

Thorne, S. E., Harris, S. R., Mahoney, K., Con, A., & McGuinness, L. (2004). The context of health care communication in chronic illness. *Patient Education and Counseling*, 54(3), 299-306.  
doi:10.1016/j.pec.2003.11.009

*Keywords:* Patient-professional relationship, self-care management, disease world, interpretive description, grounded theory.

*Summary:*

**Literature review:** The focus of this journal article was to conduct a qualitative research study on the impact of communication in healthcare, specifically among those diagnosed with a chronic illness. Being that those diagnosed with a chronic illness have no cure, the treatment plan is largely based on symptom management and preventing the progression of the disease with the goal of creating a better quality of life for the patient. Patient-professional communication is absolutely key to individuals with a chronic illness because much of their treatment plans are dependent on self-care management; the patient relies on their healthcare provider to have a thorough understanding of what that entails. Therefore, the question being asked to effectively understand and analyze communication in this relationship was: how do individuals with chronic illness describe helpful and unhelpful communication with their healthcare providers? Interpretive description was the methodology used to accurately conduct this social experiment and answer the question. Data was collected from 38 individual patients with four distinct chronic illnesses to be interviewed. The patients had one of the following chronic diseases: end-stage renal disease (ESRD), fibromyalgia (FM), multiple sclerosis (MS), non-insulin dependent diabetes mellitus (NIDDM), fibromyalgia (FM). Since each disease is different, participants were identified as belonging to a different “disease world” (as the authors of the article called it). Different “disease worlds” highlight the distinct culture, knowledge, and nature of living with a specific diagnosis that is different for each of the four diseases used in the study. In addition to heavily relying on interpretive description to collect data from the participants and their respected “disease world”, the authors of the article used the grounded theory approach to accurately express the findings of this study. The grounded theory has a rich history of use in the social sciences: it has been used to generate findings based on assumptions from our everyday lives that we take for granted.

**Method:** As stated earlier, the qualitative study used interpretive description by interviewing the 38 patient participants that were diagnosed with one of the four chronic illnesses. The interviews were conducted one-on-one and face-to-face for one to two hours and were audio recorded to refer back to. In these interviews, elements such as pain levels/discomfort levels, visibility of the illness, functional limitation, and availability to medical intervention were all considered when the patients were describing what they perceived to be effective or ineffective communication with their medical professionals. Of the 38 collective participants, 7 were diagnosed with ESRD, 10 with FM, 12 with MS, and 8 with NIDDM. These four illnesses create the four distinct “disease worlds” that were further analyzed. The diversity within the participant sample included a wide range of ages from 18 years to 50 years. The majority of participants were female, with there being only 8 males in the study. Most of the participants were Canadian with European ancestry, but there were ranges in the occupational, social, and economic backgrounds of the participants. All of the participants, in exception to two, had been diagnosed with their illness for a minimum of five years. In addition to using the patient's narrative account, their medical data

was also examined in order to review and understand the patient's medical history and to accurately represent their experience. The interviews went in depth to strengthen the patients' perception of communication in regard to their chronic illness. As patterns started to arise in the interviewing, the participants were separated into different focus group discussions where comparative analysis was used to test hypotheses in further depth. In the final phase of the research, 8 healthcare professionals were interviewed to verify that the data collected from the patients was clinically correct in their experience

**Discussion:** Across all four distinct "disease worlds", participants found the importance of communication with their healthcare professionals self-evident. Consistently, patients described three common traits that were absolutely necessary to helpful and effective communication, these three elements being respect, courtesy, and engagement. Each of these three were expanded upon what precisely this entailed among the smaller groups of different "disease worlds". Individuals felt that healthcare providers who demonstrated respect during communicating were going beyond regard for the patient's feelings. The healthcare provider had respect for them not just as patients of chronic illness, but their life beyond having their disease. Courtesy was important to patients because it reflected general politeness as well as it set the tone of address during appointments. Lastly, patients felt there was a sense of teamwork and enthusiasm to problem solve when their healthcare providers were engaged. Within the distinct "disease worlds" some of these elements were more concentrated on than others. For instance, patients diagnosed with NIDDM found respect to be one of the more critical and effective elements of communication with healthcare providers. NIDDM has a stigma for being less serious than the other illnesses in this study, and communication in the health care setting can be interpreted as judgmental easier because the majority of treatment relies on lifestyle and dietary changes. Therefore, respect, patience, and politeness is more important to patients with NIDDM. To patients with MS, a disease that is difficult to diagnose and is often dismissed prematurely and incorrectly as a psychological issue, courtesy is highly significant because it takes so long for them to get proper medical attention and treatment. To the participants with MS, it was unlikely that respect and engagement would be present in communication with their healthcare professionals if there wasn't courtesy. Similarly, patients of FM often feel discredited because of the invisible nature of their illness- their symptoms are not visible and sufferers of FM are also often accused of it being in their head. Therefore, respect and engagement were more critical to those diagnosed with FM. Lastly, ESRD is a highly life-threatening disease and patients are quickly labeled controlling because of the amount of anxiety and fear that surrounds it. ESRD patients in the study weighed engagement as being more significant because of their need to be highly attentive and knowledgeable about their life-threatening illness.

**Evaluation:** I was interested in this article in the first place because of my personal experiences communicating with healthcare professionals as someone diagnosed with several chronic illnesses. Recently, I had two different appointments that were very important where I felt more confused and upset after the appointment than I did going into it; unfortunately, I know this is more common among people with chronic disease than it should be. In addition, it is my opinion from my experience that healthcare providers should be required to take some communication courses to improve their practice- one can be the smartest doctor/surgeon in the world but unless they can communicate well and have good bedside manner, the patient won't feel completely comfortable and trusting of them as a professional. I was interested to discover what communication studies have been conducted in the past to attempt to make a difference in the patient-professional relationship of healthcare. Overall, I think the authors of this article clearly articulated their research question, methods, and findings. I wonder if any of the authors are

sufferers of chronic illness as well, because the study did such an excellent job describing the physical and emotional components of navigating effective and helpful communication between the chronically ill and their healthcare professionals. I would be curious to see what differences there might be if this study were to be repeated in another country where access to healthcare is different or varying. Access to healthcare is another significant element that contributes to effective healthcare communication especially among those with a chronic condition because it includes a lifetime of uncertainty and necessary treatments. If there are concerns about how a patient will be able to afford an appointment, there may not be any patient-professional communication at all because the individual can't afford to pay for the healthcare; or there could be more conflict and uncertainty between the patient and the provider because of high stress. This study could be applied to mental illness treatment as well due to the "invisibility" and issues of legitimacy when finding treatment for these illnesses.