Good doctor: diabetes and compliance

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THE GOOD DOCTOR:
DIABETES AND COMPLIANCE

by

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for the degree of

Master of Arts

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ABSTRACT

Physician's "talk" has been studied to discover how to achieve patient compliance. This qualitative study focuses on one physician and her nurse and how they convince diabetes patients to take care of themselves to avoid long-term complications. The physician is considered to be very effective by her peers because her patients avoid long-term complications more than the patients of other physicians. Observation and interviews are compared and contrasted with a descriptive theoretical framework taken from G.L. Kreps' and B.C. Thornton's (1992) identification of the six essential elements of communication competence needed by health care providers. Those categories are: awareness, compassion, description, receptiveness, adapting, and ethical consideration. The research questions that governed this inquiry are: 1) To what extent is the descriptive framework useful in analyzing doctor/patient relationships in this practice? How should it be modified (if at all)? and 2) How is the communication style in this practice considered different from other practices? The results confirm and extend the descriptive framework.
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CHAPTER I
RATIONALE AND LITERATURE REVIEW

The treatment of diabetes is substantially different from many other diseases because it necessitates ongoing self-care and self-monitoring by the patient between office visits to the doctor. Diabetes patients cannot look forward to a cure of the disease; it is a life sentence. Successful management of the disease depends on the ability of patients to assimilate large amounts of information and carry out complex procedures as prescribed by the doctor.

Not only must patients learn about and understand the necessarily dramatic changes in lifestyle that avoidance of long-term complications demand, they must be willing to comply with doctor’s orders to maintain health. This issue is particularly relevant to the medical community today because it focuses on preventive medicine and cost containment and there is “increasing evidence that certain behavior changes can have dramatic impact on the course of chronic disease” (Gerber, 1986, p. 14).

Given the myriad, complicated issues of patient compliance, it is interesting to look at the diabetes practice of an endocrinologist, focusing on one physician’s communication with her patients. This physician (whom I’ll refer to as Dr. E) was selected for study because she has the reputation in the local community for gaining compliance from her patients.
Literature Review: Compliance in Medical Studies

Patient compliance, as viewed from a look at a sampling of recent literature, is a complex issue. It is traditionally described as a problem of how physicians communicate with their patients, but compliance is now viewed from many different perspectives, including doctors' "talk." Kreps and Thornton (1992, p. 5) suggest that patient compliance in not a one-way practitioner-to-patient orientation, but rather a more transactional outcome.

Numerous studies show that at least fifty percent of patients do not comply with their physicians' instructions (Lane, 1983; Buckalew, 1991). This means that patients fail to "(1) comply with keeping health care appointments, (2) follow health care regimens, (3) use prescribed drugs correctly, or (4) abide by the rules of the health care institution" (Kreps and Thornton, 1992). One study conducted in 1980 reported fewer than 7% of diabetes patients totally complied with physician recommended self-care and that they are often unable to follow procedures properly (Gerber, 1986, p. 14).

Breaking down barriers to treatment including dealing effectively with patient resistance is as germane as establishing a medication dose and schedule that will successfully ward off infection. Nonetheless, providers are not prepared to deal with patients who are, themselves, barriers to better care (vanServellen, 1997, p. 232).

Burgoon et al. (1987) suggest that the "twin objectives of any helping relationship are behavioral change and positive effect. In a medical context, this translates into patients' adherence to a prescribed regimen and satisfaction with the medical care received. A key to the successful achievement of these objectives is the quality of interpersonal communication between the health care provider and patient" (p.307). This definition sets the stage for the study that examines linkages between patients' perceptions
of their physician's relational communication, satisfaction with their care, compliance with the physician's requests, relational connotations associated with the physician's choice of compliance-gaining strategies, and the frequency of contact.

Burgoon et al. (1987) and her associates point out that there are three factors to be considered when looking at the relationship between physician communicator style and patient compliance. The first is that compliance-gaining message strategies have never been studied in conjunction with the choices that may carry relational consequences. "It seems likely that selecting strategies that emphasize benefits to the patient for complying would carry connotations of true concern and caring, while selecting strategies that emphasize the physician's expertise or that are punitive in nature would connote relational dominance and possibly even hostility" (Burgoon et al., 1987, p. 312). The second factor is the impact of time and relational history on satisfaction and compliance. "...Human relationships evolve sequentially on the basis of repeated contact along a continuum of intimacy... To the extent that the relationship is increasingly perceived as a familiar, intimate, and empathic one, it seems likely that patients would experience greater satisfaction and willingness to comply, in part out of a sense of obligation to the relational partner" (Burgoon et al., 1987, p. 314). However, Burgoon suggests that a "more tentative stance regarding the impact of the amount of prior contacts on satisfaction and compliance" due to conflicting results from prior studies (p. 314). The third factor is that while past studies have been inconclusive, past research does agree that the variables of satisfaction and compliance are somehow related. "One possibility is that, although satisfaction and compliance may be associated, the relationship is spurious
in that some additional variable(s), such as physicians’ relational communication is the causative agent which influences both” (Burgoon et al., 1987, p. 315).

Lane (1983) examines the relationships between compliance, satisfaction and physician-patient communication. She

"seeks to determine: (a) the type of compliance-gaining strategies doctors most frequently use; (b) the reasons physicians use certain compliance-gaining strategies more than others; (c) whether satisfaction with physicians' communication is significantly correlated with compliance gaining strategy use; (d) whether patient satisfaction with their doctors' communication is significantly correlated with their stated level of adherence; (e) whether patient compliance is significantly correlated with specific compliance-gaining tactic usage; and (f) how physicians view the role of communication in promoting patient adherence." (p.774).

Lane (1983) notes that no studies have ever come up with much of a relationship between compliance and patient demographic characteristics such as patient age, sex, personality and social type, socioeconomic status, education and level of intelligence, religion, race, and marital status. Further, Lane states that studies have shown that while information giving has increased patient adherence, other strategies like the communication of positive affect and the communication of fear and/or threat have shown positive correlations with compliance. This study “demonstrates that infrequently used threatening compliance-gaining tactics combined with frequently used personal compliance-gaining tactics are moderately correlated with adherence to treatment regimen instructions” (p. 793).

Burgoon et al. and Lane take similar approaches: they are aimed at discovering a relationship between physicians' "talk" and compliance and other variables. They found no correlation between satisfaction and any one compliance-gaining strategy. The Lane study also found that physicians believe patient characteristics such as age, education and
medical problem are significantly influential in obtaining compliance, more so, in fact, than the physician-patient relationship.

Holloway and Rogers (1992) take a somewhat different route. They look at the ideal of shared decision making by doctor and patient and suggest that physicians must modify their approach based on the patient's locus of control. Discovering whether the patient operates with an expectation of self-management of control (internal locus of control) or with an expectation that luck, chance, fate and/or significant others such as doctors have control (external locus of control), might impact compliance. Although their study was not conclusive, the authors suggest further study of doctor-patient congruence.

Much of what is written about doctor-patient communication seems to equate communication skills with compliance (Phillips and Jones, 1991, p.758). Donovan and Blake (1992) consider the compliance issue a little differently, adding more complexity. They state that compliance ought to be thought of as a

"value-laden term, closely entangled with issues surrounding the dominance of medicine and concerns about costs. For patients, compliance is not an issue; they do not perceive taking drugs entirely in terms of obeying doctor's orders. Instead, they weigh up the costs and benefits of taking particular medications as they perceive them within the contexts and constraints of their everyday lives and needs" (p.507).

The idea of compliance suggests, in this value-laden doctor-patient context, that fault exists on the part of the doctor or the patient when compliance doesn't occur and that there are problems with communication.

These authors suggest that patients, especially those with chronic, incurable diseases, make the best decisions they can, weighing up benefits versus severity of symptoms, risk of treatment versus cost, according to the information they have without
even worrying about compliance (p.512). Donovan and Blake state the key to improving
rates of compliance (and in doing so, doing away with the concept)

"is the developments of active, co-operative relationships between doctors
and patients. For this to be successful, doctors will need to understand
patients' needs and constraints, and to work with patients in the
development of treatment regimes. For their part, patients will need to
make more explicit their needs and expectations, and particularly how they
reach their decisions about treatments" (p. 512).

Indeed Gerber (1986) suggests that the traditional medical model can actually contribute
to poor compliance and that a “therapeutic alliance” (p. 13) needs to form, that is “a
negotiated reciprocal agreement between patient and provider” (p. 13).

Gerber and Nehemkis (1986) agree and discuss the need to frame each “patient’s
unique situation without resorting to categorization within only one underlying theoretical
orientation. Rather, the clinician must appreciate the myriad of interpersonal, familial,
cultural, and situational factors which affect each individual. Only when such influences
are understood can appropriate clinical interventions be designed and prescribed” (p. 3).

Further, Gerber and Nehemkis suggest that issues of compliance with the chronically ill
are complicated by competing demands of the physician’s expectations and the
multidimensional, complex factors that determine a patient’s behavior.

Van Servellen (1997) states that when patients don’t comply with the professional
recommendations, physicians can feel disconfirmed, angry and frustrated.” At a personal
level, these patient behaviors can trigger more deep-seated issues relating to the
provider’s sense of self-worth" (p. 232). She adds that “providers are rightfully
concerned that rather than getting better, patients will get worse despite everything they
have tried to do. It is one thing to experience defeat at the hands of disease or inadequate
technology, but another to experience defeat at the hands of the patient” (p. 232).
Northouse and Northouse (1992) like Donovan and Blake (1992), and Conrad (1985) suggest that the patient's perspective must also be considered. Physician and patient may create different meanings due to different perceptual fields from which they view their realities. Patients necessarily consider a broader range of factors when being diagnosed because this is happening to them and impacting their lives, and social functioning as well as their overall state of mind (p. 83).

Value-laden judgements about patient behavior may result from ignoring the emotional life of patients. Patients may come to view somatic health as one outcome value among many other values that they might adopt. Medical staff project their values as the ultimate ones far outweighing other unique concerns of these patients... patients may choose to be noncompliant in favor of maintaining emotional equilibrium and stable family functionings... Thus the process of coping with chronic illness includes a number of substantial life adjustments, only one of which involves compliance with medical recommendations“ (Gerber, 1986, p. 20-21).

Exploring the compliance literature in medical settings does highlight the complexity of this issue, but nowhere is compliance more difficult to achieve than when dealing with chronic illness. "In the case of chronic disease, even strict adherence to a medical treatment regimen does not always guarantee a good health outcome for the patient." (Kaplan, et al., p.230). Kaplan et al. found in their study that

"greater information supplied by the doctor, in the form of instruction, education and explanation, may contribute to patients' understanding, sense of well-being, and/or confidence regarding the management of their disease. Doctors may in fact influence the outcomes of patients with chronic illness, not only by competent medical care, but also by shaping how patients feel about the disease, their sense of commitment to the treatment process, and their ability to control or contain its impact on their lives" (p.244).
However, Klingle (1993) states that chronically ill people are not motivated by foreseen long-term consequences even when long-term compliance situations are quite serious, like mortality, blindness, or amputation (p.301). Thompson (1990) states that "adherence to physician instructions decreases when they necessitate a major change in habits or lifestyle" (p.37).

For this purposes of this study, I shall consider the meaning of compliance as taking measures recommended by the physician in order to avoid long-term complications of medical problems. This seems germane to what I am focusing on here as the reputation for avoiding long-term complications was what led me to look at this particular practice.

Many models that suggest ways to view health communication are offered in the literature. Thompson (1990) suggests that compliance can "be improved by sharing control with patients, by seeking feedback, by giving unambiguous information and by demonstrating warmth and concern" (p.39). Northouse and Northouse (1992) discuss three models: (1) the therapeutic model, (2) the health belief model, and (3) the King interaction model. The therapeutic model highlights a client-centered approach that includes empathy, the ability to communicate the feeling of being understood to patients; positive regard, communicating caring and nonjudgmental support; and congruence, communicating honestly and attempting to be real in the relationship with the client. The health belief model "highlights the clients' perceptions of preventative health care measures rather than the transactional nature of the client-professional interaction in promoting health care" (p. 14). Finally, the third model discussed is the King Interaction
Model which is based on a systems perspective that focuses on the personal, interpersonal and social systems and their interrelationships.

Another model that is more specific to diabetes is the Application of the Transtheoretical Model (Ruggiero & Prochaska, 1993) to diabetes. This model is based on research on how people change and at what stages are people ready for change. Used originally for addiction problems, the application of this model poses some difficulties. With diabetes, rather than one behavior to be eliminated, the patient is faced with many behaviors that need to be altered. For example, diabetes patients do not stop eating; they must change some things in their diet and take more care with it. “In general, no research on this model has been published that examines changing multiple health behaviors in a single individual, as is often the case with diabetes management” (1993). It might be interesting to examine this practice in terms of stages of readiness. Ruggiero and Prochaska (1993) offer a way too look at diabetes care that might provide insight into how this physician in this practice takes advantage of stages of readiness.

“Based on research on how people change behaviors on their own as well as in intervention programs, the transtheoretical model postulates that cessation of high-risk behaviors (such as smoking) and acquisition of health-enhancing behaviors (such as exercise) involve the progression through five stages of change. These stages include: 1) precontemplation, not thinking about making changes; 2) contemplation, considering change in the foreseeable future; 3) preparation, seriously considering change in the near future; 4) action, in the process of changing behavior; and 5) maintenance, continued change for an extended period.

At a particular point in time, only a small proportion of individuals are prepared to take action to change a behavior. The stages of change represent a temporal dimension that provides information on when a particular shift in attitudes, intentions, and behavior may occur. Progression through the stages is not linear, because the majority of individuals relapse and recycle back through earlier stages. Individuals may cycle through the stages several times before they succeed in their efforts to change behavior” (p. 22).
Because of Dr. E's determination to begin each appointment with the attitude that each meeting presents an opportunity to begin again (see Results), she may, without being aware of it, be addressing stages of readiness instinctively.

"An important role of the diabetes health-care practitioner—and key in helping patients progress through the stages of readiness—is to assist the individual with diabetes in 1) enhancing self-efficacy for positive health behavior change and 2) tipping the decisional balance in favor of the pros of engaging in this positive health behavior" (Ruggiero & Prochaska, 1993, p. 22).

Descriptive Framework

My selection of a descriptive framework was based on what seemed most appropriate in scope and focus for this particular study of one physician's relationship with her patients. It allows for a focus not only on the physician's communication with patients, but also on the relationship between doctor and patient. Compliance involves both and, as Burgoon et al. (1987) suggests, the quality of interpersonal communication between them may reflect linkages with satisfaction, compliance issues, intimacy and empathy, for example.

I chose for my focus an empirically-derived description of a particularized, unique and individual part of a culture. Debra Roter (1989) notes that many social scientists devise their own schemes to analyze health communication interactions and she suggests instead that we build on existing work. Specifically, with the use of a descriptive framework derived from extant communication theory to direct this qualitative project, I examined meanings as perceived by individual actors that are inextricably intertwined with context. The descriptive framework that I selected is a lens through which I view my study. This descriptive tool was an aid to narrow the focus of my study, a means to
get at common knowledge of the speech community and a guide for me to see what I might have otherwise missed. The framework needed to be broad enough to include elements of communication that have been deemed essential to the study of compliance issues in health communication, yet narrow enough to provide direction.

The purpose of the doctor-patient relationship is to maintain or achieve patient well-being. Since patient compliance is thought to be related to physician communication competence, I chose as a descriptive framework six essential elements of communication competence as identified by Kreps and Thornton (1992).

1) Physicians need to be aware of how their communication impacts the behaviors of patients, understanding that they are crucial delivery vehicles for information and a major influence on health outcomes and patient satisfaction. Therefore physicians need to be aware of their own non-verbal and verbal messages as well as those of their patients and be sensitive to messages that emanate from the communication context and environment.

2) Physicians also must be compassionate, demonstrating unconditional positive regard for their patients. Kreps and Thornton include caring, empathy, sensitivity, trust, honesty and validation in their description of what comprises compassion. Moreover, they emphasize the value of careful listening and use of appropriate humor as being a necessary part of the therapeutic relationship.

3) The ability to take complex information and describe it in a way to patients so that they understand it is vital. Kreps and Thornton emphasize using stories and narratives to humanize health communication and to highlight important points. Kreps and Thornton (1992) suggest message strategies to use are:
explaining complex terms and processes, giving examples that the people they are talking to can relate to and understand, restating difficult concepts creating redundancy, and seeking feedback. Explanations describe why things are they way they are and why you are planning to behave in certain ways. Examples illustrate the ideas and concepts you are trying to convey. Redundancy refers to repetition of message and repetition of communication channel; by expressing your ideas in different ways (using different words), and through different means (for example, through writing, through interpersonal contact, using diagrams...) you can increase the chance that others will understand the information you are trying to convey. Feedback allows you to check on the accuracy of your attempts to explain a complex concept... Additionally, using commonly shared words and other symbols... will improve the descriptiveness of health communication (p. 252-253).

4) Patients need to rely on their doctors being receptive, which includes the ability to communicate openly in an affable and approachable manner. Receptive communicators encourage dialogue between people, with people rather than “at” people. Further, they must be open to information from patients and be aware of differing realities.

5) Adapting to situations and individuals and contexts is crucial to competent communication in the health setting. To meet the patient’s needs, communication needs to be adjusted to specific patients, taking into account their individuality, background, cultural differences, and recognizing the context, time and past history that must impact strategic communication.

6) Finally, physicians need to guide their behavior with consideration for ethical issues. Moral and social standards must be maintained: Kreps and Thornton believe this cannot happen without competent and strategic communication. Physicians must have the values and ideals that are necessary to be ethical and be able to communicate them, to arrive at effective ethical decisions. Some of the communication aspects that are essential
are the establishment of equal relationships, sensitivity to the needs of others, honesty, and, finally, sharing timely and accurate information.

The research questions that governed my inquiry were:

1. To what extent is the DFW useful in analyzing doctor/patient relationships in this practice? How should it be modified (if at all)?
2. How is the communication style in this practice considered different from other similar practices?

The literature review raises questions about the meaning of compliance and what behaviors help patients to comply. Kreps and Thornton (1992) suggest that the elements of their model need to be present in the communication of competent physicians. I am curious to know if these elements (and possibly more) are present in this practice and how they might contribute to compliance. I want to learn what it is about her communication that may be different than that of other physicians.
CHAPTER II

METHODS

A General Methodological Approach

I chose a qualitative method to approach this study in the hope of capturing a picture of this physician’s practice. This would allow me to see how things form and unfold. I like the idea that I should think of “qualitative methods” as procedures for counting to one (Kirk, J. and Miller, M.L., 1986, p. 5). They explain this saying “Deciding what to count as a unit of analysis is fundamentally an interpretive issue requiring judgment and choice.” Kirk and Miller further say that the choice to do this type of inquiry focuses on “meanings” rather than frequencies and these meanings assume “paramount significance” (p. 5). I want to focus on locating patterns of communication that can be explored in this particular context.

There are many available models, descriptive frameworks, and research methods that could be used to view this physician’s practice. All of them could be fruitful. “The reason Einstein originally called his theory of relativity the Theory of Invariance is because though everything displays different viewpoints, some features remain the same” (Kirk and Miller, 1986, p. 12). The use of a qualitative methods offers, as quantitative methods do not: 1) a lack of artificial contexts; 2) a lack of constraints of hypothesis (decreased freedom to look at exploratory answers grounded in observations); 3) a lack of the imposition of pre-determined units and measurement categories; and, 4) a lack of the detached involvement that produces a lack of empathic understanding (Philipsen, 1982, p. 4).
There are drawbacks to both qualitative and quantitative modes of findings. “Threats to the credibility of ethnographic research” generally are issues of reliability and validity (Le Compte and Goetz, 1982, p. 31). Philipsen addresses this in his discussion of linearity of research design (1977). He suggests that an ethnographic approach can be a reliable method for a study of a culture when the researcher specifies in advance the purpose and steps to be followed. The use of a descriptive framework provides an empirical approach to gathering data. The ethnographer obtains interpretations of observed experience reflexivity or from both the actors’ and researcher’s perspective ensuring that social realities of both are taken into consideration, thus strengthening reliability. “Natural human vision is binocular for seeing the same thing simultaneously from more than one perspective gives a fuller understanding of its depth” (Kirk and Miller, 1986, p. 12).

For this study, a series of steps were planned and include a descriptive framework. To ensure validity, the subject was visited twice, over a year apart. Vast amounts of notes were kept and different patients were involved in the interactions each time. Also, members of the physician’s speech community were interviewed to see if their observations coincided with mine.

To correct or at least acknowledge my potential bias, I look to three tests that Philipsen (1977) suggests:

“First, does the report use the native’s own terms or verbatim description? Second...do the ethnographer’s terms or descriptions refer to something which the native agrees is a recognizable feature of his social world, and if so, can the native person give it a name? Third, does the native person agree that the ethnographer’s insight enables him (the native) better to understand his own social world” (p. 49).
Because Dr. E, her nurse and I share some common background, we share some native terms and common understanding. My nursing background provided me with experience that allowed me to relate to the social world of the health-care practitioners and, as such, I had a different experience than a non-medical observer would have. Still, the world of diabetes care was out of my area of expertise and I learned a lot about that while interviewing and observing.

Finally, ensuring validity in large measures was accomplished by the careful examination of my work by my thesis director and committee. My assumptions, word choices, and meanings were discussed and questioned which resulted in further self-reflection and discussion with the physician.

Entry

I learned about a local endocrinologist, Dr. E, who was considered unusually successful in gaining compliance from her diabetes patients. Her practice has grown exponentially as a result of referrals from her peers, and they describe her success in glowing terms. She works in a team with a nurse who is also a certified diabetes educator. I was interested in discovering the elements of her approach to diabetes patient care, and how she and the nurse exercised their compliance gaining skills. (The response of the patients to the practitioners was not a part of my study at this point, except where it tended to validate my observation.)

My first lesson about the pressure on Dr. E's practice was learned when I had to wait several weeks before I could get an opening in her schedule to discuss my project with her. It is reasonable that a person under such pressure would be resistant to any
suggestions that could result in a greater workload, so I had to go to some lengths to reassure her that this would not be the case. I remained skeptical that the project could be completed in the very short time left before the deadline that was set for the first part of this study. I was reluctantly given the go-ahead. The next contact with the office was with the nurse, who arranged to have address labels printed from a central data base, of all the diabetes patients who were expected to come in for appointments during the week I had earmarked for data collection. Letters were mailed ten days before observation was due to start.

I prepared a letter (Appendix A) explaining the project to patients and at Dr. E's insistence made it very clear that I was to be a "silent observer." It was mailed out with Dr. E's signature. The letter emphasized that their participation was voluntary. It also obviated the need for detailed explanations on the day, which Dr. E feared would take up her time during the office visit. In fact, of the all the patients observed, only one (the last one!) objected to the presence of an observer. Dr. E herself intervened with the objection, and addressed the patient's concerns, resulting in permission to participate. A letter of consent was offered to all patients, and I obtained their initials or full signatures from all except one woman who has bad eyesight.

Dr. E and her nurse were concerned about keeping the identities of their patients confidential, and as a result I agreed that I would not record the names of the patients in any formal way. The physician and her nurse were the focus for this study, and I observed them working individually with patients, but I also observed them as they interacted with each other and were able to compare and contrast their individual
communication competence. It became perfectly clear that they are the core team, and at times that team includes patients.

Data Gathering

Phase One

For the first part of the study, the data were collected over the course of three days of almost full time observation. Seventeen patients were observed in the office and I listened to numerous telephone calls from patients to the nurse and doctor, and overheard the doctor and nurse talking to each other about cases. I was allowed to use the rest area, a little kitchen area, from where I could see all the activity in the hallway, and hear any and all conversations unless an exam room door was tightly shut. Each patient spent a minimum of an hour in the exam room. This time would be divided between sessions with the nurse, and then the doctor. The nurse would see each patient for a second time at the end of the visit, to clarify any points of the new instructions, dispense samples of medication or give instructions about lab tests as needed.

I was truly a silent observer during the first few times, writing down as much dialogue as possible. From the way we were seated, in very close proximity, the patient was more or less pinned between the observer and the medic. This arrangement made it easy to record notes with ease, as the patient would be turned away from the observer. Some patients tried to read the notes, but most seem unperturbed. After all, as the nurse said several times, "we're the ones being graded." I made no attempt to obscure or hide my notes, so it did not become an issue. Patients were happy to break the observational silence once the nurse left the room, and would freely talk about how long they had been
diagnosed, and sometimes disclose personal information. These periods of time with the patients presented opportunities to ask some questions, but obviously I did not want to violate their confidentiality.

There were times when I was alone with the patients. Not wanting to add to the traffic congestion in the hallway, I remained seated with the patients to wait for further treatment. These occasions were somewhat useful as some patients made comments that bore out or informed my observations. As the patients were of secondary interest to me for the first part of this study, I did not consider these people prospective informants, and did not view the conversations carried on with them as interviews.

I used the constant comparison method of analyzing data. Six categories of speech events were created using the DFW, i.e. awareness, compassion, description, receptiveness, adapting and ethical considerations (please refer to pages 11 and 12 for a full description of these elements.) I coded my field notes after the first couple of observations to see what fit and what did not. As I was observing different patients, I used detailed justifications, using quotes, non-verbal messages and specific incidents to further analyze classification. I compared the rest of the cases with the early ones as I completed each observation.

To test whether my observations intersected with the reality of the actors I first revisited my observations, comparing and contrasting my findings. These were then discussed with the physician or nurse to see if we were sharing the same understanding of what was being observed. Long interviews would have been impossible to schedule in this context, so coffee breaks were used to ask three or four follow-up questions as soon as possible after the patient visit ended. (Having established headquarters a few feet from
the coffee machine, I was extremely well-positioned to ambush the doctor and nurse as they came to replenish their caffeine supplies.) Four longer interviews did take place -- two with the doctor and two with the nurse. These interviews took place at lunchtime when there was a little extra time to ruminate, and at the end of the day, when the doctor and nurse were under less pressure. I was very pleasantly surprised at the level of frankness from both professionals.

My findings tally with my descriptive framework (DFW) and are consistent with extant literature. Further, speech events that were coded into the six elements of my DFW categories (awareness, compassion, description, receptiveness, adapting, and ethical considerations) occurred again and again. This was confirmed and recognized by the nurse and Dr. E, thus ensuring that the social realities of both the observers and the actors were taken into consideration, strengthening the validity and reliability of this study. A plan was conceived and followed as well as a descriptive theoretical framework selected to act as an empirical backbone for our study. I feel that another observer could have very similar results.

The outliers revealed the emergence of additional categories with unique qualities. These areas were ones that I felt extended existing theory by building upon the DFW, and adding to the elements of description, compassion and awareness. The discovery of additional categories consistently present confirmed to me the authenticity of my project and created great excitement. The new categories were tentatively identified and named, and I received confirmation about them also (to be covered later under Discussion).
Phase Two

When I was ready to resume this study one year later, I found both similarities and differences in gaining entry. Again, the time between my first call and when we finally connected via telephone was a few weeks. When we met in her office some six weeks later, however, Dr. E was very positive about continuing the study and even expanding it. She said "I'm so glad that you were persistent last time" and went on to say that she definitely was interested to see the results and hoped to learn more about her communication skills.

The methods for data gathering are the same as the first time. In addition to observing Dr. E and her nurse, I was trusted to interview her patients. This was sandwiched between the nurse’s and doctor’s visits, ensuring that their schedules were not disturbed by my study. A letter was again sent out over Dr. E’s signature and another letter with my signature to diabetes patients telling them of the study (see Appendix B and Appendix C). They were assured of their confidentiality and that their names would not be used. The emphasis of the patient interview was to obtain their perception of the communication of Dr. E and her nurse. They were again assured that the focus of this study was the health care giver not the patient. I was able to interview sixteen patients over the span of a week, although there wasn’t enough time to include all the questions (see Appendix F) and some of the questions didn’t apply for new patients.

Dr. E had moved to a new building across the parking lot since I had last collected data. The arrangement of exam rooms, offices, and snack room was different. I spent most of my time at the nurse’s desk when not in the exam rooms. Once again, I was
privy to her phone conversations and observed all the comings and goings of Dr. E, the nurse, and the patients.

Another addition to the study was to interview three physicians who also treat Dr. E’s patients. Two are ophthalmologists and see her patients on a regular basis. The other physician is a nephrologist. The purpose for these interviews was to compare their impressions of Dr. E’s practice; they are all part of the same speech community and essential to testing whether my perceptions are close to their realities. Again, my intention was to represent the experiences and understandings of the actors in my study from their perspective and from my own as well.

Using an audio tape to record interviews was a consideration. After discussing this with Dr. E and thinking over the advantages and disadvantages, I decided not to use this method of recording data. Many of my interview questions took place over brief segments of time, fitted in during little breaks. I was concerned that patients wouldn’t relax and forget the recorder during these short blocks of time. My questions for the nurse and doctor, except for a couple of occasions, took place in brief spurts. This was done out of necessity due to the busy schedule.

For the first phase, my goals were to discover what elements of the DFW were present and part of the communication strategies used in this physician’s practice. Also, I was curious to see if the DFW could be extended. These goals were accomplished. Each of the elements are illustrated by descriptive communication events and examples.

For the second phase, I intended to build onto the first study, using the same DFW and consider these elements of communication through the lens of other physicians and Dr. E’s patients. The interviews were based mainly on open-ended questions. From the
first part of the study, I learned that this way I ended up with interesting and relevant information that might not have been elicited with a tightly structured interview. The time lapse between studies presented an opportunity to further this project by more comparisons, further information to code and finally, perspectives of the patients and members of Dr. E’s speech community.

Using my DFW to guide this qualitative analysis, I sought answers to my research questions through extensive observations and interviews. In addition to specific questions that directly relate to the research questions and the DFW, I included some more open-ended ones that were meant to elicit information about how this part of life (diabetes and the practice of treating diabetes patients) fit into the rest of life and personal philosophy, for Dr. E as well as for her patients.
CHAPTER III

RESULTS

The findings of my study include results from both phase one and phase two discussed together.

To set the stage for reporting my results, I begin with a description of a typical office visit to Dr. E, which involves three distinct phases, seeing the nurse, the doctor, and the nurse again. Upon arrival, assuming the doctor is more or less on schedule, the nurse would escort the patient to one of two consulting rooms where the patient’s shoes are removed and the patient’s weight is recorded.

The ritual with the shoes is a very important one, as diabetes patients may lose sensation in their extremities, and if injured, the slightest scratch or cut could result in severe problems with infection. The foot report, if bad, could be an early indication that the patient’s condition has deteriorated. So while the nurse’s comments, always in an upbeat chatty tone, ranged from "perfect!" to "you've got Athlete's Foot, kiddo" there was no mistaking the thoroughness and importance of the examination.

There is something oddly intimate about peering at an adult’s naked feet while everyone else is fully clothed. Some feet were particularly badly afflicted, with swelling and discoloration. The nurse would handle each foot very precisely, check between the toes and check the soles and heels with her hands.

As the nurse continues with the examination and the patient goes through a fairly typical routine, the six elements of the descriptive framework begin to become an obvious part of this practice.
Descriptive Framework Elements

Not only do Dr. E and her nurse use all six elements of Kreps and Thornton's DFW, they extend it with their approach to patient care. Looking at this one case illuminates the framework and brings it to life. Here are real health care givers that confirm that these elements exist in what is considered to be a successful practice.

During the span of my visits, I was able to see how events unfold in this practice and it became obvious that Dr. E and her nurse extend the elements of description, compassion, and adapting. A new element to add to descriptive framework was discovered as well.

Receptiveness

Patients need to rely on their doctors being receptive, which includes the ability to communicate openly in an affable and approachable manner. Receptive communicators encourage dialogue between people, with people rather than "at" people. Further, they must be open to information from patients and be aware of differing realities.

The visit with the nurse typically took anything from twenty to forty minutes. The nurse always started with "what's going on" or "how are things going with you?" questions, confirming the element of receptiveness of the DFW. If the patient admitted to some difficulties, the nurse would unfailingly express herself positively, like "we don't expect you to conquer the world on any given day, just a consistent amount, a little at a time" or "look at the little gains." The issues of weight control and exercise were revisited time and time again.

Dr. E and her patients spend time chatting in an affable and open way. With a pregnant teen Dr. E says "Saw the baby? Got a sono? Cool. My mare got pregnant two
years ago and I got her a sono. It was great.” Later, she tells this patient, “If you get home and think... No silly questions... don’t hesitate to call.”

Another patient the next day, a young man in his thirties, told me, “It is important to me to be comfortable with my doctor. I can talk about anything with her; my sense of Dr. E is that she is my friend.” To an older man, she says, “I’m glad that you brought that up.” Later, he tells me, “I know I can call anytime.”

An aspect of this practice that is vital to patients is that both the physician and nurse make themselves available to an unbelievable degree in terms of their own time. Every patient hears at least once a visit, “If you have any troubles with sugars (or anything), call. We will see what we can do over the phone,” or “Any time you have a question, call. You got the diabetes, we got the info,” or “Call me every day, twice a day if you want.” And call they do. Constantly. All of these calls are responded to with warmth and concern. “I’m very glad that you called” is the typical reply to the patient’s concerns.

Compassion

Physicians also must be compassionate, demonstrating unconditional positive regard for their patients. Kreps and Thornton include caring, empathy, sensitivity, trust, honesty and validation in their description of what comprises compassion. Moreover, they emphasize the value of careful listening and use of appropriate humor as being a necessary part of the therapeutic relationship.

The holidays and Thanksgiving were blamed for all kinds of ills, from high sugars to weight gain to added stress. The nurse expressed her compassion and empathy by
letting people know she understood how things went in the holidays. "The holidays always mean extra running around, the kids come over and they want mother's food."

Patients would nod in agreement. "Just take a little walk, so you can have that extra sliver of pie," the nurse says. The nurse would constantly reiterate the need for patients to take care of themselves: "Now I want you to take some time for yourself -- these holidays certainly add to stress, so take a few minutes here and there, meditate, get a massage or whatever." Any weight loss, she says, should be seen as a Christmas present to themselves. "If you can lose one pound I'll be thrilled" (The patient said "me too.").

Humor is often used to soften a lecture and to show compassion. "Okay, here comes the lecture. We probably talked about this before so I won't hammer you too bad."

Humor is definitely part of Dr. E's way of making connection with her patients. She is capable of being very funny in such a way that reduces any tension and permits an optimistic atmosphere that seems to translate into "OK, we can handle this." When one young woman expressed concern over her sugars, Dr. E said, "Now, wait a minute," (looking at patient's book) "they (sugars) are not that bad. Well, a couple outrageous ones, but were you sick here at this point? That's not you then, that's someone else taking over your body" (hums theme from Twilight Zone). When this patient later remarked that she always gets weird (sugars) before the appointments, Dr. E replied, "Is it my breath?"

One woman with intestinal problems (a possible complication of diabetes) was told, "If that was a yucky night for your tummy, that would make sense." The woman replied, "Friday the thirteenth was a bad day." Dr. E replied, "Yeah--me, too. Full moon."
A particularly funny exchange between Dr. E and a seventy-year-old man began with Dr. E saying “Your sugars are crap. Here’s what we can do now so that in twenty years...” The patient replied, “I’m going to get shot by a jealous husband long before that.” Dr. E said, “More power to you. Well, if you want to keep that working, too...” Big laughs all around. This gentleman was diagnosed with diabetes sixty years ago when he was ten. Until recently, he has gotten by with injectable insulin and has rarely messed with checking blood sugars. Unbelievably lucky, he has had no discernable complications until recently. Now, he is showing signs of neuropathy (deterioration of nerves) in his hands and feet, and possible kidney problems. Quite a character, he says that, “I’ve lived with this for sixty years. I’ve told you I was impossible” with a big laugh. Dr. E responds with “I’m determined to be equally impossible.” The patient laughs and said to me, “This is a fencing duel. Sometimes I go off in the corner and pout. Then I come back and do it.” When the physician talked about revising this “dosage, of course” the patient responded, “I’ll be revising this myself, probably.” “Probably,” the doctor replied. The visit ended with them singing to each other. He told her that he had a tape for her with funny medical-joke type music and then he sang some. Dr. E said, “That reminds me...” and sang “Every little breeze brings a new disease...”

She told one patient who had been waiting to see her a while, “Sitting in the doctor’s waiting room can be like being in the Bermuda Triangle.” A middle-aged man was told, “Fats are not necessarily our friends,” and when checking his eyes noted that “I don’t see any big bad boo-boos.” When a patient remarked, “I was cold when I came in here but now I’m warm,” Dr. E came back with “It’s all my hot air, huh?” Many patients obviously feel comfortable enough to initiate a humorous exchange. When the nurse
came in during a patient visit to say that some other patient did his urine collection incorrectly, Dr. E said, “What to do, what to do. Skip it for now, or...” The woman being examined said, “Let her skip it” which elicited lots of laughs.

From “Tsk, tsk... Wherever thou goest, thy meter shall go with thee” to remarks like “you got that right,” Dr. E dispenses not only her medical knowledge but also humor to help lighten the load and make a connection.

I observed many occasions where the compassion for patients was evident. The nurse took a young pregnant teenager who was quite upset out for a walk so that she would be able to communicate privately. She put her arm around the crying girl as they left and I heard the nurse say, “Well, kiddo, hard when you throw diabetes on top of this, huh? Well, you’ve got other things to deal with, too.” Frederick Shattuck, a physician, wrote in 1907 that there is “a potentially serious gap between the developing science of medicine and what he knew as the art of medicine.” He emphasized that “disease is one phenomenon, but the diseased person is another” (DiMatteo, 1979, p. 14). The nurse later said,

I say, that’s up to you. I’ll give them the facts. I treat people like whole people. Diabetes isn’t their whole thing. If they didn’t do so well, well then, so what. Maybe we need to try a different way. Every one problem solves in different ways and some people don’t have problem-solving skills. Trust is hard. If you just find out something about them. Validate them. Get to know each patient as a whole person; find out what makes them unique. They need to feel they have a support system. If they can accept us, this helps them accept their disease.

One thirty-year-old woman who was described to me as “mentally disturbed,” had quite a bit to say about the compassion she had experienced. “The doctor and nurse have always made me feel it is okay to be here, to call. They are unbelievable, very caring. You take responsibility, but if you don’t, there is no judging. I expect them to treat me
with respect and treat me like a person. They do. Their support is instrumental in helping me deal with stress.” She revealed that not long ago, she had gotten pregnant and then went to the ER where she experienced a miscarriage. “Dr. E found out and called me from her home and told me how sorry she was that I had to go through this alone, without any family support.” This patient has always viewed herself as abnormal; only a year ago after having the disease for twenty years, had she told anyone outside her family about her disease. She also told me that since coming to Dr. E, “I haven’t been in the hospital once.”

A nine-year-old juvenile diabetic came for her first visit. Dr. E prefaced her exam by saying “Just take a few minutes... nothing uncomfortable.” Later, she said to the mother, “If she is not prepared for that today, we can just do it next time,” when discussing a pneumonia shot. One of the more touching moments was when she said to an older diabetes patient, “I’m really excited that you’re taking a walk for an hour every day.” She kissed her fingers and touched the woman’s cheek.

Kreps and Thornton (1992) included validation as part of compassion. I noticed many instances where I felt that Dr. E spontaneously confirmed patients as having valuable input or having managed well. “Sounds fair,” “Right, which is just what you said,” “Looks as good as gold” (looking at patient’s eyes), and “You make my job easy,” are among the validating and confirming statements made. To one patient she said, “We will start getting detailed now. You’re doing so well, I have to find something to pick on.” Another hears, “You know very well how hard it is to get sugars like that... coolness, great” and “A very good point... bingo.” She will say, “Well, neat, I like that” and “Yeah, that’s a good question” and “You’re doing a beautiful job, totally wonderful.
You know that’s really cool, because that shows a profound effect on your sugars.” To a patient who has lost forty-five pounds over time she says, “Holy cow! That’s great.” An older gentleman was told in response to reporting great sugars when he said, “Look at my book,” “I’m going to do exactly that right now!” After the mother of a nine-year-old diabetic talked about their routine, Dr. E said, “It sounds like you have a good handle on things already. We don’t need to beat it to death, (doses) not when things are working well.”

Perhaps one of the most explicit examples of her concern that her patient feel okay about themselves occurred when she told a patient “You need to know that taking insulin isn’t that you have failed. Only ten percent of adult diabetics can get by with no medication, just diet and exercise.”

High sugars, or low ones for that matter, are a constant shadow when you are a diabetic. Your sugars tell the story of how your body is dealing with life. Sugar levels are tested four times a day, by pricking a finger, drawing a drop of blood and placing it on a little machine that measures glucose levels. Some patient’s fingers look positively gruesome from all the testing -- I shudder to think what their bodies look like where they administer their insulin shots! Patients could usually recite their highest and lowest scores without consulting their log books, and could usually explain why things had gone haywire -- "bad choice of lunch" one had penned in next to the telltale score. "I'm not too crazy about those high ones," says the doctor, "if they don't come down, I'll probably feel I need to do something about it."
Extension of Compassion. Extending the element of compassion in the DFW is the optimism that permeates their language and actions. Dr. E tells a patient "we could have a luxury of information if you were inspired to do that (and) information is our best weapon, we have lots of tools to use now." For the mid-thirties woman in for her second gestational diabetes pregnancy who may actually have diabetes, the doctor says, "diabetes doesn't have to be like it was in your mother's day" and "complications don't have to happen like they did with your mother" and "even if it is mild, we can take the opportunity to do wonderful things." Many patients hear D. E say "I didn't make that up, it's not a fairy tale, long term reliable studies show this to be true." or, "when I think about diabetes I think about the short term and the long term. We keep an eye on possibilities of complication and nip them in the bud."

The upbeat atmosphere and occasional jokes add to the optimistic tone set by the physician and her nurse. While recognizing serious concerns and real problems, this sense of optimism seems to give a sense of hope to patients; it helps them cope.

Descriptive Abilities

Kreps and Thornton (1992) suggest message strategies to use are

"explaining complex terms and processes, giving examples that the people they are talking to can relate to and understand, restating difficult concepts creating redundancy, and seeking feedback. Explanations describe why things are the way they are and why you are planning to behave in certain ways. Examples illustrate the ideas and concepts you are trying to convey. Redundancy refers to repetition of message and repetition of communication channel; by expressing your ideas in different ways (using different words), and through different means (for example, through writing, through interpersonal contact, using diagrams...) you can increase the chance that others will understand the information you are trying to convey. Feedback allows you to check on the accuracy of your attempts to explain a complex concept... Additionally, using commonly shared words
and other symbols... will improve the descriptiveness of health communication" (p. 252-253).

The nurse completes the preliminary exam, and continues with the patient's diabetes education. She will use charts, photographs and diagrams to illustrate her point about kidney damage, retinopathy or any of the other syndromes associated with diabetes.

Much of the jargon associated with this particular disease is shared with patients and their families. Native terms such as blood sugar, sugars, logbook, insulin, crashing (when glucose levels drop to dangerous lows) and the like become part of a language that binds this doctor with her nurse and patients and adds to the shared meanings between them. The meanings shared with the patients is often the only place where the contrasting groups intersect. The doctor remains the expert even though many patients become extremely knowledgeable about their disease.

Dr. E's arrival at the office is always announced by strong footsteps down the hallway, and a flurry of activity in the suite of offices. She bursts into the exam room with a flying stethoscope and a "Well, howdy!" She reconfirms many of the points that the nurse has already been over. Her descriptive abilities are quite remarkable. She uses stories about previous patients' experiences and stories about the discussions of diabetes among specialists to illustrate the state of research on the disease, and to justify her choice of a new protocol. For example, she says "The scoop on chromium is... It might be that twenty years from now we will say 'It's the greatest thing since sliced bread' or we might be saying 'I'm sure glad I never took that.'" Or "this June at the National Diabetes Convention there was a paper on..." Her narrative about the loss of sensation in the lower extremities equates the problem with "wiring that has gone a little haywire" in the feet. Her patient at that moment was an electrician! Her language sometimes makes
use of heroic terms like "do you feel brave enough to try something new?" or "this drug is a Brave New World kinda thing." There is a sense of adventure as she and the patient set off down the insulin route to slay the diabetes dragon.

Dr. E makes frequent references to earlier visits, by saying things like "do you remember I told you about the dawn phenomenon?" or "do you remember why it is important that you get that eye exam?" She also demonstrates that she is current in her mind about previous complaints, and asks follow-up questions like "and how is that rash doing?" or "are you having a bad time again?" This technique is also used by the nurse, and it reinforces the perception that no details are overlooked in this practice, and that each patient is an individual that deserves individual attention. Whether the doctor and the nurse are truly that up-to-date about patients, or whether the charts are written in a kind of shorthand that makes it possible to do a quick read, I do not know. At the end of each visit, she says “First, I’m going to make a list so we know what we need to do,” another way of making sure that she and each patient are clear with each other.

In Dr. E’s quest for clarity and understanding, she often says, “Slow me down... Let me draw a little picture.” She models how to do upper body strength exercises with cans of tomatoes. She is very particular to distinguish between feeling okay and the reality of what may be really happening. She talked about possible complications to the baby even if “we keep you feeling good, so we have to be extra vigilant” when talking to a pregnant teen. She goes on to say to her,

“What happens if we can’t meet those goals? If the sugars are high, the baby gets fat and the shoulders can make for a difficult delivery. The baby can outgrow you... but not mature. The baby likes it better if... The environment for the baby can be hostile or friendly. A reaction to high sugars in the womb can result in some difficulties after birth... Hard way to start life for a poor little tyke... The baby’s liver responds to high sugars
by becoming fatty like fois gras. You don’t have to panic at one high sugar...”

For another patient, “The good news is that those symptoms aren’t dangerous, but are undoubtedly annoying... Would you be willing to do that? Good, okay, we’ll write that down. I’ll keep in mind what you said about... There really isn’t something called borderline diabetes. That’s like being borderline pregnant” (lots of laughs).

A favorite analogy of mine that Dr. E used with a patient was “We may have to view this as an experiment. It’s kind of like you buy a new suit and you go back for a fitting. Diabetes is like that, so we have to work together to make this work for you.” This reminds me of what she said to a new patient, “We are going to be all over you like a cheap suit.”

Dr. E’s questions are very specific, like "are you having a problem with appetite?" or "are you having a snack at bedtime?" She listens intently, making frequent eye contact, and formulates a response that solves the problem. She frequently uses humor to convey information or instructions, like the time she admonished a patient who wanted to remove a corn from her foot :"No knives, no guns."

“My job is to explain, properly explain, educate why, then they decide.” And explain she does. According to an ophthalmologist who regularly sees her patients, he can tell who her patients are without being told. They know all about diabetes including being able to relay detailed current lab reports. Additionally, her patients do well, are well-controlled and have taken charge of their own disease. Another ophthalmologist confirmed this. This physician recalled asking Dr. E how she motivates and educates her patients so well. He told me she said, “Check their backsides for teethmarks.”
The first ophthalmologist went on to say that Dr. E's notes are extremely well written. "The are succinct, detailed, organized and on target, as well as being done very promptly." He commented that over his many years in practice he has come to believe that there is a connection between poor physicians and poorly written notes that don't include enough information to get a good picture of a patient.

Extension of Descriptive Abilities. Dr. E and her nurse add to the element of description in five ways. A patient, needing further explanation of why her cells aren't using the insulin that her pancreas makes, might hear "cells get hard of hearing, like granny in her rocking chair, so we try to turn up the volume" or "each time you will get a new lesson, we'll kinda pretend you are in school here, ha! ha!" On a more somber note, a young woman who is pregnant and a smoker gets told, "Smoking is like holding a pillow over your baby's head. Every bit you can cut down is like letting up on the pillow." Dr. E's "talk" with her patients is rich with 1) metaphors that illuminate and animate information for her patients. This use of metaphor is one way of 2) demystifying medical jargon.

Moreover, Dr. E and her nurse 3) repeat crucial information over and over and over. Kreps and Thornton (1992) noted that redundancy of description is key. Well, fine, and I bet they had no idea that a physician might carry this as far as Dr. E. We could look at this in terms of time and abilities; probably no one could imagine that in today's healthcare climate, a physician would or could spend the time it takes to provide the kind of education that Dr. E's patients get. Referring physicians and patients alike are aware of this and that awareness is accompanied by a tinge of awe.

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In addition to listening, repeating and restating for mutual clarification, Dr. E will say, "Is this what you mean?" or "We need to talk about this again, just to make sure..."

Each visit to the office includes varying amounts of repetition to reinforce understanding and clarification. Dr. E might say "You remember that..." and off to a repeat of how it would pay off to lose ten pounds. Diet, exercise, insulin doses, weight and avoiding complications all are discussed each time.

At the end of every visit Dr. E tape records a complete summary of the visit for her charts while sitting with the patient. She records the new medication, her opinion of the patient's condition and any discussion that took place. I was fascinated that she would be so direct in the presence of the patient, and asked her about it during an interview:

"I had never wanted to do it before. But another doctor told me about doing it [in the presence of the patient]. But this involves the patient. There are no secrets, I want to be up-front and honest. Patients know immediately what I am thinking and what I said. I think it is useful; it serves as a reminder to them. They even correct me sometimes if I miss something!"

The fourth way that Dr. E and her nurse add to the element of description is that by education through description, they pass expertise to the patient. All the patients that I interviewed reported that the reason they come to Dr. E and her nurse is for their expert advice as well as support. "The staff here gives the best diabetes care I've had. They have expertise and a sense of professionalism" one young man reported. Another said, "She gives me a lot of good ideas. I feel better. It's that I've been at this so long myself." Yet another said, "Diabetes has caused stress, arguments, emotion... I get torn up inside and my blood sugars go haywire. If they didn't do anything for me, I wouldn't come back." An older gentleman remarked during our interview "I've always said you should go to the expert."
What I have observed is that patients do want to continue to consult with Dr. E, but they, over time, become experts themselves. She encourages that. "My intention here is that we’re both going to learn about your diabetes. I can offer you my best expertise and pretty soon you’ll get as educated as I am about your diabetes. The nature of diabetes is that you need to be able to do that" was what a new adult diabetic patient was told. She commented to another that "I would never say that you don’t know your own body; you’ve been living in it all your life." The Boston Woman’s Health Book Collective (1992) affirms this attitude. "Often when we visit doctors, what we are really coming for is solid factual information... We know a lot about our bodies; we must listen to and trust what our bodies are telling us... Most of what doctors learn about us we tell them" (p. 672).

I believe that the attempt on Dr. E’s part to pass on this expertise enables the patient to maintain or recapture personal control. "From the patient’s perspective, illness may cause patients to lose some control over their bodies. The traditionally process of medical care then robs them of more control. The loss of self-reliance inevitably leads to the loss of self-esteem and the inculcation of dependency" (Brody, 1980, p. 720). Dr. E appears to incorporate the following philosophy:

"The act of incorporating the patient into the decision-making team (see teambuilding) tends to force the physician to consider all alternatives and explain the rationale behind the final recommendation. Armed with a basic understanding of the nature of the problem, the patient is now capable of constructively challenging the foundations of the physician’s reasoning. This interchange should lead to a more rational, thorough, open consideration of the various alternatives... Clearly, the mutual agreement between doctors and patients over the definition of problems, priorities, means of evaluation, and therapeutic decisions and expectations is an essential element of the doctor-patient relationship" (Brody, 1980, p. 721).
This passing on of expertise has many benefits. The patient who feels that a physician's expertise and admonitions limit their freedom resulting in diminished personal control may experience helplessness, no longer believing "that their actions and their outcomes are not related" (Rodin and Janis, 1979, p. 63). As the patient becomes more expert on diabetes, control can become a tool to use to fit the disease into day to day life, leaving the patient more free to focus on other parts of life.

Of course, not all patients want to become experts on their disease. Dr. E's nurse commented "Many of the elderly still think the physician knows everything. They want it handled by us." "The patient comes with symptoms; the expert gathers further data by questions, by observations, and by test procedures. The problem that the patient brought is then given over to the physician" (Stone, 1979, p. 47). The issue of locus of control comes up here. (I discussed Holloway and Roger's 1992 article about this in my literature review.) "Patients high in external health locus of control might not be ready or willing to accept responsibility in the medical encounter... Some patients wish to rely on the expertise of physicians and to allow physicians to make medical decisions for them" (Beisecker, 1990, p. 119). Other patients simply aren't mentally capable of assimilating all that they need to know to manage self-care well, let alone becoming an "expert" on their disease. The retarded and the mentally ill are examples.

For those patients who do become "experts" the outcome appears to be good. They tend to avoid long-term complications and get more out of their lives. One patient told me that "I've had docs say that you can't do this with diabetes. Dr. E says you can do anything, just plan ahead." Patients come to Dr. E because they want to feel better and to some extent avoid long-term complications. Both doctor and patient want to make it
work with the patient's lifestyle. These goals don't seem to be competing ones. One of
the ways of meeting these goals is the passing on of expertise. An interesting response to
some problem sugars in a patient's book was "You ever feel when you're looking at one
of these pages (log book) and wish it was like the New York Times crossword puzzle and
you could flip to page 37 and get all the answers?" This was part of a discussion of some
problems that a patient, who clearly knew a lot about his disease, was having. The patient
came for help from an expert and his input, his own expertise was honored.

There is a fifth way that Dr. E adds to the element of description. She uses what I
will call 5) referent authority. That is, she refers to authorities in addition to, and at times
beyond, herself. An example of referring to another physician, a gastroenterologist, came
up with a young woman experiencing severe diarrhea. She had recently had a
"humiliating and embarrassing" episode in a shopping mall when she experienced sudden
onset of diarrhea. Dr. E responded "Diabetes can certainly cause diarrhea. (Nerve
endings in the intestinal track can become damaged.) But there are other causes, too. An
intestinal specialist might be the most efficient and cheapest way to go. I could look at
some things, but that is not my area of expertise."

What I observed that really captured my interest was the way in which she would
call to the patient's attention important other authority as though this gave her messages
even more credibility, extra punch. Indeed, a patient told me that Dr. E is always up on
the "latest ADA (American Diabetes Association) stuff." She says, for example, "This is
kind of where the ADA guys say you should be" or "Now we do know... in fact some
very cool people have done studies..." Another time she detailed a study and the results
when talking about the range of acceptable sugars. When she referred to one study she
said, “Haven’t we talked about that? Good God, I’m losing my edge.” The strategy is one that she uses time and time again. “This June at the National Diabetes Convention, there was a paper on...”

**Awareness**

Physicians need to be **aware** of how their communication impacts the behaviors of patients, understanding that they are crucial delivery vehicles for information and a major influence on health outcomes and patient satisfaction. Therefore physicians need to be aware of their own non-verbal and verbal messages as well as those of their patients and be sensitive to messages that emanate from the communication context and environment.

Dr. E conveys bad news, such as a deterioration in a patient's condition, without alarm or panic. When a new symptom presents itself, she will say reassuring things like "that's very common, we see that a lot" or "there is a little bit of a clog in the carotid artery, but the blood is doing just fine getting around it." She is **aware** that how she communicates is of importance to her patients. The new condition is simply noted, and practical measures are suggested to keep it at bay. When listening to symptoms, she will listen very intently, nodding as she understands, then ask concrete questions like "how would you describe it, like this or like this?"

I observed an **awareness** on the part of both women that the way they spoke to patients had an impact on the patients. The tone of speaking was always optimistic, supportive and positive, and the humor that was used never trivialized the patient's condition or ridiculed what was being done.
Several patients were required to do additional monitoring on top of their four-times-a-day routine. Dr. E broke the news of the three extra finger-prick blood tests to a patient by saying "You're probably thinking this woman is on drugs -- get a life! If it's any consolation, this is as bad as it gets" (lots of belly laughs). She seemed to know (be aware) that these extra tests would not be welcome news.

She says, “We don’t expect them to be blind sheep.” Dr. E notices the non-verbal behaviors that bear on communication. In one case, she asked a patient’s relative to trade seats with the patient so that she and her patient could be close and face each other directly. When speaking with patients, she uses direct eye contact. “I can see that look in your eyes,” she tells a patient when talking about an increase in the number of doses. “Here is the advantage for you with your schedule” she went on to say.

Adapting

Both the nurse and the doctor exhibited consummate skill in adapting to different patients, thus confirming again the Kreps and Thornton observation. There was one patient who was particularly interesting, as she was more than six feet tall, weighed in at 425 pounds, and laughed like a drain. It was obvious that she had many other problems besides diabetes, and that she was the least compliant of all patients observed thus far. The nurse was perfectly even-mannered with her, even in the face of rather paltry improvements (she had lost eight pounds since her earlier visit) and admissions that she "forgets" to take her insulin at night. Dr. E, by contrast, demonstrated very strong non-verbal cues of disapproval, in my view. The exam was as thorough as any other, but Dr. E's eye contact with the patient was minimal.
The only way to good care and the prevention of long-term complications is to adopt self-care to fit with a patient’s lifestyle. This becomes very obvious the more I observe. The nurse said,

“Lifestyle, yes, that’s a consideration of course. If we can figure out how they can take care of themselves and fit it in with what their life is like... make adjustments. Education is a big part. Sometimes, we are so rushed, I get frustrated. If I can chip away each time doing a little more every visit, it can make a difference... how to make diabetes care work for them. My job is to help problem solve. I don’t know if I could do as well as some folks. You have to look at quality of life. We are not really trying to mold people, just help them figure out how to fit in a sweet, for example.”

The process of adapting to a patient’s needs and lifestyle is not without some frustration. Dr. E discussed a patient whom she described as in her late thirties, retarded and morbidly obese.

“I used to get terrible frustrated. This patient eats non-stop! I thought (dings herself on the head), am I being appropriate here... who is crazy here. Some goals are totally unachievable. Goals must be modified, but there is some guilt involved in accepting a modified goal. It’s a constant struggle. Her caregivers (group home) are mad at me for not solving her eating problems. Her experience is if she can’t eat, she might as well be done.”

She goes on to say on another day,

“I have to consider who I am talking to... parents, children, intact adults. How does this feel or look to the patient? I’ve got to think about their point of view. I can coax and cajole and win people over, but I don’t want them to just please me; they have to want to do it for themselves. If I say do this for me, this opens up a battleground. Of course, everybody doesn’t hear things the same way.”

Extension of Adapting. A way in which Dr. E and her nurse extend Kreps and Thornton’s (1992) element of adapting, that I believe is absolutely key to the success of their practice, is what I’ll call starting fresh. Each day that patients come for appointments can be a new beginning. Patients often hear “We are starting here and
now" or "We're just going to work day by day." Many patients told me "There is no judging." She tells them "As you know, we won't conquer everything today; we will just get started." One patient said, "I never feel guilty coming in. They start from where I am that day."

This doesn't mean that a patient's condition is glossed over when there are problems or obvious deterioration. The atmosphere is more as though, well, this is where we are today. How shall we deal with it?

**Ethical Considerations**

During an interview, Dr. E confirmed that she did feel somewhat unhappy about a particularly large patient's lack of compliance, but that she also knew that she had many other problems, including a "full-blown eating disorder." When asked how she deals with this kind of patient, Dr. E explained that she feels she has to keep trying, and that she can't give up on a patient. It is clear that she is bound by very strong ethical codes, and adheres to them in the face of disappointment and lack of co-operation from the patient. My questions about this patient obviously caused Dr. E to think about the case a little more. A few days later Dr. E mentioned that although the patient was difficult to deal with, at least there was a personality there to which she could relate. She felt that this patient was basically a very nice person, that did not deserve any bad treatment from her. The nurse, when interviewed about the same patient, said, "pressure isn't going to work on her."

In sharp contrast to the case described above, I also observed a case where Dr. E clearly had an ethical dilemma about continuing treatment of a patient who "was just not
present.” Dr. E doubted that the long trip to town was offering the patient any better treatment than she was receiving at home, from nurses. This particular patient has already suffered a few small strokes, and obviously can not longer really take responsibility for her own treatment. She has lost most of her eyesight, which meant that even her insulin shots had to be prepared by nurses doing house calls. Sensing that she can play no more useful role than presently, Dr. E. doubts that she should require the patient to make the long trip, wonders "whether I am wasting my time."

I was pleased to note that Dr. E always asked for permission to send reports to other physicians. I was pleased for two reasons. This indicated that communication between the referring physicians would be enhanced (as confirmed by the opthamologists). More importantly, it is clear that she operates within ethical constraints.

One day, I had a lengthy discussion with Dr. E about her overall concerns and frustrations with the practice of medicine. It is clear that she has given a great deal of thought to the ethics involved. The conversation started off this way:

“Compliance is now thought to be a dirty word, value-laden, doctor-oriented and politically incorrect. There is value though to compliance or why do we do what we do? The patient doesn’t hear the word compliance (from me). I look at where is the non-compliance coming from and what’s keeping them from doing what they need to do? I’m here to provide a service for people. Part of that service is figuring out how to help them help themselves.”

Later, Dr. E got into her overall concern with trends in medicine and the impact of HMO’s on patient care. I include this to illustrate that Dr. E’s ethical concerns include not only considerations for patients, but also the practice of medicine in general.

“The big push now seems to be controlling type two diabetes with diet and exercise. That is what you hear in the media. Only ten percent of type two diabetes can be handled with diet and exercise, and diet and exercise won’t cure it or necessarily prevent it. People shouldn’t be set up to fail.
"The HMO perspective on this is, get your money and give back as little medical care as they can. This is a business. There is a medical loss ratio: how much comes in as compared to how much care ($) goes out. Care equals loss. We were sold a bill of goods by HMO's who pushed preventative care. Now I'm seeing articles in what were reputable medical journals that purport to show how to handle expenses better. What they are really doing is offering cut-rate medicine."

She went on to describe a particularly upsetting article dealing with diabetes patients written by an endocrinologist who has quite a bit of stature in the ADA. She questions whether HMO's are buying off journals. "What I'm afraid of is that a new culture is being created. Doctors and patients won't even realize that they are giving and getting half-assed care."

Dr. E has strong views on medicine and looks at ethical considerations in her own practice and those in the larger community. What happens to medical care matters to her.

**Teamwork: Extension of Theory**

Kreps and Thornton discuss the notion that an "unspoken implicit contract" (1984, p. 102) occurs over time between partners in health care. This implicit contract directs the doctor and patients to behave and adjust to the behavioral boundaries of each other's role expectations. Effective health care relationships have clearly understood and agreed-upon implicit contracts.

The doctor and her nurse emphasize and model teamwork with patients. This approach is exemplified by the use of "we" and "our" in their speech. "This is something we girls have to do," Dr. E says when speaking to an elderly woman about taking her calcium. "We will work on that," and "there are several things we can do here" are her responses to changes in medication levels. "Let's try something else" and "we want to
remain in close touch" are comments that both women frequently use. And Dr. E says, "We will look at your book and see if our plan is working for you so that we can individualize it. We kind of have to do this as partners."

When asked in a lengthy interview about the use of "we," Dr. E had the following to say: "I' sounds a little small. Who am I? 'I' alone? 'We' rally the troops -- the nurse, me and the patient." Patients are included in the team comprised of the doctor, the nurse, and the patient. They work together to control the diabetes.

When a patient said, "My goal is to get off the pills totally," Dr. E responded "Well, good; it's a possibility. Let's set a goal then..." The patient told me "This doctor has come a long ways with this old turkey. When we started together, I was getting two insulin shots a day... only take pills now." Notice the use of "we" and "let's" that they use; they operate as a team.

To one patient she said, "This is a decision we have to make together, well, you need to be the main one here." Another day with a patient she said, "That brings up something else. You and I both sit on our butts all day and we both need to work exercise into our schedules." This highlights the similarity between them and contributes to a feeling of teamwork.

For a young woman who has had many difficulties dealing with her diabetes both physically and emotionally, Dr. E and her nurse provide a place to come and be accepted. "They work as a team. I'm part of that team, not equal, but they don't control; they are mentors in my health care. They are very caring. I take responsibility. They don't control; they don't judge when I haven't done what we agreed to do." A comment from one patient was "my input is as important as hers." So in this practice, the physician
shares responsibility for medical decision-making with her patients (Speedling and Rose, 1985, p. 117).

This teamwork extends over time such that patients, Dr. E and her nurse all acquire a shared history. The relationship unfolds over time and is alluded to in conversation like "for all the time we've known you..." To another man Dr. E said "we might be saying in ten years that we're glad we didn't do that." And "well, we are up to date on everything we do once a year."

Evidence was found to support all the elements and one was added that I call teamwork. Further, the element of compassion was extended, as was the element of adapting. The element of descriptive abilities was extended in five ways.
CHAPTER IV
DISCUSSION AND CONCLUSIONS

Discussion of Findings

The elements of Kreps and Thornton's model of competent health communication are present in Dr. E's practice. This model proved to be quite useful for examining the communication strategies observed in physician/patient relationships. This study broadens, enhances and strengthens the model in special ways that clarify and bring to life the elements of competent health communication that Kreps and Thornton define. Specific strategies and examples illuminate and add to each element. The model proved to be a DFW that worked well as a lens to view this practice and I have extended it and as Debra Roter (1989) suggested, built on existing work.

Dr. E and her nurse not only are receptive, they are available beyond the definition of being receptive. This proves to be one of the reasons for patients doing well and for establishing close relational ties between patients and the physician and nurse; it also adds to the time management problems of the practice.

Kreps and Thornton's model lists appropriate humor as being a part of compassion. The humorous exchanges in this practice seem to be of more importance to the atmosphere and relational aspects in this situation than the model suggests. Additionally, optimism is always present and is an extension of the element of compassion. Indeed, there is not mention of optimism in this model.

Descriptive abilities, another element of competent health care communication, is one where this team particularly excels. They seem able to explain concepts in a myriad of ways to achieve optimal communication and understanding. This element is extended
in five ways: Dr. E and her nurse use metaphors, a way of demystifying medical jargon, repetition, transfer of expertise, and referent authority. These extensions expand this element far beyond its original scope.

**Awareness** of how her verbal and non-verbal communication behaviors impact patients is obvious. Her experience in practice allows her to adjust to each patient and is sensitive to the context and environment. For example, she provides a safety net when delivering bad news by immediately following this by a plan to handle the problem. Many patients commented on coming to this physician for support and her awareness of how she and her patients communicate is one of the reasons patients feel supported.

**Adapting** to patients' personalities and lifestyles is certainly a large consideration. Beyond enjoying the rapport that develops between doctor-nurse-patient, it is only through adapting communication that they can help fit this disease into a particular patient's life. This element is extended beyond the model by encouraging patients to begin each appointment as a fresh start which enables patients to come without guilt.

**Ethical issues** are addressed and reflected upon continually. Kreps and Thornton add equal relationships as part of this element. I'm not quite sure what is meant by that in the doctor-patient relationship. If it includes mutual respect, mutual acknowledgment of knowledge and expertise, and the weight that is given to each when communicating, then this relationship is equal.

**Teamwork** is an element I add to Kreps and Thornton's model. This is not present in the model and teamwork is a large part of this practice. Working together, Dr. E and her nurse coordinate their efforts to help patients. Working together,
form a team with their patients. This teamwork provides support and is a basis for a relationship between them.

Overall, what I found in this study adds to Kreps and Thornton’s model. I began this project because I was curious to test what effective health communication is. Today’s emphasis on cost containment impacts this notion. There are other considerations as well. The definition of compliance is at issue as well as ethical concerns. “There is growing recognition, at least with respect to certain dramatic decisions fraught with ethical ambiguity and value dilemmas, that patients have a right to control over their lives and their bodies” (Stone, 1979, p. 48).

Dr. E and her nurse view their job as helping patients feel better (what many come in for), which also results in avoiding long-term complications. Compliance may be a dirty word, but that’s what they try to accomplish. However, what they do doesn’t follow the traditional paternalistic model of an authoritarian physician telling a submissive patient what to do. So, they approach patients in such a way as to respect their experiences and lifestyle and try to help figure out how to fit in diabetes care in a way that can work for each patient.

I believe that Kreps and Thornton’s model is wide-ranging and fairly complete. However, there are key aspects of communication present in this practice that appear to greatly add to health communication practice and those are not included in or emphasized enough in the model that was used for the descriptive framework that I chose.

Here are the aspects of Dr. E’s communication that I feel are particularly essential to her success. The feeling of teamwork is what gives patients feelings of support and personal control. The optimistic attitude that pervades each appointment is necessary for
hope and this is enhanced by the attitude of “Let’s start today fresh.” Humor is a key part of communication and may be part of what keeps patients coming back and enjoying at least parts of each appointment. The ability to educate patients and pass on expertise has been noticed by referring physicians, a very impressive feat.

What do the findings indicate that is a downside to this practice? Time, time, time. There is little time for a life for the physician outside of medicine. There are fights with hospital administrators about how many patients Dr. E sees. She is pushed to see more people faster. Because she takes so much time and is perhaps a bit disorganized with her management of time, patients have to wait often a very long time in the waiting room.

I began to wonder if this study would appear credible after reporting all these positive results. So, I decided to ask consulting physicians and patients about any negative aspects of this practice. This is what I found. None of her patients that I spoke to had any complaints other than one man who said that he didn’t like to wait; the others seem to accept it as part of the visit. One of the ophthalmologists that I spoke with said that he had come across two patients who quit seeing Dr. E because “it is too much work.” Both ophthalmologists commented that from the rest of Dr. E’s patients, all they hear are rave reviews. One of them suggested that perhaps she attracts more motivated patients. I didn’t notice that amongst the new patients I saw. They said they came because they wanted to feel better or, for one pregnant teen, to have a healthy baby. Of course, wanting to feel better can be a motivation. One pregnant teen obviously didn’t want to be there at all and I doubt the visit was very beneficial. One mother of a juvenile diabetic is a nurse who, until recently, managed hemodialysis for patients, some of whom had renal
failure as a result of diabetes complications. She said that all she has ever heard from patients, physicians, nurses, and acquaintances was that Dr. E was the person to see.

All in all, the interviews with physicians and patients were of importance to confirm my observations. Without them, I would have to question my results. Because I bring to this study my previous experiences, attitudes and bias, it was necessary to get other independent views as well.

Conclusions

Implications for Theory and Practice

In one way, the presence of the elements of the DFW in this practice prove that the model is adequate. If Dr. E’s reputation amongst her colleagues and patients is any measure of successful and competent health communication, then she proves the model. She goes beyond the model and so, I would suggest that the model be expanded to include the qualities of communication that seem to have such a positive impact on patients.

This new expanded model could be used to train all health care communicators, especially medical students and physicians who are interested in improving their communication and patient outcome. In practice, I wouldn’t expect that all the aspects of this model would survive through training and implementation. Dr. E once told me that an acquaintance of hers, a psychologist, remarked that Dr. E’s personality might be a reason for her success with patients. Dr. E’s way of communicating might be like a gift: you either have it or you don’t. I feel that there may be some truth to that, in that good interpersonal skills may come more easily to some. However, I also consider that
motivated health care workers could learn and take away valuable knowledge from Dr. E’s way of communicating.

While teaching someone to have a sense of humor that is appropriate and appealing might be difficult, there are many aspects of this practice that could be usefully taught.

A training program could teach receptiveness. What makes a physician appear approachable and available can be modeled and practiced. Compassion can be modeled and role-playing could be helpful. Health care givers may need to be reminded of reasons that led them to a helping, service-oriented profession. Optimism can be modeled as well.

For enhancing descriptive abilities, a rationale for each part of this element should be included. How and why each of these work and how to implement them in practice can be taught. For example, taking notes for themselves and consults that are complete, timely and helpful can be learned. Communication and the elements of a clear message, clarifying and the education of patients can be taught. Further communication training that included being aware of the impact of communication and adapting to each patient can be taught. Teamwork has been a concept that is the focus of all kinds of training situations; surely, it could be incorporated here.

Limitations of the Model

In terms of using this model to benefit health care givers, there are possible drawbacks. A great deal of Dr. E’s connection with her patients may be a personality issue. Can this be translated into teachable elements? How do you pass on her bounce,
her humor, her enthusiasm and her dedication? Perhaps these elements of the model
would work in different ways with different physician styles.

Most of all, perhaps, the major limitation is not of the model, but of translating Dr. E’s communication into a workable example for others and the time involved. Time is a huge factor in this practice, time that many people would legitimately not care to spend. Time that is not permitted by bottom-line financial calculations.

It is interesting to examine the issue of time versus bottom-line considerations. Should the aim be education and preventative care which also impacts the final cost of medical care? Or should we not take the time in the beginning and worry about the cost (in both money and human considerations) of long-term complications later?

Future Research Possibilities

For expansion of this study and verification of the elements of the DFW, as well as the extensions of this model, there are several possibilities. This kind of study applied to other patient groups (besides diabetes patients) and other types of medical specialists would be of interest. For example, using this model for a look at both other groups of chronically ill patients and other patients who are not chronically ill is possible.

All the interviews and observations could be taped. This would provide more material that could be used in different ways. For example, a quantitative approach might add interesting details to this study. Using the Application of the Transtheoretical Model (Ruggiero & Prochaska, 1993) could determine if stages of readiness influence how this physician gains compliance. This model might be used to examine a practice that
includes pregnant teenagers who, like diabetes patients, are considered part of the huge cost containment/compliance issue.

Future research using this model could include a look at the practices of other physicians who have different characteristics and styles. Male physicians, various ethnic backgrounds, and different specialties, such as surgeons, obstetricians, and oncologists, would provide studies that contrast with Dr. E. Further, different styles that characterize a physician's communication are worth a study. The traditional authoritarian paternal physician who is deemed effective by his peers and patients would make a particularly interesting study.

Further, a look at patient demographic characteristics as Lane (1983) suggests might be interesting to see if there is a correlation between compliance and these factors. I would venture to say that education and level of intelligence would have a definite relationship; managing diabetes self-care successfully is a complex procedure.

Issues from the Rationale and Literature Review

After my observations I would agree with Burgoon et al. (1987) that compliance gaining messages have a relational component, and that time and relational history are a large factor in doctor-patient relationships. This element also allows Dr. E to alter to some degree how she approaches a patient as suggested by Holloway and Rogers (1992). She is aware that her patients have whole lives apart from their diagnosis and takes this into consideration when teaching, cajoling and implementing decisions with patients.

About half the patients I observed have experienced a family member with diabetes, or a
spouse with diabetes. This experience is yet another direct source of information, although conceivably a less complete and scientific one.

Donovan and Blake (1992) and Kaplan (1989) suggest that more information supplied to a patient may be worthwhile and as noted previously, Dr. E and her nurse could be thought of as teachers who reinforce learning or introduce new material with each patient’s visit. Both women seek to shape patients' view of diabetes with their explanations, repetitions and especially with metaphors. That is, they try to show patients how to manage, to fit diabetes care into their lives. There is a very high level of congruence in the speech events observed with both women. While Dr. E is arguably the tougher one, the nurse says "I don't play hardball as much. I'm not as blunt. I don't beat people over the head. People expect the doctor to be the heavy" (teamwork again).

Donovan and Blake (1992) and Gerber and Nehemkis (1986) discuss compliance issues and physician's expectations. They suggest doing away with the traditional medical model. I think that the therapeutic alliance that seems to form between doctor, nurse and patient in this practice works because of the various elements of communication present in this practice. While Dr. E and her nurse may feel that their roles are to urge some brand of compliance, the fact is that they all negotiate goals and plans. Dr. E and her nurse are aware of this and aware that patients must be listened to, respected and that patients have a life apart from diabetes. This doesn’t stop Dr. E and her nurse from cajoling and nudging, but the goals are definitely negotiated and adapted to the patient’s unique set of circumstances.

Kaplan et al. (1989), as well as Van Servellen (1997) discuss chronically ill patients who don’t do well either as a result of not complying with medical
recommendations, or because even strict adherence to medical treatment regimen doesn’t always guarantee good outcomes. It is easy to understand the frustrations of health care givers. A physician to whom Dr. E refers kidney problems told me that she has only seen four or five of Dr. E’s patients. They all had end-stage renal failure. This physician, a nephrologist, said that sometimes no matter how well people take care of themselves, this can happen. I think Dr. E would argue that point. Fortunately, in this particular practice, the diabetes patients who do well far outnumber those who don’t.

Dr. E has unique qualities that set her apart from many of her peers and earn their respect and positive regard. These qualities are attested by the medical community in this town and her practice has grown because of her successes. This has been confirmed by conferring and consulting physicians. These qualities contribute to the extending of the DFW beyond Kreps and Thornton's model of competent health communication.

These same qualities and the resulting achievements with her patients have also, however, lead her to say

"I see my practice expanding out of control. What am I supposed to do? I like to take more time with people and diabetes patients need it. It's a blessing and a downfall that I like to talk with people. I've always got some hospital administrator talking about the bottom line. I've got to get it done faster. My husband tells me I'm deviant -- I don't get home until midnight. I have to make a link with these people so that they believe in me and trust me and you don't do that in fifteen minutes. I have to establish a rapport with them. I think people come to women with different expectations. They are looking for warmth and caring and you are the wicked witch of the west if you don't do it."

She is facing the same frustration that many of her more dedicated colleagues do: the tension between cost-containment and adequate time with patients. Time spent with patients has been shown to impact doctor/patient rapport; the more time spent, the stronger the rapport (Beisecker, 1990).
Clearly, this disease is a life sentence that requires some major life adjustments to stay reasonably healthy. As such it is very difficult to motivate folks (Klingele, 1993 and Thompson, 1990). My observations validated this. As the good doctor says, "Diabetes is a quirk. Shit happens. It is a pain in the ass. But we can deal with it, we have the tools. It is not going to go away. The complications don't have to happen." A key to Dr. E's appeal to patients may be her philosophy that she tries "to make things equal." She tells them "you’re (the patient) the boss, You’ve hired me as a consultant. I can give you tools. Think of me as an employee you’ve hired." There are no secrets to the success of this doctor's practice -- they are plain to see. The two members of the team are direct, honest, compassionate and meticulous about their care for the patients. They demonstrate an impressive level of health communication competence.
REFERENCES


Dear Patient,

A graduate student from The University of Montana is presently working with us on a research project about diabetes patient care. She will be observing myself and the nurse diabetes educator during patient visits. The focus of her study is to observe the elements of diabetes patient care.

If you are willing to be a part of this study, one student will be present during your next visit, as a silent observer. Please be assured that your appointment will not be disturbed in any way whatsoever, and that your privacy and confidentiality will be absolutely protected.

Sincerely,

Dr. ________
Appendix B

Dear Patient,

I am a graduate student and registered nurse from The University of Montana and am presently working on a research project about diabetes patient care. I will be observing your physician and the nurse diabetes educator during patient visits. The focus of my study is to observe the elements of diabetes patient care. The purpose of this letter is to inform you about this study; you do not need to decide whether you care to participate until you come for your appointment.

If you are willing to be a part of this study, I will be present during your next visit, as a silent observer. In addition, if you are interested, I may wish to ask you some questions concerning your feelings about taking care of your diabetes. This should take about fifteen minutes in between the nurse’s and physician’s visits. I hope to learn how your health care providers can do the most effective job of helping you with your diabetes. Please be assured that your appointment will not be disturbed in any way whatsoever, and that your privacy and confidentiality will be absolutely protected.

Sincerely,

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Appendix C

Dear Patient,

With this letter, you will receive a letter from a graduate student who is doing a research project in my office. Her letter will explain further.

I wanted you to know, if you are not interested in taking part in this study, you may decline to participate and your appointment with me will be conducted as usual. Be assured that there will be no consequences to you for not taking part. Further, this letter is being mailed out from my office and your name was not revealed to the graduate student.

Sincerely,

Dr. ____________________
Appendix D

Interview Questions for Dr. E
(Questions for the nurse are derived from these.)

Questions that relate to research question one: To what extent could I confirm that the DFW was present in this practice and could I extend it?

1) How has my presence altered what you do here?

2) Here is what I see ______. How does this compare with your perception?

3) Talk to me about when you tape your records and how this impacts the patient sitting next to you. (Awareness)

4) Describe how you keep going with patients who clearly don’t comply? (Compassion, receptive, ethical)

5) How do you see yourself as contrasting with your nurse? (Awareness, descriptive)

6) How do you see your nurse as complementing you in this practice? (Awareness, descriptive)

7) Have you watched your nurse when she educates patients? (Awareness, descriptive)

8) Is using the term “we” a conscious act? If so, why do you use it? (Awareness)

9) Do you use different ways of talking to different people? (Adapting, receptive)

10) Do you speak differently with patients who comply? (Adapting)

11) When, if ever, do you lay it on the line with patients if they show up time after time without sticking to the plans that you make together? (Adapting, awareness)

12) Do you consider that the patient is an equal partner? Talk to me about how you view this relationship. (Adapting, awareness)

13) How do you see yourself resolving the differences between expectations for compliance and the goals of the patient? For example - how do you let your knowledge of the patient’s unique, complex situational factors (family, age, rigors of treatment, quality of life, etc.) inform your talk with your patients? (Compassion, receptive, adapting, awareness, ethical)

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Appendix D (continued)

Interview Questions for Dr. E

14) Where did the form come from that you use for new diabetic patients? (Descriptive)

Questions that relate to research question two: How is the communication style in this practice considered different from other similar practices?

1) Where do most of your referrals come from?

2) Given that I’ve been told that you have more success at compliance from long-term diabetes patients than other docs, how would you describe how your approach differs?

Questions that don’t necessarily fall under the two research questions, but that might illuminate them in ways that acknowledge the lack of total discreteness between communication competencies and contribute to unmeasurable qualitative perceptions that inform this study.

1) What metaphors would you use to describe this disease, diabetes?

2) What is your intuition about what diabetic patients have in common? Could you describe a type, a personality?

3) How would you deal with being diagnosed a diabetic yourself?

4) What do you get out of your practice?

5) How would you contrast a diabetic support group with a breast cancer support group?

6) Describe how you might like to see your practice change.

7) Do you think that your gender has any impact on the way you practice medicine?
Appendix E

Interview Questions for Referring Physicians

1) Describe how you first became aware of Dr. E and her practice.

2) Tell me how you view Dr. E’s approach to diabetes/patient care and how it differs or not with other referring physicians.

3) (If you view her as more successful) can you be specific about the elements of her approach that make her successful. Can you identify some...

4) How do you see yourself as complementing Dr. E in the treatment of diabetes patients?

5) Do you see yourself as being part of a team that includes Dr. E and her nurse.

6) What metaphors would you use to describe diabetes?

7) How would you deal with being diagnosed a diabetic yourself?
Appendix F

Interview Questions for Patients

1) What helps you to take care of yourself most (family support, etc)?

2) What barriers exist that make it difficult to take care of yourself?

3) What part of your care do you find most difficult?

4) Overall, do you view your health as limiting what you want to do... and how do you rate the quality of your life?

5) How do you feel about your care from this physician and nurse?

6) What do they do that you find most helpful?

7) What expectations do you have of Dr. E and her nurse? Do they meet them? Which ones?

8) How do you view your relationship with Dr. E as compared to relationships with other physicians?

9) How do you view how diabetes impacts your life in terms of, perhaps, a metaphor...?