CHAPTER 1

A Brief History of U.S. Health Care

For the purpose of this text, we are going to use the following as working definitions:

- *Communication channels:* Various means for transmitting messages (verbal and/or nonverbal); includes, but is not limited to air (voice, face-to-face), mechanical/electronic (phone, Internet, etc.), written (e-mail, texts, newspapers, etc.), visual (movies, TV, etc.), and more
- *Health care provider:* Any member of the health care team who directly (or indirectly) impacts a patient's health/wellness/quality of life (e.g., doctors, nurses, advanced practice registered nurses [APRNs], physician assistants [PAs], respiratory therapists, physical therapists, and many others)
- *Intercultural communication*: How individuals communicate across cultures (e.g., American, French, Spanish, etc.), but also within and across subcultures (e.g., physicians, nurses, patients, etc.)
- *Interpersonal (also known as dyadic) communication:* Interactions between two people who know each other and share common goals (e.g., friends, lovers, family members, professionals, and a provider and a patient); not the same as an infrequent conversation between a customer and a store clerk or waitperson
- *Interpersonal relationship:* A bond between two people who share common goals that requires effective interpersonal communication to develop and/or maintain
- *Interprofessional communication:* How providers from different health care professions (MD/DO [doctor of osteopathy], RN, PA, technicians, etc.) share information, tasks, and so on
- *Intraprofessional communication:* Interactions between members of the same profession (physician–physician, RN–RN, PA–PA, physical therapist–physical therapist, etc.)

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- *Organizational communication:* How institutions (e.g., hospitals, governments, health insurance payers, etc.) communicate internally with staff, providers, administrators, and externally with customers, clients, patients, vendors, and/or stake/stockholders
- *Pedagogy:* The study of teaching

HEALTH COMMUNICATION

For the purpose of this book, *health communication* is defined—using a generalist's view—as any exchange of information (verbal, nonverbal, or written) that relates to an individual's or the public's health (clinically, pedagogically, politically, professionally, institutionally, economically, commercially, legally, etc.). This broad view has been chosen to highlight the countless and complex ways health communication touches the lives of not only health care professionals and patients, but all Americans. It is important to recognize that at its core, most health communication is dyadic; however, it would be extremely shortsighted to ignore the enormous impact of organizational (especially the federal government), intercultural, and team communication on U.S. health care delivery. This book is intended to help readers understand the dynamic and complex roles health communication plays in Americans' daily lives. From wellness to illness, effective health communication is one of the keys to enhancing everyone's quality of life. And, armed with an understanding of the theories and realities of health communication for professionals, the book's goals are to encourage readers to apply their learning both in their personal and professional lives. Therefore, to begin our exploration of health communication in America—let us start at the beginning.

A HISTORICAL OVERVIEW OF HEALTH COMMUNICATION: THE FIRST AMERICAN HOSPITAL

Thanks to one of our founding fathers, organized health care in America can be traced to the first U.S. hospital. Franklin (1754) wrote *Some Account of the Pennsylvania Hospital: From Its First Rise to the Beginning*. As a cofounder of the first hospital in the 13 colonies, Franklin points out how important health care delivery was to the early settlers of Philadelphia. In addition, more than a decade later, the first American medical school was opened at the University of Pennsylvania. Therefore, health care in this country, at least from an organizational perspective, can be traced from those meager beginnings 260-plus years ago. It is important for us, in the current era of multichannel communication, to recognize the information sharing and scientific limitations that existed for the majority of American health care history. It was only within the

last century that so many of the breakthroughs in science, health care, and communication all occurred. Therefore, for most of the first 150 or more years of health care in this country, providers and patients had not only rudimentary diagnostic and therapeutic options for treating illnesses and injuries, but similarly limited access to information, as well as tools for, or education about, how to best share it. Although there may have been some providers who could receive printed materials, many, if not most, learned from other providers and whatever textbooks were available. There were no phones, no electricity, and very limited postal service. In short, in this country health care education was highly restricted until after 1910 and, therefore, so too were providers' information sources. Combine the lack of clinical assessment tools and communication opportunities and it should be no surprise that the average life span in America for men and women was less than 48 years. In fact, it is a testament to our forefathers/mothers that with so little medical knowledge and health communication they were able to live as long as they did.

Reflection 1.1. With so few scientific instruments at his or her disposal, what would you hypothesize would be most important to a provider's analysis of patients' diagnostic success and why?

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IMPACT OF WARS ON HEALTH CARE DELIVERY

Although there were medical schools opening across the United States during the 18th and 19th centuries, one of the key methods for learning new diagnostic and treatment regimens during this time was to try out various procedures and tests during war time. Physicians and surgeons, starting with the American Revolution through the Spanish–American War, had no shortage of ill and injured patients and, with no real alternatives for the soldiers, they were ideally suited as research subjects. Therefore, many of the emerging methods for organizing care, triaging patients, diagnosing illnesses and injuries, and a wide variety of orthopedic and surgical procedures were conceived, practiced, and routinized in makeshift outdoor medical aid stations and surgical areas during American warfare.

BARTERING FOR HEALTH CARE

During America's preindustrial revolution, because of the largely agricultural society, patients and providers who were not involved in wars experienced most of their health care delivery in patients' homes. House calls, as they were known, were common and bartering was a typical way for farmers, shopkeepers, and others to pay for a doctor's services. Therefore, a bushel of potatoes might cover the cost of repairing a child's broken arm, or a small pig might be payment for delivering a baby. During this period, these methods of compensation were as primitive as much of medical education. Because many of the doctors during this time trained as apprentices by studying with a similarly trained, practicing physician, they could only learn what their mentors knew. However, prior to 1900, even in the emerging medical and nursing schools there were no real standardizations of curriculum, procedures, or policies being used or taught.

Reflection 1.2. What are three communication issues that you think contributed to the lack of standardization in health provider education from 1751 to 1900?

1. ____________________
2. ____________________
3. ____________________

A DISEASE-CENTERED APPROACH

As America evolved during the Industrial Revolution, health care too had to adapt to the changing societal landscape. With more people needed in urban areas to work in the emerging industries, the number of providers required to care for them expanded. During this same period, the federal government began to question the lack of medical standardization, licensure, and educational consistency. Based on these assessments, today's health education models were developed. The evolution of modern health care was based on a scientific model that sought to identify and treat diseases and injuries using objective assessments and data analysis. This disease-centric approach led to a standardization in medical education and licensure; the discovery of countless technological advances from the microscope, to antibiotics and x-ray machines—and throughout the 20th and into the 21st century—to vaccines, surgical robots, and gene-based therapies.

THE RISE AND IMPACT OF TECHNOLOGY

However, as science and technology became more normative in health care, providers became more specialized. Therefore, as x-ray machines become more common in everyday medical practice, a specialty in radiology was created to provide expert x-ray interpretation. Similarly, a specialty in pathology was perceived as critical to the burgeoning field of tissue and laboratory analyses. Over the past century, more than 120 specialties and subspecialties have developed in American health care to focus on specific anatomic and/or physiologic systems/processes. Some of these specialties include cardiology, dermatology, endocrinology, ophthalmology, urology, and so forth, all of which require post-medical school training (internship and residency) to focus on a specific anatomical (or physiological) area of study. However, there were also specialty areas developed that focused on specific disease processes: allergy, oncology, rheumatology, and so on. Although on one hand, specialization provides patients with a provider who is credentialed as an expert in a particular aspect of diagnosis, disease, and/or treatment, it also creates a number of personal and societal issues.

Reflection 1.3. Why might the term *specialist* have negative implications for patients?

As will be discussed in future chapters, the expanding role and utilization of technology have impacted health care and health communication in diverse ways, for example, today there are:

- Fewer general/family practitioners graduating from medical schools
- Markedly increased health care costs
- Heightened language barriers between specialists and patients
- Frequent status disparities among providers
- Access to care inequalities

Although there is little doubt that technology and the rise in specialization and specialty care (surgical intensive care units, burn centers, coronary care units, dialysis centers, etc.) have helped increase life expectancy in America to around 76 years of age for men and 80 years of age for women, technology and specialization have also contributed to many societal problems, the most critical of which is—rising U.S. health care costs.

Reflection 1.4. What are three reasons why technology is a major force in rising health care costs in America?

1. ____
2. ____
3. ____

PHARMACEUTICAL CONTRIBUTIONS TO HEALTH AND COSTS

But technology is not just about developing diagnostic and treatment equipment. Another of the byproducts of the technological era is the vast advancement in pharmaceutical research and development (R&D). In the United States, beginning with the release of penicillin in the 1940s until today, the Food and Drug Administration (FDA) has approved over 1,500 prescription drugs. So in 70 years, technology has helped bring about a wide variety of treatment and/or prevention options for diverse diseases like hypertension, hypothyroidism, polio, hemophilia, osteoporosis, arthritis, and countless others. However, as with other aspects of technology, pharmaceutical advancements have come with a steep price tag. In 2013, U.S. spending on prescription drugs exceeded $325 billion. Although these products have helped expand Americans' life expectancy, the economic price has created enormous micro- and macrofiscal issues for individuals', families', and the nation's health care budget.

Reflection 1.5. If you could only afford one of the two, how would you decide between buying food for dinner and refilling your blood pressure prescription? Why?

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CONTEMPORARY AMERICAN HEALTH CARE AND ITS IMPACT ON HEALTH COMMUNICATION

President Obama and Congress created the 2010 Affordable Care Act in an apparent tripartite effort to reduce escalating health care costs. First, the Act was intended to get as many uninsured Americans health care coverage as possible. Second, the Act sought to reduce national health care costs through numerous steps, including the use of electronic medical/health records (EMRs) in hospitals and providers' offices. Third, the Act promoted preventive care by eliminating copays for insured citizens.

If you examine a few of the major foci of the Affordable Care Act highlighted previously, it becomes obvious the role health communication plays in America's health care delivery system. For example, without insurance, people generally have to go to a community clinic and do not see the same provider (continuity of care) from one visit to the next. This reality makes an interpersonal relationship between provider and patient less likely and thus diminishes patient trust, comfort, and, often times, adherence with recommended treatment plans. In addition, the lack of insurance and an interpersonal relationship also increases the likelihood that the next time the patient is ill she or he may go to the emergency department (ED) for care—because it is open 24/7/365 and by law cannot refuse service to anyone. But the communication exchange in an overworked ED between patient and provider is more likely to be even less interpersonal than in a busy community clinic. The Act also tried to improve access to patients' medical records for a number of communication reasons (legibility, information sharing, less duplication/redundancy, content consistency, etc.), but also for finance-related issues. Insurers (like Medicare and Medicaid, as well as private plans) wanted to be certain what services were provided and whether they met local/regional/national providers' standard of care. Therefore, health professionals' communication in an EMR becomes even more important (personally, organizationally, and for the patient) from both clinical and financial perspectives. Finally, because even with insurance many patients cannot afford copays or deductibles (the patient's required costs for care based on different plans) and therefore it can be hypothesized that many individuals do not seek preventive/wellness care, for example, annual exams for adults, breast and Pap smears for women, prostate exams for males, skin and eye evaluations, and so on. Without these interpersonal communication and relationship-building interactions between providers and patients, there is less opportunity for information sharing, collaborative decision making, and health education. As a consequence, it is more likely that patients' health/wellness will be less maintained and, as a result, will require treatment for an illness or injury with the associated higher cost of curative versus preventive care. Although the Affordable Care Act was intended to provide more access to health care, it almost certainly concomitantly encourages more interpersonal health communication exchange, education, and enhanced interpersonal relationship building, which, it

is hoped, will lead to an increased health/wellness goal/attainment and reduced long-term health care costs for the nation.

Over the past 260 years, health care in America has evolved from a largely unregulated, unlicensed individual vocation, to a multicultural, diverse, interprofessional, interdependent, technologically driven, 21st-century corporate enterprise. What Benjamin Franklin could not predict when he cofounded the first U.S. hospital were the ways health care delivery and health communication would change from a predominantly single-focused doctor–patient dyadic interaction to a multiprofessional, multiorganizational, "mass communication" experience in which patients, providers, and/or organizations communicate across diverse channels (face-to-face, phone, Internet, written, electronic, etc.). For example, think of the typical hospitalized patient of today. In the course of a fairly routine 3-day stay, she or he will likely communicate, across 8- and 10-hour shifts, directly with dozens, perhaps even 100 or more health care providers:

- Doctors (MD/DO)
- RNs
  - Licensed practical nurses (LPNs)
  - Certified nursing assistants (CNAs)
  - Nurse technicians
- Midlevel providers
  - PAs
  - APRN/nurse practitioners (NPs)
  - Certified nurse-midwives (CNMs)

and many more. But these providers are likely each communicating with several other providers about the patient, including adding documentation to the patient's medical record. That written communication is then sent to the hospital's billing department, which submits it to the patient's insurance company, Medicare, or Medicaid. In addition, if there were any adverse events (complications that cause unexpected/unintended harm to the patient) that occurred during the patient's stay, then those have to be communicated to the risk-management department, perhaps to the hospital's legal staff, depending on the severity, even to the state regulatory office, and so on. And we cannot forget the patient's prescriptions being communicated to his or her pharmacy, information being sent to the patient's primary care provider (PCP) and/or specialists, and so forth. Like modern health care delivery, health communication has evolved to be equally multifaceted, interdependent, and critical to each patient's successful health outcome.

Although there is no doubt that 21st-century health care is not only highly scientific, expensive, and disease focused—it is also at its most basic totally dependent on effective interpersonal, health, intercultural, and organizational communication. And yet, as the one common denominator

that crosses all health professions, interactions, diagnoses, treatments, and outcomes—communication is the one aspect of daily health care delivery that is not a *major* focus in health care provider education. The purpose of this book is to help you understand the importance of effective interpersonal, intercultural, health, and organizational communication for successful prevention, diagnosis, treatment, and wellness outcomes. It is hard to imagine anyone in 21st-century health care provider education who would suggest not teaching medical terminology. And yet what good is knowing a language (medical terminology) if you do not know how to use it effectively (with the intended audience: other providers), when/how to translate it (for patients and families), and how to communicate verbally and nonverbally using behaviors that instill trust and encourage collaboration and relationship building with others (patients, providers, organizational members, etc.). Communicating in the emotionally charged context of the 21st-century American health care system requires an understanding of the theories underlying interpersonal communication and interpersonal relationships, as well as team/organizational and intercultural communication. Armed with this knowledge you should be able to listen, assimilate, and communicate with patients, peers, and your organization more effectively. In addition, applying these theories to your health care role should help you share information, power, and decision making with patients and/or families to provide a truly collaborative health/wellness outcome.

Reflections (among the possible responses)

1.1. With so few scientific instruments at his or her disposal, what would you hypothesize would be most important to a provider's analysis of patients' diagnostic success and why?

One of the most important tools a provider has at his or her disposal for assessing a patient's health is interpersonal communication. Especially without the diagnostic tools we have today, a provider's interactions with a patient/family become even more critical. In such a situation, it would be very important to learn as much as possible about the patient's current symptoms, as well as his or her past medical as well as current social, occupational, and family histories. With basically only observation, palpation, and the provider's other senses to guide him or her, interpersonal communication and information gathering from the patient and family become critical to any efforts for a successful diagnostic and treatment outcome. However, as this book tries to highlight, these same communication needs continue to exist for 21st-century providers and, it could be argued, that with so much technology, cost, and access issues, provider–patient information exchanges are even more important.

1.2. What are three communication issues that you think contributed to the lack of standardization in health provider education from 1751 to 1900?

In general, all three are likely communication related: (a) lack of sufficient medical knowledge; (b) lack of scientific research, publication, and standardization; (c) lack of information sharing among health care providers, providers–patients, and also among health care organizations. Although there are certainly many other reasons (e.g., lack of federal/professional guidelines as well as professional and institutional licensure), these are three obvious differences between health care education/standardization then and now. It seems impossible to imagine how isolated an 18th- or 19th-century provider must have felt as she or he tried to help people with diverse diseases and injuries, many of which she or he had never seen or heard of before. Communication in health care education has clearly helped transform America's providers and delivery system.

1.3. Why might the term specialist *have negative implications for patients?*

Perhaps as you pondered this question you asked yourself how being classified as "special" might impact a provider's self-perception, perceived status, role, power, control, and so forth. Language is very powerful and therefore it would not be unexpected for the term *specialist* to illicit quite different perceptions from patients, peers, and other providers. We can certainly hypothesize that patients who already feel uneasy with providers because of their differences in education, experience, socioeconomic status, and so forth would feel even more uncomfortable around a "specialist." And this "dis-ease" would likely manifest itself in less patient communication, feedback, and collaboration. Research has shown that the more dissimilar Americans are from peers, the less likely we are to try to develop or maintain a relationship.

1.4. What are three reasons why technology is a major force in rising health care costs in America?

Again, this question has many possible answers, but among them surely are (a) not only is technology itself expensive (MRI machine), but in order to use it, a special room has to be constructed at an enormous price; (b) even with the cost of some technology being in the hundreds of thousands, if not millions of dollars, the competitive capitalistic system in America drives hospitals, clinics, and so on only a few miles apart to spend money for similar technology, instead of sharing the costs; (c) increased technology has resulted in increased specialization and therefore unique staff to operate equipment and specialist providers to interpret the results or utilize the technology with further increased costs (more expensive to see a specialist than a PCP). However, in addition, to the direct cost resulting from increased specialization related to technology is the indirect costs of having fewer PCPs, who are paid less money for frequently more time and work with patients and who, by definition, are not "special" providers.

1.5. If you could only afford one of the two, how would you decide between buying food for dinner and refilling your blood pressure prescription? Why?

Clearly, there is no good answer to this question and yet it is estimated that in the United States almost 20% of Americans cannot afford their prescription medications. For these patients, it is clearly a choice of food, shelter, or therapy. Although providers cannot directly impact patients' purchasing decision making, they can recognize the potential for patients, especially older Americans on a fixed income, to have financial difficulties and discuss the patient's situation and whether a different drug or generic medication might be available at a lower price to make utilization more possible. Although providers cannot change the cost of treatment, they can use interpersonal communication and their interpersonal relationship with a patient to help collaborate and find the most effective (cost and clinical) option possible and demonstrate their understanding of the patient's situation, their empathy, and the need for joint decision making.

Skills Exercise

While you are conversing with someone you know, try following up one of their statements with a series of questions, the more questions the better—even interrupting to make sure your questions get answered; try to ask them as quickly as possible. Once you are done, reflect on how it felt to be a "detective" controlling the conversation? Ask the other interactant (if she or he is still speaking to you) how it made her or him feel to suddenly be quizzed, instead of listened to, and frequently interrupted?

In a different conversation, ask a friend/classmate/loved one to tell you about his or her day, or week, and just listen until she or he finishes. Try to be conscious of your nonverbal behaviors and nod your head appropriately if you understand, or frown or make an uncertain facial gesture to show your confusion, but try very hard not to stop the other person's flow of information. When she or he is done, you should ask any questions needed to clarify and/or demonstrate your understanding of what she or he told you. When finished, think about how you felt being focused on assimilating information, not thinking about what questions you needed to get answered. Also, ask the other person what she or he noticed and/or felt about the interaction and the information she or he wanted to communicate? How do these two experiences impact your thoughts about gathering patient's information, listening versus talking, and considering the other person's needs/views in a health care setting? If you find them valuable, then why not try this latter approach to sharing information in your provider–patient interactions?

Video Discussion Exercise

Analyze the video

- *Escape Fire: The Fight to Rescue American Health* (2013)

Role-Play Using These Interactive Simulation Exercises

Pagano, M. (2015). *Communication case studies for health care professionals: An applied approach* (2nd ed.). New York, NY: Springer Publishing Company.

- Chapter 3, "The Biomedical Model" (pp. 27–34)

Health Care Issues in the Media

Nursing shortage
http://www.nytimes.com/2015/05/28/opinion/we-need-more-nurses.html?_r=0

The costs of treating cancer
https://www.youtube.com/watch?v=zf-4E9KjgQk

Health Communication Outcomes

This chapter highlights only 265 years of health care. It is important to remember that the study of illness/injury and wellness is more than 4,000 years old. However, the vast changes in health care delivery, education, and communication in contemporary America are the focus of this text. Health care in the United States has evolved exponentially over the past 100 years in large part because of changes in provider education, health insurance, technology, specialization, pharmaceutical and medical device R&D, team versus individual approaches, and government regulations. But these unprecedented scientific, clinical, and pedagogical advancements have further heightened an illness/injury focus and accompanying economic issues. The costs of health care delivery in 21st-century America is both a driving economic force (diverse employment opportunities, highly profitable health care organizations, etc.), but simultaneously a potential budget-buster for individuals, corporations, and the U.S. government. The focus on disease/injury processes, diagnosis, and treatment creates a self-perpetuating system that not only relies on illnesses and injuries for sustainability, but rewards providers, manufacturers, and health care organizations for treatment, not prevention. As long as American health care is focused on diseases/injuries and their cures, not patients, the easier it is to minimize the need for effective provider–patient communication.

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