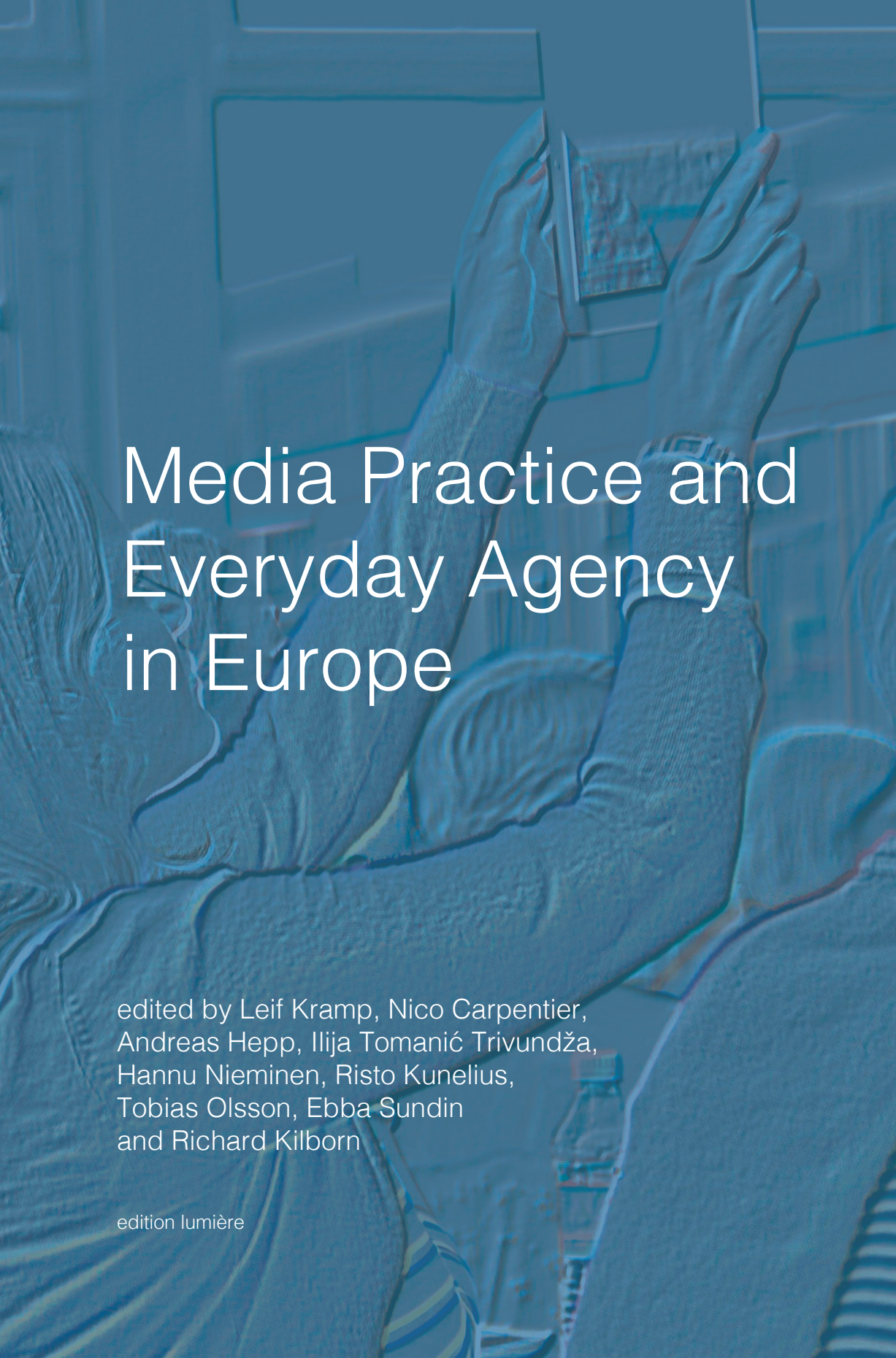

Media Practice and Everyday Agency in Europe

edited by Leif Kramp, Nico Carpentier, Andreas Hepp, Ilija Tomanić Trivundža, Hannu Nieminen, Risto Kunelius, Tobias Olsson, Ebba Sundin and Richard Kilborn

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PART 2
The European Media and Communication Doctoral Summer School 2013 and its Participants

Doctor-Patient Relationship in a Digitalised World

Dorothee Christiane Meier

1. Introduction

The current wave of "mediatization" (cf. Hepp, 2013; Krotz, 2001; 2007; 2009) – the establishment of digital internet-based services and the related overall transformation of our media environment – has the potential to shape the doctor-patient relationship through changes in role models and communication. In the past, patients could either gain a (first) impression of their doctor through recommendations and experiences of acquaintances, friends, and family members, or through a direct visit to the doctor's office. Nowadays, patients can use personal or institutional websites to inform themselves prior to treatment or after consultations in order to gain a deeper impression of the physician and/or their reputation. Examples of this are doctor rating sites such as RateMDs.com, DoctorsDig, and vitals.

Instead of having to visit the doctor's office or calling by telephone, patients can now use both synchronous and asynchronous internet-based communication technologies such as instant messaging or e-mail to contact their doctor. Specialised websites offer online consultations to patients that include diagnosis, advice, writing of prescriptions, and the delivery of drugs. Examples are DrEd, DrThom and netdoctor.

Moreover, the internet enables simplified access to specialised knowledge for patients. Expertise no longer just resides in the minds of doctors and in expensive books, but can be found through search engines and health information websites. There are many websites containing health information (e.g. healthfinder.gov, MedlinePlus, FamilyDoctor.org), some of which contain information certified or created by doctors. Patients also share their personal experiences of illnesses in discussion forums (e.g. patientslikeme). These services offer patients the possibility to inform themselves prior to, during, or after a visit to the doctor's office.

Finally, the internet and especially the availability of (mobile) internet-enabled devices allow the use of technologies that can take over some of the functions doctors otherwise perform, such as forming a diagnosis (e.g. myS-

Meier, D. (2014) 'Doctor-Patient Relationship in a Digitalised World', pp. 115-126 in L. Kramp/N. Carpentier/A. Hepp/I. Tomanić Trivundža/H. Nieminen/R. Kunelius/T. Olsson/E. Sundin/R. Kilborn (eds.) *Media Practice and Everyday Agency in Europe*. Bremen: edition lumière.

ugr, iHealth Log, and iHeadache). They can accompany patients in their daily routine in the form of health coaches and they support learning processes related to health information. If doctors have continuous access to the same app as their patients do, they are able to monitor their patients' progress and can contact them when necessary.

On the one hand, these examples demonstrate to health-related online services open up new ways of communication that build up or maintain relationships between doctors and patients. On the other hand, they show that health-related online services have the potential to shake up traditional role models, for example the role of the doctor as an expert. They allow patients to gather and exchange information on health issues by themselves and to come up with their own diagnosis. Patients can thereby become experts for their own illness or complaint and take over some tasks that usually rested with the doctor's ability.

The following chapter deals with this increasing mediatization of the doctor-patient relationship. It begins with a description of the relationship on the basis of doctor-patient communication and the traditional role of the doctor and the patient. In a next step the shift from direct communication between doctor and patient towards a variety of different forms of mediated communication is shown. This development is exemplified by describing the increase in the use of health-related online services according to current surveys, as well as through a visualization of the variety of such services. The chapter concludes by pointing out the importance of qualitative research, focusing on the actual changes in doctor-patient communication, and therefore in role models and relationships.

2. The doctor-patient relationship

The following arguments are based on the assumption that reality – and therefore social relationships such as the doctor-patient relationship – is constructed communicatively (cf. Berger, Luckmann, 1967). Luckmann (2006: 24) states that all social realities are formed, maintained, and transmitted through and in communication. Similarly, Krotz (2007: 210) argues: "Identity, the structure of man, his relationships, his every-day experiences, are primarily based on his communication [...]" (translated by the author). Communication, meaning symbolic interaction (cf. Krotz, 2001: 48), between partners in the relationship can happen verbally, non-verbally, or even in the form of an inner dialogue in the other's absence. Krotz (2007: 204) suggests that as long as people have an inner picture of their counterpart they can always return to it while communicating with this person in an inner dialogue or in actual face-to-face communication. This inner picture is always cross-situational in a social relationship[1]

(cf. ibid). Hence, expectations and orientations that accompany the inner picture are not just present in the current situation but predominantly outside of it (cf. Krotz, 2004: 40).

Another aspect of social relationships is that they exist between people and between the social roles that these people assume within a relationship – for example between employee and employer, policeman and criminal, or between doctor and patient (cf. Krotz, 2004: 39). These specific roles are acquired, developed, and updated through communication (cf. ibid: 35). At the same time, one learns about one's counterparts and their specific social role through communication (cf. Krotz, 2004: 35).

Mediated communication[2] represents a large share of today's communication. The current wave of mediatization, the advance of digital media, enables new ways to create new relationships and to maintain and intensify existing ones (cf. Krotz, 2007: 205).

In order to be able to describe the mediatization of doctor-patient communication and therefore the mediatization of roles and relationships in section 3, the following section will outline conventional doctor-patient communication and successively the traditional role of the doctor and the patient.

2.1. Doctor-patient communication

The communication between doctor and patient takes place in a situational context that defines the goals of the communication as well as the expectations and perceptions of the conversational partners (cf. Meyer, Löwe, 2010: 21). Nevertheless, one can generalise overarching phases of the doctor-patient communication with distinct tasks and goals (cf. ibid.). These phases of communication could form a heuristic basis for understanding changes in the communication between doctors and patients caused by the integration of media. Accordingly, Duesberg et al. (2009) divide the process of treatment into three phases. The first phase includes the patient's decision for a specific doctor, contacting the doctor's office, and making an appointment. The patient can already receive some information on treatments during this phase. The second phase deals with the treatment and care of the patient on the doctor's behalf. The last phase includes medical findings, medical certificates, medical estimates, as well as the arrangement of follow-up appointments and referrals. A further distinction can be found in the Calgary-Cambridge Guide, which concentrates on the direct face-to-face communication in the doctor's office. It prototypically names five primary phases: (1) Initiating the Session, (2) Gathering Information, (3) Physical Examination, (4) Explanation/ Planning, (5) Closing the Session (cf. Silverman et al., 2005: 16ff, 117ff). The doctor, who takes the role of the communication guide, is also in charge of structuring the session

and keeping up the communication through appropriate verbal and non-verbal behaviour (cf. ibid.). This guideline is used in medical education and is commonly used by doctors for orientation during a treatment.

2.2. The role of the doctor and the role of the patient

A social relationship always exists between individuals and between their respective social roles as defined above. Parsons (1951: 439-454) was among the first sociologists to define the social roles[3] of doctor and patient, and with that also the concept of the doctor-patient relationship. Following Parsons, the role of the doctor is characterized by the following properties (cf. ibid.): an absolute willingness to help (universalism), independent of patient characteristics such as race or social background, a professional expertise corresponding to current medical knowledge (functional specificity), rational behaviour, restraint of negative emotions and positive attention to the patient (affective-neutrality), and disregard of personal (economic) interests (collective-oriented). Key properties of the patient's role are that the sick persons are exempt from daily responsibilities (mainly professional responsibilities, but also family commitments) through a diagnosis by the doctor, that they seek the support of a doctor, contribute to a quick recovery, and that they did not get into the problematic situation by their own doing.

The doctor-patient relationship as a social entity has seen drastic changes since Parsons' time. The roles of the doctor and the patient have gained in complexity and can no longer be partitioned as rigidly as described above. Various medical textbooks and many articles dealing with the changes in doctor-patient relationships base their description of changes of these role models on Parsons' historical or traditional idealized characterisation. This change in roles is mostly discussed in the context of related economic, political and legal changes[4]. As roles and relationships are constructed through communication, the change in roles, and therefore the changes in the doctor-patient relationship, cannot – from a media and communication studies perspective – be described without a discussion of communicative change itself.

3. The mediatization of the doctor-patient relationship

Krotz (2007: 38) defines mediatization as a metaprocess of social and cultural change. This metaprocess is a long-lasting, overarching change of media, their meanings, and the opportunities and problems resulting thereof. The process is asynchronous and diversely expressed in different cultures and historical phases. Mediatization describes changes in culture, society, daily routines, social

relationships and identities (cf. Krotz, 2012: 38). Mediatization deals with the continuous expansion of media and mediated communications. It includes (at least) three dimensions of dissolving media boundaries (cf. Krotz, 2001: 22): An increasing amount of media is available at all times (temporal dimension) and can be used in and connect to an increasing amount of localities (spatial dimension). Furthermore, media are used in an increasing number of contexts and situations for more and more purposes (social dimension). In a long-term perspective, mediatization therefore means that direct, reciprocal communication increasingly happens through different forms of mediated communication (Hepp, Krotz, forthcoming). The increase of mediated communication is not linear, but happens in "waves" or "leaps" (Hepp, 2013: 54). Krotz (2007: 44) exemplarily names the establishment of books, newspapers, radio as well as digital networking through PCs and the internet – the current wave of mediatization. These waves have modified the communication of man as a "basis of social and cultural reality" (ibid.; translated by the author) and continue to do so. Based on these theoretical concepts, one can argue that these waves of mediatization have also shaped and continue to shape the doctor-patient relationship. The current change in the doctor-patient relationship is mostly driven by the wave of mediatization[5] that is characterized by the establishment of new health-related online services (see Fig. 1).

The rapid increase in the use of online health information is an indicator for mediatization through digital media and the accompanying shift from direct communication to mediated communication. According to a survey by the Pew Research Center, for example, 72 percent of US American internet users search for health information online (cf. Fox/Duggan, 2013). A third of them diagnose themselves based on online information (cf. ibid.). German usage numbers grew from 15 percent to 45 percent between 2002 and 2012 (cf. Schneller, 2012: 28). Furthermore, mobile search for information has increased as well (cf. Fox/Duggan 2012). The internet is, however, not just used by patients but also by doctors (cf. Stadtler et al., 2009: 256). Nevertheless, direct doctor-patient communication is still the most important source of medical information (cf. Lausen et al., 2008).

There is not just an increase in usage of online health information but also in the amount and variety of available health-related online services (cf. Rossmann, 2010: 356). The range of online services as well as their offline variants (journals such as the Apotheken Umschau[6], TV-Shows such as Grey's Anatomy) can be classified according to Hepp's (2013: 64f.) systematisation[7] of communication as four basic types:

- "direct communication" (meaning direct face-to-face conversation with other people),

- "reciprocal media communication" (meaning mediated personal communication with other persons; for instance, through the use of a telephone),
- "produced media communication" (meaning the area of mediated communication that is classically associated with the concept of mass communication – newspapers, radio, television), and
- "virtualized media communication" (meaning communication with interactive systems – e.g. computer games and robots).

These four types are not mutually exclusive as there are forms of mediated communication that show characteristics of more than one type. Fig. 1 illustrates paradigmatic health-related services for each type.

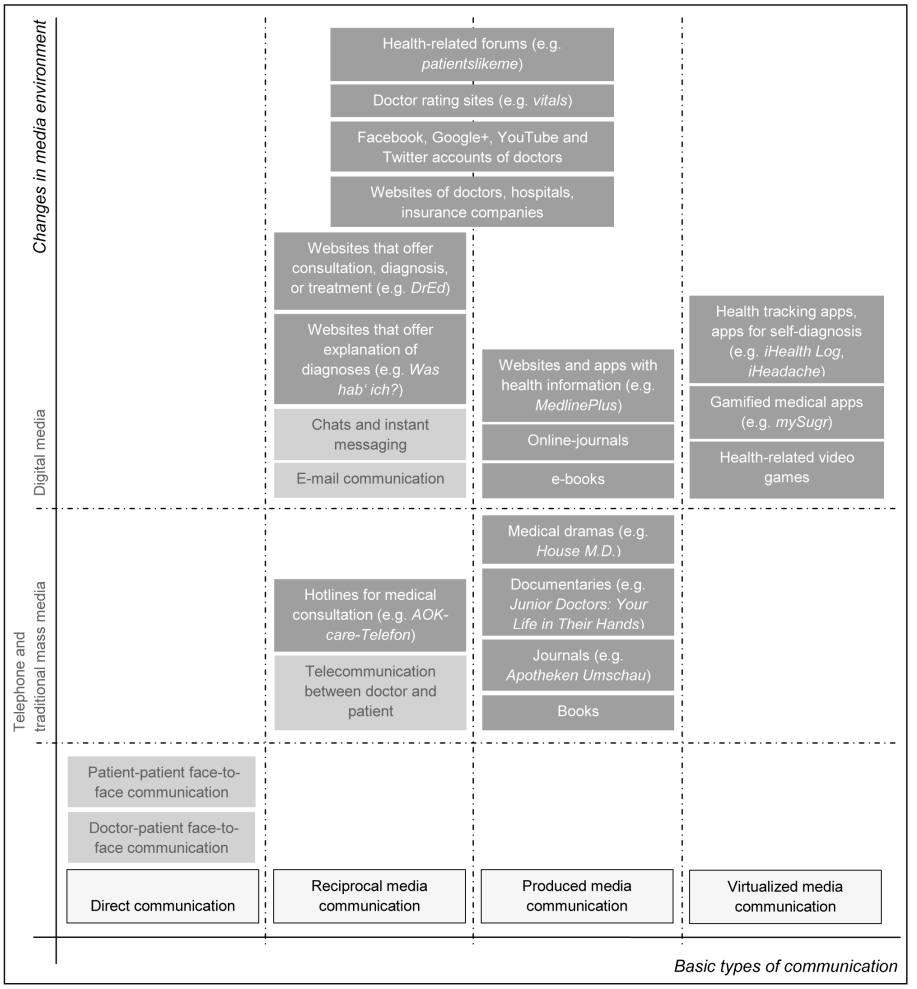

Fig. 1: Mediatization of the doctor-patient relationship

The first type of communication includes "direct communication" between doctor and patient. It still has a central role, especially in countries like Germany that do not allow exclusively mediated consultation, diagnosis, and therapy. Furthermore, this type comprises the communication between patients, such as recommendations for a new doctor or an exchange of experiences with sickness.

The second type, "reciprocal media communication", does not only include phone calls (independent of the technology used – be it mobile phones, landlines, or voice over IP) but all other services that allow synchronous (e.g. chat) or asynchronous (e.g. e-mail) communication. An example of a website that focuses on reciprocal mediated communication is Was hab' ich?/washabich.de, which was created by German medical students and students of computer science. It translates doctors' diagnoses into readable language, thereby enabling an asynchronous communication between (future) doctors and patients. The website DrEd also belongs to this type as it allows individual medical consultation online.

Next to these examples, there are services that mainly belong to the third type, "produced media communication", but often contain specialised functions (such as commentaries or e-mail functions) that also include the potential for mediated interpersonal communication. Examples for these mixed types are social media services, such as YouTube, Facebook, Google+, and Twitter. Many professional Facebook pages of doctors, for example, are mostly used for advertising or as a source of information for (future) patients. However, due to the functionality of the platform used they also offer the potential for communication between the doctor and the (future) patient. Traditional websites of hospitals and doctors as well as doctor rating portals (e.g. vitals) also often offer functions for mediated communication between doctor and patient. In order for these services to be assigned to the second type, the opportunity for reciprocal communication must be seized. There can only be a dialogue between doctor and patient if the doctor actually responds to queries posted by patients. A further subtype that has to be assigned to both the second and the third type are the various forums dealing with health issues. Depending on the usage pattern of the individual user, these are either used solely for passive information retrieval or for the exchange with like-minded individuals or even doctors.

In addition, there are internet services whose primary role is one-sided communication. They purely provide information in form of an app or website. These are part of the third type, "produced media communication". Examples are websites of medical insurance providers, online journals, and eBooks. Even documentaries (e.g. Junior Doctors: Your Life in Their Hands) and medical dramas (e.g. House M.D. and Emergency Room) belong to this type.

The last type, "virtualized media communication", includes services that allow for communication with interactive systems. A characteristic example is

software that enables self-diagnosis. Medical expertise plays an important role in the conceptualization of such applications. Examples are health tracking apps like iHealth Log, iHeadache, and apps like the patient diary Wie geht's (for patients with clinical depression). This type also includes video games, used in rehabilitation after a stroke, for example, and gamified applications, such as mySugr.

This systematisation does not aim to fully visualize all possible services, but shows and conceptualizes their variety. Furthermore, it depicts that central parts of the doctor-patient communication (e.g. consultation or diagnosis) can also happen through mediated communication. The availability of these services does not shape the doctor-patient relationship per se. Their individual usage and adoption open up specific opportunities for action, they have the potential to shape the role (model) of their counterpart, and therefore also the doctor-patient relationship.

The scientific literature often refers to the internet as having a strong influence (cf. e.g. Kardorff, 2008: 249), but does not differentiate between different online services and their specific moulding potentials. Anderson et al. (2003: 69) report that the influence of the internet is especially strong regarding the role of the patient, for example changing the patient's self-perception from that of a passive receiver of medical care to an active consumer of medical services. Hattemer (2012: 78) states, accordingly, that the previously dominant paternalistic doctor-patient relationship is no longer valid and the evolving eye-level relationship contains new challenges for both doctor and patient (cf. ibid.). Some authors also write about the patient's role changing from being an amateur to becoming an expert (cf. e.g. Kardorff, 2008: 249). This also creates further challenges for the (traditional) role of the doctor, since the effort of dealing with incorrect information obtained from the internet is very high (cf. Hoppe, 2009: 4).

4. Conclusion

This chapter has described the increase in volume and variety of health-related online services, and proposes a preliminary systematisation of these different services. The question of the exact ways in which individual services shape communication and role expectations and therefore the doctor-patient relationship has not been answered here. Likewise, their individual adoption and integration into the everyday lives of doctors and patients have not been discussed. This shows that further empirical research is necessary. In this regard, answers to the following questions seem interesting: "How do internet-based services and different types of mediated communication shape existing doctor-patient relationships?" and "How does direct communication between doctor

and patient (during a consultation) change with the increasing use of mediated communication?". Patients could, for example, refer to the content of or experiences with various health-related online services and question the doctor's competence based on information taken from the internet. This leads to the question whether there are new forms of doctor-patient relationships emerging that do not even require face-to-face communication. The changing roles of the doctor and the patient caused by the current wave of mediatization need to be examined in order to be able to sufficiently describe the moulding potential, leading to the following question: "How do health-related online services shape the role expectations of the doctor and the patient?" This is especially interesting for the growing field of interactive health-related applications. The doctor becomes essentially invisible in these applications and patients form their own diagnosis. The doctor could, for example, become irrelevant or less trustworthy in the eyes of patients, since the latter are now able to form their own diagnosis. Depending on the adoption of these interactive systems, new practices arise that have to be evaluated empirically.

In order to identify the moulding potential of individual forms of mediated communication, one has to analyse the applications themselves (taking infrastructure, hardware, and software interfaces into account). More importantly, the corresponding practices have to be investigated. Ethnographic studies are especially well-suited for this. One could observe doctors and patients in general practitioners' offices during the consultation as well as interview them beforehand. Additional interviews or observations in the daily life of patients could be very useful to evaluate the usage and adoption of specific services.

Notes

1 Krotz follows Max Weber (1978) in this. Weber argued: "The social relationship thus consists entirely and exclusively in the existence of a probability that there will be a meaningful course of social action – irrespective, for the time being, of the basis for his probability" (Weber, 1978: 26f.).

2 Mediated communication is a modification of the basic form of communication, face-to-face communication, with and through media (cf. Krotz, 2007: 19; 85ff.). Media, in this context, are understood as technical instruments of human communication including all related forms of institutionalization and (symbolic) practices (Hepp, Hartmann, 2010: 11). This definition includes traditional mass media, the internet, computer games, as well as other interactive media (cf. ibid.).

3 Parsons (1951:24ff) defines a social role as a rigid set of behavioural expectations that are targeted at the holder of a certain social position. Since this chapter follows the paradigm of symbolic interactionism (Blumer, 1969), as opposed to structural functionalism, social roles will be defined differently. Within symbolic interactionism, role-taking is seen as an active and dynamic process. Therein, norms and values of society are adopted through the role-taking of a "generalised other" (Mead 1973) while the individual stays the subject of the action (cf. Abels,

2010: 30ff.). Essential characteristics of the role of the doctor and the patient as described by Parsons shall nevertheless be considered in the following, always keeping in mind that the characteristics are negotiated individually and depending on the situation.

4 Increasing economisation (cf. Siegrist, 2012: 1102, Hoppe, 2009: 3), legislative and regulatory changes (cf. Katzenmeier, 2012: 1093, Bundesministerium für Gesundheit, 2013), and the fast progress in medicine and medical technologies as well as the correlated improvement of diagnostic and therapeutic possibilities (cf. Hess, 2009: 117) are seen as essential drivers of change in the role of the doctor and the patient.

5 Depending on context, waves of mediatization can be subdivided in much more detail than shown in Fig. 1. Especially the wave "telephone and traditional mass media" could be differentiated further into the wave associated with the telephone and those associated with individual mass media.

6 The Apotheken Umschau is a German health care magazine that customers can acquire for free in almost all German pharmacies. Founded in 1955, the Apotheken Umschau has a circulation of 7.2 million. 80 percent of Germans know the magazine and it has become a staple in the German media landscape (cf. Kanzler, 2005: 205).

7 Hepp (2013: 64) combines the typologies of Krotz (2007: 90) and Thompson (1995: 82-87) in his systematisation.

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Biography

Dorothee Christiane Meier is a PhD student and research assistant at the Institute for Information Management Bremen (ifib) at the University of Bremen, Germany. She is also a member of the Centre for Media, Communication and Information Research (ZeMKI), an inter-faculty research institute at the University of Bremen. The focus of her research is on media change, mediatization, media reception and media use, health communication, and the development of new tools for qualitative data collection. In her PhD-project, she deals with the moulding potential of various online-services on the doctor-patient relationship.

Contact: dcmeier@uni-bremen.de