Case Studies in HEALTH COMMUNICATION

EDITED BY
EILEEN BERLIN RAY

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Eileen Berlin Ray
Cleveland State University

To *George, Bryan*, and *Lesley*,
who account for 100% of the variance
in my regression equation for happiness.

And to *Sarah*,
for helping me stay within one
standard deviation of the mean.

CONTRIBUTORS

Terrance L. Albrecht
Dept. of Communication
University of South Florida
Tampa, FL 33620

Carolyn Aydin
Cedars-Sinai Medical Center
8700 Beverly Blvd.
Los Angeles, CA 90048

Lorraine M. Bettini
Dept. of Communication
University of Oklahoma
Norman, OK 73019

Linda Burnes Bolton
Cedars-Sinai Medical Center
8700 Beverly Blvd.
Los Angeles, CA 90048

M. Faye Boyd
Dept. of Communication Processes &
Disorders
University of Florida
Gainesville, FL 32611

Dawn O. Braithwaite
Department of Communication
Arizona State University-West
Phoenix, AZ 85069

Rebecca J. Welch Cline
Dept. of Communication Processes &
Disorders
University of Florida
Gainesville, FL 32611

Eric M. Eisenberg
Dept. of Communication Arts & Sciences
University of Southern California
Los Angeles, CA 90089

Vicki S. Freimuth
Dept. of Communication
University of Maryland
College Park, MD 20742

Patricia Geist
Dept. of Speech Communication
San Diego State University
San Diego, CA 92182

Catherine Gillotti
Dept. of Communication
University of Dayton
Dayton, OH 45469

M. Christina Gonzalez
Dept. of Communication
Arizona State University
Tempe, AZ 85287

Jane G. Halsey
Health and Hospital Services, Inc.
1715 114th SE, Suite 110
Bellevue, WA 98004

Monica Hardesty
Dept. of Sociology
University of Hartford
W. Hartford, CT 06117

Willard Harris
Dept. of Internal Medicine
University of South Florida College of Medi-
cine & James A. Haley Veterans Hospital
Tampa, FL 33620

Thomas J. Kean
AMC Cancer Center
1600 Pierce St.
Denver, CO 80214

Gary L. Kreps
Dept. of Communication Studies
Northern Illinois University
DeKalb, IL 60115

Linda Costigan Lederman
Dept. of Communication
Rutgers University
New Brunswick, NJ 08903

Susan Orpett Long
Dept. of Sociology
John Carroll University
University Heights, OH 44118

Alicia A. Marshall
Dept. of Communication
Michigan State University
E. Lansing, MI 48824

Kelly S. McNeilis
Dept. of Communication
Ohio State University
Columbus, OH 43210

Katherine I. Miller
Dept. of Communication
Arizona State University
Tempe, AZ 85287

Jon F. Nussbaum
Dept. of Communication
University of Oklahoma
Norman, OK 73019

Dan O'Hair
Dept. of Communication
Texas Tech University
Lubbock, TX 79409

Roxanne Parrott
Dept. of Speech Communication
University of Georgia
Athens, GA 30602

Geraldine Popolow
Cedars-Sinai Medical Center
8700 Beverly Blvd.
Los Angeles, CA 90048

Eileen Berlin Ray
Dept. of Communication
Cleveland State University
Cleveland, OH 44115

George B. Ray
Dept. of Communication
Cleveland State University
Cleveland, OH 44115

David H. Smith
Dept. of Internal Medicine
University of South Florida
College of Medicine
Tampa, FL 33620

Judith A. Stein
National Eye Institute
National Institutes of Health
Bethesda, MD 20817

Beverly Davenport Sypher
Dept. of Communication Studies
University of Kansas
Lawrence, KS 66045

Teresa L. Thompson
Dept. of Communication
University of Dayton
Dayton, OH 45469

Eric Zook
Dept. of Speech Communication
Pennsylvania State University
University Park, PA 16802

INTRODUCTION

Eileen Berlin Ray
Cleveland State University

All of us have experienced health-care situations where the caregiver's communication made a difference. It may have been at a very personal level, like when we were given instructions regarding a necessary health regimen, or when we had to interpret information for our young child or elderly parent. It may have been during an acute health crisis when expedient life-or-death decisions had to be made. Or it may have been at a less personal, but none the less important, level, like when hearing public service announcements or Magic Johnson's announcement of being HIV positive. The bottom line is that our willingness to comply or take preventive action often depends on the messenger as well as the message and receiver.

In most health-care situations, caregivers' technical competence is assumed as long as they are perceived as competent communicators (see, e. g., the cases by Thompson & Gillotti, chapter 7 and Sypher, chapter 8). This impression is critical because it is the basis from which we make subsequent decisions, including whether to comply with a regimen, seek additional opinions, agree to organ donation, prevent mass health catastrophes (i. e., AIDS), and even pursue lawsuits (Thompson, 1990). It is the communication of health-related messages, whether at the individual, organizational, or mass level, that is the critical variable around which other variables must revolve (Donohew & Ray, 1990). And it is these relationships that have been the focus of the field of health communication.

The study of health communication has seen a dramatic rise since the mid-1970s. As a field, health communication first received formal recognition

with the establishment of the Health Communication Division of the International Communication Association in 1975. Since that time, the discipline has continued to grow with the establishment of the Speech Communication Association's Commission on Health Communication, the journal *Health Communication*, many scholarly articles appearing in communication and allied health journals, and numerous textbooks to meet the growing curriculums at both undergraduate and graduate levels. All of these occurrences are positive signs of the emergence of health communication as an exciting area for communication scholars. It offers the opportunity to conduct timely, theoretically based applied research that really can make a difference in people's lives. And it is this wedding of theory and application that holds the most promise for the field of health communication, for either one without the other is useless. Case studies are particularly appropriate for the study of health communication, because they provide a vehicle for applying theory, resulting in insight and understanding unattainable from other methods (Sypher, 1990).

It should be noted that most health communication scholars have homes in one or more other subdisciplines of communication (i. e., interpersonal, organizational, mass). This crossover adds a richness to the field. However, it would be inaccurate to assume that one can simply apply theories and concepts from these other areas. This view is overly simplistic and neglects the unique features of communication in a health-care context (Donohew & Ray, 1990). When dealing with health communication issues, of particular salience is the exigency of outcomes. Whether the focus is preventive health issues or health crises, the impact of communication at every point of health care by all health-care providers has the potential to critically influence the outcome. These outcomes include prevention, palliative care, as well as education. And the educational outcome includes health-care practitioners (see, e.g., the cases by Miller, chapter 1; Marshall, chapter 2; and Smith & Harris, chapter 3), health-care recipients (see, e.g., the cases by Freimuth, Stein, & Kean, chapter 20 and Kreps, chapter 21), as well as students.

For the purposes of this book, the case studies highlight the role of communication in the arena of health care. One of the primary goals of these cases is to consider health-care contexts in which communication becomes critical. It is important that the unique features of communication in these contexts are made salient, not neglected or underplayed.

ORGANIZATION OF THE BOOK

For organizational purposes, the cases are divided into sections. It should be noted, however, that these divisions are arbitrary. There is much overlap of relevant concepts among cases. For example, the threads of personal control, uncertainty reduction, and social support are woven throughout many of the

cases. In Part I: Issues in Medical Training, these issues are pertinent to health-care *providers*. Part III: Issues in Medical Care, highlights the need for personal control (or at least the illusion of control), uncertainty reduction, and social support for health-care *recipients*. Cultural differences regarding the importance of these concepts are included in Part V: Issues in Cultural Dynamics, whereas Part VI: Issues in Health-Care Delivery, applies these concepts to change at the organizational level. These are certainly not the only concepts embedded in these cases. But this example highlights some common core issues that keep emerging. Their emergence, and their impact on outcomes, are significantly influenced by the contexts they occur in. Whether dealing with chronic or acute illness, proactive or reactive health care, or preventive as opposed to reactionary public health campaigns, the dynamics of the communication process and its sphere of influence vary, are seen in an overview of the cases.

AN OVERVIEW OF THE CASES

Part I begins with a more global perspective, provided by Miller's case (chapter 1), which follows a medical student through medical school and residency/internship. Miller taps into critical issues faced by medical students—their feelings, their transition into doctors, their coping strategies, their self-doubts, their communication with professors and other students. From this case, we move to two more specific issues for medical training: the teaching of interviewing techniques (Marshall, chapter 2) and ethical issues medical students must consider (Smith & Harris, chapter 3). Marshall focuses on a specific communication training technique currently being used in the medical school at Michigan State University. As seen in this case, physicians' typical orientations to patients, as reflected in their interviewing skills, tends toward a traditional biomedical orientation. The training Marshall presents enables physicians to become more patient-centered and take a more holistic view of patients. In Smith and Harris's case, medical residents are forced to address very difficult ethical issues. Communication scholars have not studied various communicative aspects of this decision making, yet communication is clearly critical to reconciling many of these issues.

Part II focuses on issues in caregiver–recipient communication. Both the Parrott (chapter 4) and O'Hair and McNeilis (chapter 5) cases examine three-party communication. Although both focus on the triad of physician–parent–child, Parrott examines the context of the young child with the parent being the primary communicator, whereas O'Hair and McNeilis examine the elderly parent with the child being the primary communicator. The reactions of all involved to the role reversal issues highlighted in this case raise important concerns for both caregivers, care recipients, and their third-party advocates. Nussbaum and Bettini (chapter 6) compare communication between family members, caregivers, and administrators and its impact on the resident in two nursing homes. The

cultures of each home become clear through the verbal and nonverbal communication in each of them, and their subsequent impact on the resident show how poor care for a chronic condition can result in a serious acute health problem.

Part III continues some of the issues raised in Part II but has the added dimension of focusing on crisis/acute care situations. Thompson and Gillotti (chapter 7) examine communication issues in a neonatal unit as a mother recovers from her own injuries due to a car accident and her prematurely born infant fights for her life. The uncertainty and lack of control surrounding this crisis, juxtaposed with the expectation of having a healthy baby, raises issues that can be mediated by effective communication strategies. How the parents and staff communicate, and how the staff communicates with the baby, are pivotal for the infant's recovery. Sypher's case (chapter 8) moves to the sudden diagnosis of a tumor, the uncertainty of its malignancy, the swiftness with which life-saving or -threatening decisions must be made, and the incompetent communication skills used by some of the health-care providers. Finally, the case by Zook (chapter 9) examines the reflections of a lover after the death of his partner from AIDS. This poignant case emphasizes issues of decision making in life-threatening situations, the dance of their daily life around the partner's illness, and the final illness that leads to his death.

Part IV emphasizes issues of social support. Again focusing on AIDS, Cline and Boyd (chapter 10) present a case study of two HIV-positive persons. As they tell their stories, the importance of different types and sources of support, and the lack of support each has experienced, is particularly salient. Braithwaite (chapter 11) focuses on how a disabled person learns to live with her disability and teach others along the way. The stages of acceptance, structural, and interpersonal barriers that block her goals, and an acceptance of reliance on others when necessary raises important concerns regarding when what types of support are most appropriate and from whom. The case by Lederman (chapter 12) examines a weekend dormitory party on a college campus where the beer is flowing heavily. The types of support provided by the friends, in sickness and in health, as well as the university's attempt to deal with problem drinking among students, are key issues in this case. E. B. Ray (chapter 13) focuses on issues of support among nursing aides in a nursing home. Sources of support include the administration, supervisors, co-workers, residents, and residents' families. Types of support received from these sources, and incongruent perceptions of what support actually is, are highlighted in this case.

Part V examines health-care issues across several specific cross-cultural settings. G. B. Ray (chapter 14) looks at how a man rooted in Appalachian culture deals with life changes after the sudden death of his wife. Cultural norms prevail, and later conflict, in both his choices of coping strategies and his ability to seek help before he becomes ill. Long (chapter 15) observes how Japanese cultural differences in their determination of relationships influences decisions regarding health care, and Gonzalez (chapter 16) examines how Mexicans in

Chihuahua perceive care received at home and in the United States, with these perceptions often factually inaccurate.

Part VI emphasizes issues of change in health-care delivery. Hardesty and Geist (chapter 17) focus on the "dirty work" of having to tell patients and their families about changes since the implementation of DRGs for Medicaid patients and highlights the proffering of these responsibilities and the impact of this major change on caregiving. Halsey and Albrecht (chapter 18) apply a feminist perspective to understanding why change initiated by a nurse administrator in a hospital fails. Hidden agendas, lack of forthright communication, and lack of support from those most likely to feel threatened by the change are key issues. Aydin, Eisenberg, Bolton, and Popolow (chapter 19) describe an actual change strategy implemented at a major medical center. Here we have an example of successful change implementation and can follow what makes this attempt successful.

Finally, Part VII examines two mass systems of medical information dissemination, both sponsored by the National Cancer Institute. Freimuth, Stein, and Kean (chapter 20) explain the formation and workings of the Cancer Information Service (CIS). Kreps (chapter 21) explains the origins, updating, and workings of the Physician Data Query (PDQ), a computer-based program to allow physicians and cancer patients access to the most current treatment protocols. Typically, the CIS is available to the public and provides written information about specific types of cancer, as well as information about the most current treatments available. The PDQ is available to physicians, enabling them to provide invaluable information for anyone confronting cancer, directly or indirectly.

This book focuses on the complexities of the communication of health-related messages and information through the use of case studies. The contributors to this volume are scholars who, through their research, consulting, and expertise grapple with many of the issues of concern to those studying health communication. Although several introductory books offer brief cases to illustrate concepts covered in a preceding chapter, this book provides in-depth cases that enable more advanced students to apply theory to real situations.

ACKNOWLEDGMENTS

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