumers that smoking had been determined to be a serious health risk. The mechanistic view of communication would predict that as consumers noticed, read, and digested this message, they would understand the dangers of smoking, react logically to the message, and make an effort to quit immediately. In fact, initial exposure to these messages brought about only limited $MS = MR$ impact. More than 40 years later, as a consequence of purposeful, highly redundant message-sending from a multitude of sources through multiple channels, a striking decrease in smoking occurred—from 42.4% of the U.S. population in 1965 to 19.8% in 2007. While impressive in its longitudinal impact, even this massive, systemic, and highly organized communication campaign has been less than fully successful with some 20% of the smoking population—many of whom are new smokers and not subject to addictive influences in their initial decision to smoke or not.⁵ This case underscores the limitations of the linear, cause-and-effect view of communication; reminds us that single messages and single message-sending events seldom yield momentous message-reception outcomes; and suggests the more useful view of communication as a process of messages washing over and shaping individual sensibilities overtime, much as waves wash over and gradually shape the shoreline.

The challenge of communication in typical health care settings is exemplified in the classic study by Wertz, Sorenson, and Heeren (1988), which demonstrated that at the end of 40- to 60-minute genetic counseling sessions, just less than half (47.4%) of patients and counselors understood the primary issues the other had wanted to convey, despite their information-sending and information-receiving efforts. Other studies report the presence of similar communication problems in 84–94% of clinical encounters (Fallowfield, Lipkin, & Hall, 1998; Foot & Sanson-Fisher, 1995; Lerman et al., 1993).

Viewed from the perspective of human communication, the complexity of health care provider–patient encounters is extraordinary, and efforts to reduce this complexity to a simple linear description of the process are inaccurate and assure

that communication has little to contribute to an understanding or improvement of health care. Fundamentally, such characterizations fail to clarify the role of communication in health communication (Parrott, 2004).

Relationships and Impressions

While the transmission of information is generally the explicit goal for communication, the longer term and enduring relational consequences of these message-sending/message-receiving dynamics can be easily understated or ignored (Watzlawick, Beavin, & Jackson, 1967). In the process of strategically pursuing explicit communication goals, impressions and relationships emerge and evolve, creating the backdrop and context for future message-sending and message-receiving, and predisposing the parties involved to particular expectations, patterns, and outcomes.

These dynamics are important in all communication situations, and especially in professional–lay encounters, but nowhere more so than in health communication settings, which embody all the complexity and challenge—and even greater stress—than present in most other interpersonal settings. As with the teacher and student, the attorney and client, or the librarian and the information seeker, the challenge of creating effective relationships between the provider and the patient is particularly difficult because these relationships are asymmetrical. In such relationships, expertise and power are unevenly distributed. While both parties can be said—in a very general sense—to have a common purpose, they seldom share common perspectives, experiences, or expertise. Moreover, they seldom share a common view as to the relative importance of the instrumental and relationship function of communication. Unlike most other asymmetrical relationships, provider–patient communication can have life-and-death consequences, making the relational functions of the process particularly important to understand and attend to.

The relational dimensions of communication also may be of primary importance to patients and their families in their judgments of provider competencies and the quality of the care being provided. Because, as mentioned previously, most patients and family members lack the knowledge necessary to assess the clinical quality of the care they receive, their evaluations emphasize relationship quality, the interpersonal communication skills and competencies of the provider, and the manner in which they are treated personally (Korsch & Negrete, 1972; Ruben, 1990). These priorities influence reactions to professional providers, and also to support and administrative staff, whose communication behaviors can have a significant influence on health care decisions by patients and family members, even though such decisions are not based on the medical quality of the treatment (Tallia, Lanham, McDaniel, & Crabtree, 2006).

While this duality of communication outcomes is well recognized by scholars within the field, its significance

⁵See *Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965–2011*. http://www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking

and role in the practice would seem to be less than fully appreciated in health and wellness settings where the focus is understood to be primarily on instrumental goals. The intricacies of relational functions of communication and their impact on instrumental functions of health communication are not at all apparent from an information exchange view of process, yet they are vital to making sense of a broad range of health communication outcomes.

Provider–Patient Communication Is Cross-Cultural

In many respects, health communication interactions are most appropriately viewed as cross-cultural encounters. When traveling to a foreign country where the language, monetary system, and geography are unfamiliar, there is no mistaking the fact that one is engaged in an intercultural experience that requires careful observation, listening, and care in translation. Though far less obvious in most cases, health care encounters embody many of the defining characteristics of an intercultural experience. For their part, physicians, nurses, lab techs, receptionists, administrators, and other staff come to health care encounters as knowledgeable professionals, “at home” in the environment in which the interactions are occurring, and seeing patients on a schedule that they set. They are familiar with terminology and protocols, comfortable with the tasks at hand (e.g., exams, diagnostics, and treatment modalities), and equipped with substantial experience regarding the range of problems and circumstances that are likely to arise.

For the patient or family member, these are very difficult situations often accompanied by considerable stress from trying to grasp, interpret, and retain the names for procedures, medical specialties, medicines, diagnoses, treatment options, and an array of opinions and advice, in a foreign environment and at a time when the normal information-processing capabilities are taxed. All these impediments to communication are magnified by differences, for example, in age, language capability, cultural competence, and education, as illustrated in the following⁶:

A young pharmacist walked into the hospital room of my 96-year-old father, and began to explain that she was there to show him how to give himself insulin shots. She had several pieces of equipment and a large pile of materials with her. My dad is hard of hearing, which the pharmacist did not seem to detect.

As she spoke, my father’s expression clearly indicated that he was confused and frightened, but the pharmacist proceeded with her presentation on the glucose monitoring system that he would need to learn how to use. I found myself repeatedly reminding the pharmacist that my father was hard of hearing, that the procedures she was describing were all new to him, and asking that she please speak more

slowly and more loudly. After several minutes had passed, with my father trying to hold one of the devices with trembling hands and limited dexterity, I interrupted and asked the pharmacist whether she had a monitor that was easier for elderly people to use. She agreed to check and (with obvious relief) said she would return later.

Differences in vocabulary, rate of speaking, age, background, familiarity with medical technology, education, physical capability, and experience can create a huge cultural and communication chasm—all too easily overlooked because all parties speak the “same” language.

The Diminishing Centrality of Face-to-Face Health Communication

Given the changing health care landscape, only a limited—and likely a decreasing—amount of the communication that plays a role in shaping health care practices occurs directly between a professional provider and his or her patient.

There was a time when physicians enjoyed more complete control of the message-sending, message-receiving process related to health communication. In these circumstances, knowledge differentials, professional deference, and limited direct access by patients to alternative information sources greatly privileged physicians and other professional providers in their efforts to more directly shape and control patient communication. Diagnosis and the provision of health care typically were administered by doctors and nurses in professional health care settings—the physician’s office, a clinic, or a hospital. But alternatives to provider-patient face-to-face communication are proliferating, creating new opportunities, but also new challenges, for providers and for patients.

To illustrate, consider the following actual transcription of a health communication event, with names and other minor details changed for anonymity and clarity. The vignette involves Ned (a 9-year-old boy), Rene (Ned’s mother), Mike (Ned’s father), their pediatrician, Jane (Rene’s mother/Ned’s grandmother), and Bruce (Rene’s father/Ned’s grandfather).⁷

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

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

⁶A personal experience involving the author’s father while being hospitalized for treatment for stroke, January 2013.

⁷An edited transcript of an e-mail exchange—slightly condensed and with names changed—in which the author was a participant, January 8, 2013.

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

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

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

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

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

From: Rene@aol.com
Sent: Friday, January 8, 2013 1:19 PM
To: Mike; Jane; Bruce
Subject: RE: first degree heart block

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

From: Bruce@comcast.net
Sent: Friday, January 8, 2013 1:22 PM
To: Rene; Mike; Jane
Subject: RE: first degree heart block

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

From: Rene@aol.com
Sent: Friday, January 8, 2013 1:28 PM
To: Jane; Bruce
Subject: RE: first degree heart block

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

From: Jane@comcast.net
To: Rene, Bruce
Sent: Friday, January 8, 2013 1:43 PM
Subject: RE: first degree heart block

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

From: Bruce@comcast.net
Sent: Friday, January 8, 2013 1:44 PM
To: Rene; Mike; Jane
Subject: RE: first degree heart block

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

From: Rene@aol.com
Sent: Friday, January 8, 2013 1:52 PM
To: Jane; Bruce
Subject: Re: first degree heart block

The cardio is in the hospital near our office.

From: Jane@AOL.com
To: Rene, Bruce
Sent: Friday, January 8, 2013 1:33 PM
Subject: Re: first degree heart block

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

From: Rene@AOL.com
Sent: Friday, January 8, 2013 1:53 PM
To: Jane; Bruce,
Subject: Re: first degree heart block

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

From: Mike@aol.net
Sent: Friday, January 8, 2013 1:57 PM
To: Bruce, Rene, Jane
Subject: RE: first degree heart block

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

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

utilized for self-education, and the Web was also used to identify and assess physician credentials and the hospital's reputation. All of this interaction occurred outside of the scope of awareness, control, and direction of physicians or other health care professionals.

The vignette demonstrates the complexity and evolving dynamics of health communication. Even in the absence of intentional message-sending by physicians or other health care professionals, some of the most critical functions of health communication occur. A number of the health communication roles that were once primarily the province of professionally trained and licensed physicians and nurses interacting with patients in face-to-face contexts are being provided in a broadening array of settings and health care providers. Today, patients may go to their local grocery store for comprehensive diagnostic scans; health communication occurs in health food stores, retail "box stores," pharmacies, and through television, billboards, and magazine ads, as well as through the Internet and telemedicine. Health care provider roles are being performed not only by trained and licensed professionals, but also by support groups, pharmaceutical advertisements, health food store personnel, TV celebrity product endorsers, and peer and group sourcing sites via the Internet (Pilzer, 2003).

On the one hand, this increasing array of options offers new opportunities and empowers patients. At the same time, however, these options introduce formidable challenges for patients and providers. These new sources may be accurate or inaccurate, helpful or harmful, directing or misdirecting. As the options have expanded, information has become less centralized, and those traditional professional providers with specialized expertise and training for their roles have increasingly less direct control over health communication processes. It is significant to note that often a primary professionally trained provider has no opportunity to mediate the information received from "other" caregiving sources, and as a result is unable to control the quality, safety, accuracy, or applicability of the information in a given situation. In such circumstances, because providers are not a part of the communication process, we can speculate that the credibility and the perceived influence of their professional expertise not only may be diminished in a particular instance, but over time this may well have a cumulative effect as well.

The professional health and wellness community is actively exploring new models and methods for encouraging integrated and inter/multidisciplinary professional training and patient care (Interprofessional Education Collaborative Expert Panel, 2011). As professionals struggle to develop more integrated and cross-disciplinary approaches to medical practice, ironically, the consumer community has already become quite multidisciplinary in its use of health sources, services, and settings. Patients, families, and the general public are increasingly comfortable acquiring health information from a growing pool of traditional and alternative health resources and services provided by an expanding group of

health and wellness advisors in a widening assortment of locales. Not all of these sources are equally accessible to all, and this factor alone may be critical in choices patients make as to whether to seek information and care. Does an individual try to locate a qualified nutritionist, or schedule an appointment with a physician who may have no available times for a month? Or, does a person decide to search out nutrition information online, stop at a health food store to get advice from the clerk, or make decisions based on product endorsement by a celebrity on a television infomercial? In the emerging health care environment, communication dynamics are even less predictable, less controllable, and less directed by physicians and other professional providers than the popular conceptions of the process suggest.

COMMUNICATION THEORY AND PROVIDER EDUCATION AND TRAINING

Training for providers has been, and will continue to be, an important vehicle for the translation of communication theory. However, in professional education and training, as in patient care, outcomes are not easily shaped by message senders or their messages, but rather are more fundamentally guided by the predispositions, susceptibilities, and capabilities of receivers. Intended instructional messages—in the clinic or the classroom—must compete with a plethora of other messages in the learner's environment, and the instructor has little direct influence over the way in which intended teaching messages are attended to, received, interpreted, remembered, or integrated behaviorally, which helps to explain why health communication training efforts may not necessarily yield the desired results:

- Changing communication behaviors shaped over the course of a lifetime is an extremely difficult task that is not easily or quickly accomplished, regardless of how clear or compelling messages—lectures, books, or training programs—advocating change may be.
- Being knowledgeable as to desirable communication behaviors is considerably easier than enacting them, and neither conceptual knowledge nor good intentions are necessarily good predictors of successful practice.
- Even self-reflective and highly motivated learners face significant challenges when it comes to consistently translating communication principles into effective practice.
- Exhibiting appropriate understanding and skills in a classroom or assessment situation does not assure consistency in displaying these behaviors in everyday practice.⁸

⁸Volunteer or formally required internship experiences in which medical students serve for extended time periods in communication support roles for physicians, spending time with patients, explaining diagnoses and

- Self-assessing one's behavior with any degree of accuracy, which is essential to reflective learning in this area, is an extremely difficult process. Often, those who would most benefit from ongoing self-assessment are least equipped and motivated to engage in the process.
- Acquiring third-party, "objective" observation and reports on one's behavior is generally essential to accurate assessment and change, but systematic observation and feedback methodologies are complicated, difficult to implement, and frequently resisted.

It is also the case that health care training efforts often emphasize particular skills associated with steps thought to be important in information exchange and sharing. While a focus on greetings, attending behaviors, eye contact, listening or paraphrasing, and leave-taking, for example, can certainly have value, it is possible that a focus on the core concepts of communication, and a more nuanced understanding of the dynamics of the process, would result in more successful outcomes. More specifically, emphasis could be placed on analyzing health communication situations, perspective taking, needs assessment, goal clarification, sense-making, and partnering in the negotiation of the meanings necessary to achieve the desired outcomes. How such training might best be organized and delivered, and whether it would result in enhanced integration of core communication understanding, core competency, and behavioral adaptability, are worthy topics for future study.

Another promising strategy is to treat communication competencies as entry requirements for those aspiring to medical careers. This approach recognizes the reality that teaching communication competency to those who have limited skill is far less productive than directing those same energies to identify and recruit professionals who already understand and are competent in these areas (Eva, Rosenfeld, Reiter, & Norman, 2004; Terregino, Kramer, & Dunleavy, 2014). Identifying the critical communication understandings and competencies, and assessing these capabilities behaviorally, are among the significant hurdles to be overcome in the application of this approach (Kealey & Ruben, 1983; Ruben, 1976, 1977; Ruben & Kealey, 1979).

COMMUNICATION THEORY AND PATIENT EDUCATION AND TRAINING

Various authors have recognized the merits of encouraging patients to become more informed and proactive, and this approach is certainly consistent with an understanding of the

treatments, and answering questions, could be one approach to enhancing communication training and the ability of future physicians to relate to, understand, and anticipate patient communication needs. This idea was suggested by Luming Li, medical student, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ, March 14, 2013.

central role patients play in shaping health communication and health care outcomes (Zarcadoolas, Pleasant, & Greer, 2006). For instance, Jeppson and Thomas (1994) provide the following useful list of suggestions.

- Ask a nurse or doctor to answer questions that you have before, during, and after your care experience.
- Become educated about your health care insurance policy-covered benefits.
- Learn about scientific evidence and the most current treatment options related to your condition by reading articles or information on the Internet.
- Make a list of questions in advance of your medical appointment to ask about your condition and care options.
- Practice telling doctors about your symptoms and how you are feeling. Practice asking questions when you need more information.
- Keep a notebook of current medications, specialists, and other relevant information to discuss with a doctor. If hospitalized, be sure to ask every time you are given a medicine what you are being given.
- Bring an advocate/friend who can listen, take notes, and help ask questions. Remember that family members are there to support you; inform them when issues are too difficult for you to handle alone.
- Be honest with yourself and your provider about your needs, expectations, and feelings about your care. Be specific about what treatments you want or do not want. If you are unsure, ask for time to think about your decision prior to signing consent forms, and speak to your physician about those uncertainties.
- Keep communication open at all times. Find out the appropriate channels so that questions and concerns may be brought to your care team when your main contact is unavailable. Make sure you have designated "power of medical decision making" in writing in the unlikely event that you cannot communicate those wishes—and give a copy to your doctor.
- Ask for and review written discharge instructions for medications, return appointments, and information for follow-up and ongoing care.
- Ask caregivers for alternatives to the treatment options they are proposing, and ask for their perspective on the benefits and liabilities of each.⁹

These suggestions are illustrative of the communication strategies the public, patients, and family members can learn to utilize. Tips such as these can be useful—especially if incorporated into broader frameworks of patient understanding regarding the complexities of health

⁹The last item was suggested by Dr. Alfred Tallia, Professor and Chairman of the Department of Family Medicine and Community Health, Robert Wood Johnson Medical School, Rutgers University, New Brunswick, NJ, February 24, 2013.

communication—and would seem to be another potential strategy worthy of experimentation and evaluation. Such efforts would benefit from being considered in the context of broader efforts to evaluate health and wellness promotion campaigns (Hornik, 2002; Maibach & Parrott, 1995; Rice & Atkin, 2001), current patient education and behavioral influence initiatives (National Prevention Council, 2011; U.S. Department of Health and Human Services, 2012), and innovative uses of Internet- and cellphone-based technology and applications.

Another intriguing communication strategy for patient education engages consumers in the process of developing health promotional messages for themselves and other consumers (Greene, 2013; Lederman & Stewart, 2004). Using what researchers Lederman and Stewart (2004) termed socially situated experiential learning, consumers in effect educate themselves and their peers as to appropriate wellness behaviors—in one case, behaviors related to alcohol consumption. Generically, this model fits the definition of a “prosumer” approach, which involves consumers as collaborators in the creation of the products or services they themselves consume. “Prosumers” become co-innovators and collaborate with producers to develop better products and services (Tapscott & Williams, 2006). Formalizing and giving greater structure to these prosumer networks can have value in identifying and communicating about innovative treatment strategies and in sharing information on perceptions of physician expertise.¹⁰

Beyond patient- and family-centered training, there are other strategies to explore for enhancing the public’s knowledge of health and wellness. For instance, training programs and core courses in health consumer literacy taught at the high school and university levels could work to better prepare individuals to be competent health and wellness consumers. A course on “Health and Wellness Services, Sites, and Sources: Becoming Literate Consumers,” for example, could include such topics as managing one’s own health; evaluating health care claims; using the Internet appropriately for health information; locating and evaluating health care experts and expertise; learning from other patients; being an effective advocate for one’s own and family members’ health care; and becoming better prepared to interface with health care systems.

The challenges of translating communication theory also point to the value of educational programs to develop patient and family advocates, facilitators, or advisors—who essentially serve as cross-cultural translators for patients struggling to navigate the medical, regulatory, and financial dimensions of health care for themselves. Health communication intermediaries are likely to be especially valuable

given the growing complexity of health care systems and the increasing diverse and aging population in this country.

CONCLUDING COMMENTS

Variouly described in the professional and research literature as a symptom, partial cause, and potential cure, communication continues to be a critical focus in health care theory, research, and practice. The discussion provided in this article indicates some of the ways in which information-exchange perspectives on the communication process often do more harm than good when applied in health communication, and in fact help to explain the persistent communication theory–health communication practice gap.

Communication, along with metabolism of matter–energy, can be viewed as one of two basic processes for all living systems (Miller, 1965; Ruben, 1972; Ruben & Kim, 1975; Thayer, 1968). It is the process by which people create the messages that inform and shape their lives (Ruben & Stewart, 2006). While this view affords attention to messages, media, and purposeful message-sending, it also suggests the need for a broader focus on human communication systems and the way patients and family members make sense of and respond to the vast array of health and wellness-related messages that inundate them on a daily basis.

Major efforts are being undertaken currently to encourage interdisciplinary and interprofessional knowledge and collaboration for improved patient focus (Interprofessional Education Collaborative Expert Panel, 2011; Parrott & Kreuter, 2011). These and other changes in the health care landscape, many of which envision an increasingly important role for communication, make this a particularly important time to refocus attention on the very fundamental question of how communication is understood, translated, and applied in health communication theory, education, and practice (Parrott, 2004; Pilzer, 2003; Robinson, Turner, Levine, & Tian, 2011).

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REFERENCES

- Arora, N. K. (2003). Interacting with cancer patients: The significance of physicians’ communication behavior. *Social Science & Medicine*, 57, 791–806.

¹⁰The websites <http://www.everydayhealth.com/forums/heart-health/topic/hearing-heart-beat-in-my-ears.html> and Transparency Life Sciences (<http://transparencyls.com/node/9>) provide two examples of the “prosumer” concept applied to health care and health science.

- Bertakis, K. D. (1977). The communication of information from physician to patient: A method for increasing patient retention and satisfaction. *Journal of Family Practice*, 5, 217–222.
- Bowman, J. C., & Ruben, B. D. (1986). Patient satisfaction: Critical issues in the implementation and evaluation of patient relations training. *Journal of Healthcare Education and Training*, 1(2), 24–27.
- Brown R. F., & Bylund, C. L. (2008). Communication skills training: Describing a new conceptual model. *Academic Medicine*, 83, 37–44.
- Cegala, D. J., & Lenzmeier Broz, S. (2002). Physician communication skills training: A review of the theoretical backgrounds, objectives and skills. *Medical Education*, 36, 1004–1016.
- Cleveland Clinic. (2012). Patient experience is next measurement in value-based care. *American Medical News*. Retrieved from <http://www.amednews.com/article/20130304/business/130309987/4>
- Cleveland Clinic. (2013). Patient experience empathy and innovation summit. Retrieved from <http://www.clevelandclinic.org/collective/default.htm>
- DiMatteo, M. R., & DiNicola, D. D. (1982). *Achieving patient compliance: The psychology of the medical practitioner's role*. New York, NY: Pergamon.
- Eva, K. W., Rosenfeld, J., Reiter, H. I., & Norman, G. R. (2004). An admissions OSCE: The Multiple Mini-Interview. *Medical Education*, 38, 314–326.
- Fallowfield, L., Lipkin, M., & Hall, A. (1998). Teaching senior oncologists communication skills: Results from phase I of a comprehensive longitudinal program in the United Kingdom. *Journal of Clinical Oncology*, 22, 4401–4409.
- First, L. R. (2013). Quality, cost, and value of clinical skills assessment. *New England Journal of Medicine*, 368, 963–964.
- Foot, G., & Sanson-Fisher, R. (1995). Measuring the unmet needs of people living with cancer. *Cancer Forum*, 19, 131–135.
- Gilliland, W. R., La Rochelle, J., Hawkins, R., Dillon, G. F., Mechaber, A. J., Dyrbye, L., . . . Durning, S. J. (2008). Changes in clinical skills education resulting from the introduction of the USMLE step 2 clinical skills (CS) examination. *Medical Teacher*, 30, 325–327.
- Greene, K. (2013). The Theory of Active Involvement: Processes underlying interventions that engage adolescents in message planning and/or production. *Health Communication*, 28, 641–643.
- Greenfield, S., Kaplan, S., & Ware, J. E. (1985). Expanding patient involvement in care: Effects on patient outcomes. *Annals of Internal Medicine*, 102, 520–528.
- Greenfield, S., Kaplan, S., & Ware, J. E. (1986). Expanding patient involvement in care: Effects on blood sugar. *Annals of Internal Medicine*, 34, 819A.
- Hornik, R. C. (2002). *Public health communication*. Abingdon, UK: Lawrence Erlbaum Associates.
- Hulka, B. S., Kupper, L. L., Cassel, J. C., & Mayo, F. (1975). Doctor-patient communication and outcomes among diabetic patients. *Journal of Community Health*, 1, 15–27.
- Interprofessional Education Collaborative Expert Panel. (2011). *Core competencies for interprofessional collaborative practice: Report of an expert panel*. Washington, DC: Interprofessional Education Collaborative.
- Inui, T. S., Yourtee, E. L., & Williamson, J. W. (1976). Improved outcomes in hypertension after physician tutorials. *Annals of Internal Medicine*, 84, 646–651.
- Jeppson, E., & Thomas, J. (1994). *Essential allies: Families as advisors*. Courtesy of the Institute for Family-Centered Care, Bethesda, MD. Adaptation: *Remaking American medicine*. Retrieved from <http://www.pbs.org/remakingamericanmedicine/quality.html>
- Kaplan, S. H., Greenfield, S., & Ware, J. E. (1989). Assessing the effects of physician-patient interactions on the outcomes of chronic disease. *Medical Care*, 27(suppl. 3), S110–S127.
- Kealey, D. J., & Ruben, B. D. (1983). Cross-cultural personnel selection: Issues, criteria, methods. In R. W. Brislin & D. Landis (Eds.), *Handbook of intercultural training: Volume 1* (pp. 156–175). New York, NY: Pergamon Press.
- Korsch, B. M., & Negrete, V. F. (1972). Doctor-patient communication. *Scientific American*, 227(2), 66–74.
- Lederman, L. C., & Stewart, L. P. (2004). *Changing the culture of college drinking: A socially situated health communication campaign*. New York, NY: Hampton Press.
- Leebov, W. (1988). *Service excellence: The customer relations strategy for health care*. Chicago, IL: American Hospital Association.
- Lehman, E. P., & Guercio, J. R. (2013). The step 2 clinical skills exam—A poor value proposition. *New England Journal of Medicine*, 368, 889–891.
- Lerman, C., Daly, M., Walsh, W. P., Resch, N., Seay, J., Barsevick, A., . . . Birenbaum, L. (1993). Communication between patients with breast cancer and health care providers: Determinants and implications. *Cancer*, 72, 2612–2620.
- Like, R. C. (2005). Culturally competent family medicine: Transforming clinical practice and ourselves. *American Family Physician*, 72, 2189–2190.
- Like, R. C. (2011). Educating clinicians about cultural competence and disparities in health and health care. *Journal of Continuing Education in the Health Professions*, 31, 197–207.
- Maibach, E. D., & Parrott, R. L. (Eds.). (1995). *Designing health messages: Approaches from communication theory and public health practice*. Thousand Oaks, CA: Sage.
- Malcolm Baldrige Program. (2013). *Baldrige Performance Excellence Program*. National Institute of Standards and Technology. Retrieved from <http://www.nist.gov/baldrige>
- Miller, J. G. (1965). Living systems. *Behavioral Science*, 10, 195–237.
- National Prevention Council. (2011). *National prevention strategy*. Retrieved from <http://www.surgeongeneral.gov/initiatives/prevention/strategy>
- Omachonu, V. K. (1990). Quality of care and the patient: New criteria for evaluation. *Health Care Management Review*, 15(4), 43–50.
- Parrott, R. (2004). Emphasizing “communication” in health communication. *Journal of Communication*, 54, 751–787.
- Parrott, R., & Kreuter, M. W. (2011). Multidisciplinary, interdisciplinary and transdisciplinary approaches to health communication. Where do we draw the lines? In T. L. Thompson, R. Parrott, & J. F. Nussbaum (Eds.), *The Routledge handbook of health communication* (2nd ed., pp. 3–17). New York, NY: Routledge.
- Pascoe, G. C. (1983). Patient satisfaction in primary health care: A literature review and analysis. *Evaluation and Program Planning*, 6, 185–210.
- Pew-Fetzer Task Force. (1994). *Health professions education and relationship-centered care: Report*. Pew Health Professions Commission and the Fetzer Institute. Retrieved from <http://www.rccswmi.org/uploads/PewFetzerRCCreport.pdf>
- Picker Institute. (2011). *Always events. Creating an optimal patient experience*. Retrieved from <http://www.ihl.org/offering/Conferences/Forum2011/Documents/1%20FINAL%20Always%20Events%20Creating%20an%20Optimal%20Patient%20Experience.pdf>
- Pilzer, P. Z. (2003). *The wellness revolution*. Hoboken, NJ: Wiley.
- Reeder, L. G. (1972). The patient-client as a consumer: Some observations on the changing professional-client relationship. *Journal of Health and Social Behavior*, 12, 406–412.
- Rice, R. E., & Atkin, C. K. (Eds.). (2001). *Public communication campaigns*. Thousand Oaks, CA: Sage.
- Robinson, J. D., Turner, J. W., Levine, B., & Tian, Y. (2011). Expanding the walls of the health care encounter: Support and outcomes for patients online. *Health Communication*, 26, 125–134.
- Ruben, B. D. (1972). General system theory: An approach to human communication. In R. W. Budd & B. Ruben (Eds.), *Approaches to human communication* (pp. 120–144). New York, NY: Spartan-Hayden.
- Ruben, B. D. (1976). Assessing communication competence for intercultural communication adaptation. *Group and Organization Studies*, 1, 334–354.
- Ruben, B. D. (1977). Guidelines for cross-cultural communication effectiveness. *Group and Organization Studies*, 2, 470–479.
- Ruben, B. D. (1985). *The Bottomline: A patient relations training program*. Morristown, NJ: Morristown Memorial Hospital.

- Ruben, B. D. (1990). The health caregiver-patient relationship: Pathology, etiology, treatment. In E. B. Ray & L. Donohew (Eds.), *Communication and health: Systems and applications* (pp. 51–68). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Ruben, B. D. (1992). What patients remember: A content analysis of critical incidents in health care. *Health Communication, 5*, 99–112.
- Ruben, B. D., & Bowman, J. C. (1986). Patient satisfaction: Critical issues in the theory and design of patient relations training. *Journal of Healthcare Education & Training, 1*, 1–5.
- Ruben, B. D., and Kealey, D. J. (1979). Behavioral assessment of communication competency and the prediction of cross-cultural adaptation. *International Journal of Intercultural Relations, 3*, 15–47.
- Ruben, B. D., & Kim, J. Y. (1975). *General systems theory and human communication*. New York, NY: Spartan-Hayden.
- Ruben, B. D., & Stewart L. S., (2006). *Communication and human behavior*. Dubuque, IA: Kendall-Hunt.
- Tallia, A. F., Lanham, H. J., McDaniel, R., & Crabtree, B. F. (2006). Seven characteristics of successful work relationships in primary care practices. *Family Practice Management, 13*, 47–57.
- Tapscott, D., & Williams, A. D. (2006). The prosumers. In *Wikinomics: How mass collaboration changes everything* (pp. 124–150). New York, NY: Portfolio (Penguin Group).
- Terregino, C., A., Kramer, M. R., & Dunleavy, D. (2014). Implementation of the Multiple Mini Interview at Robert Wood Johnson Medical School: Process and preliminary outcomes. Manuscript submitted for publication.
- Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*, 117–124. Retrieved from http://info.kaiserpermanente.org/communitybenefit/assets/pdf/our_work/global/Cultural_Humility_article.pdf
- Thayer, L. (1968). *Communication and communication systems*. Homewood, IL: Richard D. Irwin.
- Thompson T. L., with Parrott, R., & Nussbaum, J. F. (2010). Why is it so difficult to talk about impact? *Health Communication, 25*, 560–562.
- Thompson, T. L., Robinson, J. D., & Brashers, D. E. (2011). Interpersonal communication and healthcare. In M. L. Knapp & J. A. Daly (Eds.), *Handbook of interpersonal communication* (4th ed., pp. 633–678). Thousand Oaks, CA: Sage.
- U.S. Department of Health and Human Services, (2012). *Healthy People 2020*. Retrieved from <http://www.healthypeople.gov/2020/default.aspx>
- Waitzkin, H. (1984). Doctor-patient communication: Clinical implications of social scientific research. *Journal of the American Medical Association, 252*, 2441–2446.
- Waitzkin, H. B. (1986, August). Research on doctor–patient communication: Implications for practice. *Internist*, pp. 7–10.
- Ware, J. E., Jr., & Davies, A. R. (1983). Behavioral consequences of consumer dissatisfaction with medical care. *Evaluation and Program Planning, 6*, 291–297.
- Watzlawick, P., Beavin, J. H., & Jackson, D. D. (1967). *Pragmatics of human communication*. New York, NY: Norton.
- Wertz, D. C., Sorenson, J. R., & Heeren, T. C. (1988). Communication in health professional–lay encounters: How often does each party know what the other wants to discuss? In B. D. Ruben (Ed.), *Information and behavior* (Vol. 2, pp. 329–342). New Brunswick, NJ: Transaction.
- Wouda, J. C., & van de Wiel, H. B. M. (2012). Education in patient–physician communication: How to improve effectiveness? *Patient Education and Counseling, 90*, 46–53.
- Zarcadoolas, C., Pleasant, A., & Greer, D. (2006). *Advancing health literacy*. New York, NY: Wiley.
- Zolnierok, K. B. H., & DiMatteo, M. R. (2009). Physician communication and patient adherence to treatment: A meta-analysis. *Medical Care, 47*, 826–834.

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