CHAPTER 15
DOCTOR-PATIENT RELATIONSHIPS THE MODERN ERA

[Can We Talk - A Collaborative Shift in Bedside Manner?]

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“The single biggest problem in communication is the illusion that it has taken place.”
— George Bernard Shaw

Star Trek fans have seen the future of medicine.

Leonard McCoy, also known as “Bones,” describes himself as a “simple country doctor,” although he plies his trade using 23rd-century medical technology. A deeply caring humanist, Bones often spars with the hyper-logical Spock—half human, half Vulcan. But as the Star Trek saga unfolds through The Next Generation, Deep Space Nine, and finally Voyager, Star Fleet physicians become increasingly rational and less recognizably human. The Voyager’s “Doctor” is no person at all. “He” is an infallible computer program designed to mimic compassion, self-assurance, and other soulful qualities.¹

Today, when patients communicate through instant messaging, Twitter, Facebook, and other Web 2.0 electronic mediums, they might feel that health providers are already more like the virtual “Doctor” than the all-too-human “Bones.” Before long, according to one technology expert, 20% – 50% of all doctor-patient communication will be virtual.² But we suggest you pause before rocketing ahead into this brave new future
that advocates call Health 2.0—the application of social media tools to the health care environment.

Electronic technology in all of its forms has obviously had a profound impact on medicine. We focus here on just one of its most notable effects: the changing doctor-patient relationship. We believe Health 2.0 has the potential to deepen this relationship—or not. It depends on how you use it.

There are an almost overwhelming number of social media tools for managing the doctor-patient relationship. How do you choose the right ones? We offer some guidance in this essay by focusing on three issues:

1. What matters most in the doctor-patient relationship?
2. What counts as a good relationship?
3. How should you use social media tools to build a relationship?

We have found that there is no one best way to use Health 2.0 technology. But there is just one rule. As the novelist E.M. Forster said, “Only connect.”

**CONNECTION MAKES A DIFFERENCE**

Web 2.0 is all about connecting. Take your pick: you can communicate via blogs, tweets, IMs, wikis, or social networks. And then, of course, you can opt for just plain old face-to-face dialogue.

On the face of it, the explosion of communication options seems like a very good thing indeed. In the most basic ways, human beings need connection. Without the give and take of social interaction, our health suffers. In extreme situations—in solitary
confinement or similar conditions—the brain almost completely shuts down. The journalist Terry Anderson was held hostage in Lebanon from 1985 to 1992, enduring months at a time of almost complete isolation. In his memoir Den of Lions, Anderson described the catastrophic result: “The mind is a blank.... Where are all the things I learned, the books I read, the poems I memorized? There’s nothing there, just a formless, gray-black misery. My mind’s gone dead.”

On the positive side, studies have established a link between social connection and good health. (Even contact with people you dislike is better than having no contact at all.) The same goes for the relationship between doctor and patient: data show that when the relationship is satisfying, it has tangible health benefits. For example, when patients have a positive emotional connection with their doctors, they remember a higher percentage of care-related information and even experience significantly better physiological outcomes. And the way doctors converse with patients—apart from the actual content of the conversations—has an equally powerful effect. Do you want your patient’s nagging headaches to go away? Discuss their expectations and feelings, in addition to the neurological facts. This is much more effective than sticking to the facts alone, since a strong psychological bond is strong medicine. Do you want your advice to be followed? Draw your patient into conversations about treatment. The research shows that engagement makes a difference.

**ONE SIZE DOES NOT FIT ALL**

So far, so good. Social connection equals better health. Web 2.0 equals better social connection. Therefore, Web 2.0—and by extension Health 2.0—seems to equal
better health. No wonder that lead-users have made enthusiastic pronouncements about
the wired world.

Dr. Ted Eytan, a nationally recognized proponent of digitally enhanced patient
care, has blogged his own “declaration of health care independence”:

Health 2.0 is participatory health care. Enabled by information, software, and
community that we collect or create, we the patients can be effective partners in our
own health care, and we the people can participate in reshaping the health system
itself.

This is more than hype.

Web 2.0 has helped Rachel Baumgartel, a patient we came across in our research,
to create her own Health 2.0 community. Rachel suffers from type-2 diabetes. She tweets
with dozens of people about what she ate in the morning or how much time she spent
exercising at the gym. Her social network extends far beyond her hometown of Boulder,
Colorado, so she has a support group that is always there for her, supplementing the care
she receives from her doctor. “Because I have people who follow me on Twitter,” she
relates, “it means I have some kind of audience that is caring for me in the background.
It’s helpful if I’m having a rough day.”

Health 2.0 works for Rachel. And it works for a lot of other people, too. Some
patients are much more likely to reveal information about psychiatric issues on-line than
they are speaking in person to a therapist. And men seem to do better managing prostate
problems when they spend time on the Internet researching questions and accessing
support groups.

But it doesn’t work for everyone in every situation.
For a lot of patients, virtual contact is not good enough. As one real-world die-hard put it, “I think that if I meet a new doctor and we don’t have that face-to-face contact, I would not feel comfortable telling him all my ills.” And for other patients, virtual relationships lead to undesirable results. A physician we interviewed for this article told us flatly that eating-disorder patients should not have an on-line community. Facebook has such a group. Members support each other—in all the wrong ways.

More generally, our own research into communication has shown that people have different preferences for how they like to give and receive information, on- and off-line. In talking with a patient, a doctor might use her professional status to give medical advice extra force. Some patients respond positively to this kind of authoritative style—they do well when they feel an expert is giving orders. Data-oriented people find studies more persuasive. As patients, they like knowing their treatment is based on reliable research and that their surgeons have performed a procedure more times than most specialists. But others, because they value relationships, want to feel they have a partnership with their doctors. Data is less important to these patients than an experience of emotional connection. In *Star Trek* terms, some patients long to be treated by a compassionate physician like Bones, while others prefer a more coldly authoritative—and even authoritarian—clinician like the computerized “Doctor.”

Thus, when it comes to the quality of a doctor-patient relationship, one size does not fit all. What counts as “connection” differs from person to person, depending on their psychological and technological preferences. A truly patient-centered physician pays attention to these communication differences and the demands of each situation.
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HEALTH 2.0 EXAMPLE

Evolution of Health 1.0, 2.0 and 3.0

Web 1.0 - information is relayed from business to consumer (basic B2C website). The web becomes one big encyclopedia, of sorts.

Web 2.0 - information is communicated between business and consumers (B2C) and between individual patients (P2P). This is the "Post a Comment"/"Start a Blog"/Skype/YouTube web. If web 1.0 was a textbook, web 2.0 is a live discussion.

Web 3.0 - it's not information anymore; it's artificial intelligence (AI). You'd interact with it almost like another person. The web won't just blindly do what we tell it do to, it'll think for you.


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WHAT COUNTS AS A GOOD RELATIONSHIP?

Researchers at the University of Pennsylvania are experimenting with an electronic nose that literally smells disease. In the not-too-distant future, it may be able to detect whether a patient has an infection in the lungs or somewhere else. There is no need
to be radiated with an X-ray, or to wait anxiously for two days as bacteria sprouts from a biological sample. One simply lies in a hospital bed while the super-sensitive machine monitors the body’s exhalations.\textsuperscript{xv}

Hippocrates, the founding father of Western medicine, did it differently. He relied on smell, too. But he used his actual nose. He sniffed and inspected his patients’ stool, as well as their earwax, pus, and phlegm. Then he went further, recording the details of his patients’ diets, the water they drank, the local weather, and even the positioning of their house. He spent a lot of time getting to know the highly personal facts of his patients’ lives. He was an early practitioner of individualized and holistic medicine.\textsuperscript{xvi}

But doctors in the Hippocratic tradition have not always had this kind of intimate relationship with their patients. In 17\textsuperscript{th}- and 18\textsuperscript{th}-century Europe, the standards of human dignity imposed limits, especially on physical contact. Health providers were just as likely to scrutinize the story of an illness as its observable symptoms. Dr. John Symcotts, who had a successful practice that encompassed two English villages, captured his patients’ narratives in casebooks that contained vivid descriptions of intense subjective experiences. One patient, Miss Christian Tenum, complained of “a heavy burden or weight continually pressing down upon the top of her head,” a “pulsing of the arteries,” and “images passing before her eyes.” The diagnosis was unclear. Symcotts prescribed a fluid diet and a medicine that helped her expel stones with her urine. The outcome? Miss Tenum was cured.\textsuperscript{xvii}

In Symcotts’ era, physicians treated subjective reporting as a valid source of information. Using an ancestral form of telemedicine, they even based diagnoses on letters. John Morgan, a founder of the University of Pennsylvania’s Medical School in
the late 1700s, offered his expert opinion on patients who lived “a distance from Philadelphia, whenever the history of the case is properly drawn up and transmitted to me for advice.” Why the emphasis on spoken and written first-hand accounts? In the words of one physician, there was a “repugnance” to physical examination that was “natural and proper.”

Bottom line: intimacy can take strikingly different forms. This is especially important to remember in the world of Health 2.0, where you have so many choices for communicating. In purely human terms, we think the relationship that Hippocrates had with his patients was neither better nor worse than the one Symcotts had with Miss Tenum or that Morgan had with his epistolary advice-seekers. Hippocrates paid meticulous attention to a patient’s circumstances: emotional outlook, diet, bodily secretions, family relationships and friends, climate, dwelling. Symcotts may not have known his patient in all of these ways, but he could hardly have been more committed to understanding Miss Tenum’s story in her own terms. In different but equally valid ways, Hippocrates, Symcotts, and Morgan were patient-centered.

INTIMACY CAN BE ELECTRONIC

Today’s electronic mediums make possible yet another kind of intimacy. ICTs—information and communication technologies—enable 24/7 monitoring of basic information such as blood pressure, glucose levels, pulse, and respiration. In one study, an ICT not only made it easier for patients to stay in touch with their doctors, the outcomes were also significantly better. Today, Hippocrates is no longer trailing patients around the house to keep track of their snacks and moods. But Hippocrates has
gone digital in the form of a wearable device that records subtle changes in biological markers and communicates them instantaneously to a health provider.

While this is obviously a great advance, we suggest you pause for a moment before plugging in. Why? ICTs and social media tools can make a difference to one of the most important dimensions—physiological outcomes. But you can have the latest interactive technology at your disposal and still fail to be connected.

A story that a friend told us shows how. One morning, her elderly father was touching up the paint on his sailboat. Nearby, another boat-owner, who happened to be an emergency medical technician, noticed her father was struggling to breathe and that his lips had turned purple. A trip to the local community hospital led to a barrage of high-tech tests and procedures, a diagnosis of emphysema, later complications with cerebral hematomas, and hospitalizations and re-hospitalizations that brought him into contact with a neurologist, a neurosurgeon, a cardiologist, and a pulmonologist. Throughout her father’s medical ordeal, the team of specialists stayed in touch with each other and the primary care physician via various electronic media. But one person remained out of the loop—her father. One day, six months into the experience, the primary care physician phoned our friend’s mother to check on his patient. Her father recalls thinking, “Why was he calling her?” The physician was communicating, but he was emotionally disconnected.

The moral of the story: communication needs to be patient-centered in both electronic and psychological terms. That means understanding how someone likes to communicate and making sure the medium fits the message. Electronic media are just part of the equation. The other is the doctor-patient relationship. Once a relationship is
established, it may be fine to use e-mail to send information about dosage. But delivering a new diagnosis may require the extra effort of scheduling a phone call or a face-to-face visit. Today, since you have so many Health 2.0 choices, it takes some effort to select the right way to communicate in a particular situation.

USE THE RIGHT RELATIONSHIP STRATEGY

A colleague recently shared a story about an encounter with a specialist. After an examination for a minor ailment, he was told that there might be a medicated lotion that could ameliorate his condition. The doctor thought for a moment, then swiveled around to the computer on his desk. As our colleague watched the screen, his physician typed a few words into a search engine. Up popped a list, and he wrote out a script. “Try this,” his doctor concluded. “I think it will help.” It did, almost overnight.

Even though his physical problem had disappeared completely, our colleague felt there was something missing in the interaction. “It bothered me that my doctor turned to the Web for help at that moment. He found a cure, but I felt he wasn’t paying attention to me.” The physician is supposed to be an authority who has a special relationship to the patient. “Anybody can Google,” our colleague complained. Was he being unreasonable? Maybe. But this story tells us something important about technology—it cuts both ways.

Everyone has their own preferences when it comes to how they want to interact with each other and with technology. If these preferences are explicit and aligned, the chances for a productive partnership are high. The preferences, however, are many and complex. You can easily get lost in the tangled thicket of interpersonal styles and virtual mediums.
In the Web 2.0 environment, it helps to narrow down the endless choices to just a few options. Based on our communication research, we recommend four basic relationship strategies, each representing a blend of face-to-face and virtual connection:

[Insert Table 15.1]

Every situation is different, so you need to exercise clinical judgment in choosing the appropriate strategy. But in every case, it pays to ask one central question: What is the right balance of emotional and informational needs? When the need for emotional contact is high - lean toward “high touch” encounters! If informational needs are strongest, rely more on social media tools. We give illustrations of each relationship strategy below.

**High Touch**

Some situations clearly require face-to-face contact. Among the most important: when you first deliver a diagnosis or when information is potentially upsetting. At these times, patients need the comfort that only a live discussion can provide.

But even in these situations, interactive technology can play a part. Consider the following story involving a family member. Having had surgery for a benign brain tumor, he was at his annual follow-up appointment. After an MRI, he waited in the examining room to see his neurosurgeon. As he waited, his anxiety mounted. A young neurosurgery fellow came in to review the case and to share preliminary information about the MRI results and the overall status of the tumor. “Do you want to see it?” he asked. The fellow quickly turned to the computer on the exam room table and within seconds pulled the
original MRI scan (from six years prior) and the scan that had been taken a few hours earlier. He put them up, side by side, pointed out the visible difference between the two, and proceeded to explain the treatment.

The news was good. The artful use of technology made it even better. The patient was relieved—but also engaged and informed. He actually looked forward to future encounters with his medical team.

Irrespective of the nature or stage of their physical conditions, some patients always prefer “high touch,” like the person we quoted earlier who required face-to-face contact to share her “ills.” With these people, you should expect to use virtual mediums sparingly, if at all.

**Balanced**

In general, patients do better when they are knowledgeable and actively involved in their care. When your primary goal is to give them the information they need to make the best decision, you should strike a balance between virtual and face-to-face communication.

The researchers Ben Gerber and Arnold Eiser found that, as decision-makers, patients fall into two categories: the “knowledge acquirer” and the “informed decision-maker.” The knowledge acquirer is the more passive one—more comfortable with the physician as the ultimate authority. But this patient may still want to learn about his condition. In this case, you can “prescribe” a website that provides background on healthy diets or home care. These patients are more likely to comply with behavioral
advice if a health provider has “primed” them before they review online material that supplements other information sources.

The informed decision-maker wants to participate more fully in making decisions. You can make face-to-face meetings with these patients more productive by directing them to sites where they can use credible information to educate themselves. Be prepared to spend time with informed decision-makers sifting through options. The payoff: they will be more likely to follow through on a course of care.

**High Tech/High Touch**

New York-Presbyterian hospital is using personal health records to create a high tech/high touch relationships with heart patients. Patients receive help accessing a Web portal, myNYP.org. Once they get online, they control their own data, bringing it via the Internet to appointments within the New York-Presbyterian health system and elsewhere and checking it whenever they want to. Administrators expect the online record to yield several positive results: better communication and collaboration between doctors and patients, lower readmission rates for easily preventable conditions, and improved continuity of care. Patrice Daly Cohen, who recently had heart-valve replacement surgery done at New York-Presbyterian, used the site when she was recovering at home to read the reports from her hospital stay. She had a too-much-information experience, but she satisfied her urge to be in the know. “I am someone who likes to be in control. I think it’s great.” High tech/high touch was perfect for the high-control Ms. Cohen.

**High Tech**
Patients who are comfortable working online can handle routine informational issues using high tech tools. At Patientsite.org, at Boston’s Beth Israel Deaconess Medical Center, patients use the site to read and send e-mail, make appointments, see personal test results, and refill prescriptions. They can also access information about wellness services, medication management programs, and decision-making tools. This is one place where the future has already arrived for empowered, electronically enabled patients.

The history of the physician-patient relationship, in different ways, is all about connecting. Hippocrates kept track of his patients’ every habit and idiosyncrasy. John Symcotts listened to the nuances of their stories. At myNYP.org and Patientsite.org, patients exercise direct control over their clinical data and other aspects of their care—they are empowered to keep track of themselves and tell their own stories. But even in these high-tech settings, where patients collaborate electronically with health providers, relationships still matter. And maybe they matter more than ever.

HEALTH 2.0 NEEDS GUIDELINES

When it comes to the doctor-patient relationship, Health 2.0 needs guidelines. Several leading health providers have begun to call for them. We think guidelines would, among other things, help define the right mix of virtual and live communication. Our four relationship strategies take a step in this direction. Such a framework can be used to start a productive dialogue among health providers about social media. A hospital committee or some other governing body could easily use Web 2.0 tools—a blog or a wiki—to start
the discussion. Before long, there would be ample case material to flesh out general principles.

Guidelines would also address a big barrier to using Health 2.0: getting paid. Currently reimbursement policies do not cover electronic communication, so physicians have little financial incentive to use it. In a 2003 study, only 9% of physicians were willing to use e-mail to communicate with patients. This has something to do with old habits. But it has a lot to do with payment schedules, too. Guidelines should feature the research that shows the positive health outcomes of strong physician-patient relationships and how social media tools help build relationships. In today’s “pay for performance” market, these outcomes help build credibility for wired communication.

We also think Health 2.0 guidelines need to be supported by training. Studies show that training in interviewing and interpersonal skills produces substantial differences in the quality of care. Training in Health 2.0 communication would likely have a similar impact.

Paradoxically, as patients can access and control more data, they have a greater need for trusted physicians who communicate well using various mediums. As Ted Epperly, President of the American Academy of Family Physicians, has said, patients need “wise counsel” in sifting through the prodigious amounts of information available via Health 2.0. And physicians as well as patients need to learn how to navigate this environment. No longer the sole authoritative source of medical information, physicians need to adapt, becoming an experienced partner and guide for inquiring patients. Training can help doctors get comfortable in this new role.

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HEALTH 2.0 EXAMPLE

On Doctors Censoring Patients

www.MedicalJustice.com

As consumer-oriented websites arise, some insecure doctors are telling their patients to censor comments, or find another physician. This, of course, is anathema to collaborative websites like RateMDs and Vitals.com. The sites give internet users the chance to recommend physicians and review hospitals nationwide. Yet, some ethicists believe that such self-interested behavior is not professional and when a doctor acts primarily out of self-interest it is ethically suspect.

However, other healthcare organizations encourage this activity and take it to the next level. For example, Henry Ford Hospital in Detroit uses Twitter from the operating room, and Methodist University Hospital, in Memphis, promotes itself with video-casts from the operating room.

Today more than 250 hospitals use YouTube, Facebook, Twitter, blogs or other Health 2.0 promotional strategies.

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ASSESSMENT
One early physician leader of the emerging movement fostering patient collaboration is Donald M. Berwick MD; first the CEO of the Institute of Healthcare Improvement [IHI.org] in Cambridge, MA and more recently named to head CMS. Along with his administrative staff, there are hundreds of expert faculty members from around the world who dedicate extensive energy to help spread the core ideals, methods and philosophies of participatory medicine. And, a cadre of advisors from the Associates in Process Improvement brings tools to support the change [APIweb.org].

Another early lay advocate of the electronically enabled [i-doctor and i-patient] relationship is Matthew Holt from TheHealthCareBlog.com. He is co-founder of the international Health 2.0 Conference who, along with citizen and medical journalists like Scott Shreeve, Roger Collier, Charles Baker, Maggie Mahar, Joshua Seidman, Adam Bosworth, Brain Klepper, Jane Sarasohn-Kahn, Heanne Scott, Ian Morrison, Joseph DeLuca, Indu Subaiya, Hilary McCowen, Lizzie Dunklee, John Irvine and Gary Schwitzer, are leading the paradigm shift from bedside manner to patient empowerment [Health2con.com].

Other affiliated Health 2.0 consultants include:

- Esther Dyson (EDventure) is founding chairman of ICANN and early investor in Medscape who is actively involved in health care, both as an investor–Medstory (Microsoft), PatientslikeMe, 23andMe, ReliefInSite and many more.

- David Kibbe, MD (AAFP) is Founding Director of the Center for Health Information Technology for the American Academy of Family Physicians, and co-developer of the ASTM Continuity of Care Record (CCR) standard for interoperable health information exchange.
- Doug Goldstein (eFuturist) is the author of: Health eGames: How Video Games, Social Media and Virtual Worlds will Revolutionize Health; eHealthcare: Harness the Power of eCommerce and eCare; and Medical Informatics 20/20: Quality and EHRs through Collaboration, Open Solutions and Innovation. As President of iConecto, he develops innovative Health@Everywhere strategies and solutions. iConecto is also the sponsor of Gaming4Health.com.

- Enoch Choi, MD (MedHelp.org) is a full-time physician at the Palo Alto Medical Foundation, and Product Manager of Community at MedHelp.org. He uses an eMR in his practice and provides consulting services for Sutter, Epic, and Misys. He blogs at MedMusings.

- Jane Sarasohn Kahn (ThinkHealth) started THINK-Health to deliver insights on trends, technology, and policy to clients across healthcare. She writes a monthly online column in iHealthbeat, is a founding principal of Health 2.0 Advisors, and blogs at Health Populi. She’s the author of the seminal California Health Care Foundation report on social networking in health care called The Wisdom of Patients.

- Sunil Maulik (Bottom Line Time) is a long time leader at the integration of bio-sciences and information technology. He is a Principal at Bottom Line Time but was previously Founder & CEO of GeneEd, an clinical e-learning company and ran business development at DoubleTwist.com
In participatory dental medicine, the name to know is Darrell K. Pruitt DDS, of Fort Worth Texas. He is author of Pruitt’s Platform, published on the Medical Executive-Post blog site and communications forum.

And, in collaborative podiatric medicine, the Health 2.0 go-to guru is Dr. William P. Scherer MS of Boca Raton, Florida, another Medical Executive-Post thought-leader.

Still, the Health 2.0 philosophy is not an organization with walls; it is really more of concept and movement for collaboration and change. And, such a transition is only possible to the extent that change-minded people and organizations are part of the work.

CONCLUSION

Yet, as enthusiastic as we are about the transformative potential of Health 2.0 in enhancing the doctor-patient relationship, we think it has limits. Health 2.0 is not for everyone or every situation. In a recent Wall Street Journal article, Drs. Jerome Groopman and Pamela Hartband remark that medical care will never be like other activities that have become completely virtual, much like online banking or retailing. Many treatments require that health providers promote behavioral changes: healthy diets, exercise, weight loss, and smoking cessation. To make these changes, people need the emotional support found in a relationship—a relationship in the form of an actual, caring person.xxv

One of our colleagues at the University of Pennsylvania, Dr. William Hanson, has written movingly about his father, who as a physician used his hands as diagnostic tools. His father treated his hands like a craftsman, cleaning, filing, and polishing his nails, because he cared for his patients by literally touching them with his practiced fingers. His
hands were critical sources of information. Advanced technology may one day completely replace the physician’s hands as diagnostic tools, but even the most educated, tech-savvy patients will continue to need the wise counsel provided by a physician. A sensitive hand placed on the patient’s shoulder may be the optimal medium for communicating that counsel. Health 2.0 guidelines thus need to emphasize that healing occurs in a relationship.

The future has arrived: Health 2.0 is already revolutionizing communication. But the computerized “Doctor” will never completely replace the all-too-human Bones.

COLLABORATE NOW: Continue discussing this chapter online with the author(s), editor(s) and other readers at: www.BusinessofMedicalPractice.com

Acknowledgements

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References

4 Gawande, “Hellhole.”
Table 15.1

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