Discussion paper

Relational responsibility within the doctor-patient relationship
The potentials of an electronic health record

PhD student: Drs. Bettine Pluut
Supervisor: Prof. dr. Dian Marie Hosking
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About this paper
This paper starts with an introduction of the main concepts of the proposed research project: relational responsibility and the electronic health record. After this the motivation for and relevance of the project are discussed. This is followed by the central research question. Last, possible ingredients of the proposed project are described.
The purpose of this discussion paper is to stimulate reflexive discussions on the proposed research project, which is considered emergent, i.e. open to various voices and ideas.

Introducing the main concepts
Interactions between doctor and patient can be seen as an exchange and construction of various knowledges. A patient generally draws upon knowledges such as knowledges of his physical symptons, medical histories and possible causes of illness, whereas a doctor brings specialized medical knowledges from the health community into the relationship (Treichler, Frankel, Kramarau, Zoppi, & Beckman, 1984). Through relational processes in which patients, doctors and other persons involved in the health care process participate, deficiencies and the treatment that is necessary to heal the patient are co-constructed. In addition, identities and the responsibilities of the people participating in the health care process are constructed. So for instance, the knowledges of one participant (e.g. the doctor) can be constructed as more valuable or more important. The project focuses on such relational processes within the doctor-patient relationship in general, and on the potentials of an electronic health record for these processes in particular.

Relational responsibility
It is fairly common in Western society to hold individuals responsible for (the outcomes of) the health care process. For instance, the Dutch ‘law on the medical treatment agreement’ (WGBO) states that the patient is responsible for the decision to undergo a particular treatment, based on the information s/he is given; an informed consent (see e.g. Witmer & De Roode, 2004). The doctor is responsible for making sure that the patient gets all the information s/he needs for making this decision.

Within the proposed research project the doctor-patient relationship is studied from the perspective of relational responsibility (McNamee & Gergen, 1999), a concept that follows from a relational constructionist thought style (see e.g., Gergen, 1994, 1999; Hosking, 2002). Relational responsibility within the doctor-patient relationship can be seen as a reframing of the individualist and generalist concept of informed consent. The concept does *not* refer to shared responsibility. Rather, it refers to a relational process in

which participants are responsive to each other's constructions of e.g. what 'good', 'real' and 'ethical' health care is. So sometimes both patient and doctor might feel good about what can be called 'a subject-object understanding of the health care relationship', which refers to an individualist construction of the doctor as an expert (the knowing subject) who tries to get information out of the patient – a ready to be acted upon object in need of a diagnosis and treatment (see also Hosking & McNamee, 2006). Such an understanding of health care relations can be considered dominant in Western countries. However, within a relational responsible health care process other possible ways of carrying out (doctor-patient) relationships can be created. Here participants are open to each other's constructions, for instance the construction of the identity of the patient as an expert on certain areas. In this way more equal ways of interacting could emerge, ways that can be called 'soft' self-other differentiation (Hosking, 2007; McNamee, 1994). In these cases the different knowledges that both patient and doctor bring into the relationship are valued more or less equally.

The electronic health record

An electronic health record (EHR) can be considered a general concept that refers to a collection of electronically stored and electronically accessible information about the health care process (adapted from Witmer & De Roode, 2004). The information that is stored and made accessible within an EHR can vary: it can be restricted to medication, but it can also include qualitative reports of a diagnosis. In addition, different people can be given the right to add information to the EHR. Google, for instance, has announced a new service, Google Health, that will give every internet user the possibility to maintain a record in which they write about for instance their symptoms and medicine they use. They can then decide for themselves who can read this record. From the perspective of relational responsibility this development is interesting, because the EHR opens up new possibilities for distributing knowledges and negotiating responsibilities. As a consequence, the (social construction of the) position and identity of both patient and doctor could change, opening up new ways of carrying out the doctor-patient relationship.

The proposed research project reflects on the possible meanings of an electronic health record for the creation of relational responsibility for the health care process. The EHR is seen as a practical way of stimulating reflections upon people's ideas of how to construct the doctor-patient relationship. In addition, these reflections can lead to ideas of what the EHR could look like and how it can be used.

In the remainder of this paper I will discuss my motivation for and relevance of studying the concepts described above. After this I will present the central research question, followed by a proposal of the research design (i.e. the various ingredients of the research project).

Motivation and relevance

Based upon numerous dialogues about experiences with medical encounters with family, friends and people from the health care community, I have developed a deep interest in doctor-patient interactions. I myself, as a patient, have experienced rather big differences in doctor-patient relationships. Whereas sometimes Ifelt that their was a sense of relational responsibility for the health care process in which the doctor was open to my ideas of carrying out the doctor-patient relationship, during other encounters I had the feeling that my voice was seen as instrumental to the doctor's objective of getting a diagnosis and deciding on a desirable treatment. In these cases the doctor was not

responsive to my preference of have a open dialogue on possible treatments. This sometimes resulted in unpleasant conversations when I had other ideas about a treatment than the doctor had. These differences in experiences with medical encounters also resonate through the stories of family and friends. For that reason I am interested in studying the multiple constructions of ‘good’ and ‘ethical’ health care by patients, doctors and others involved in the health care process. And in finding ways of working with this ‘multiplicity’ during doctor-patient interactions.

Dutch news papers and research publications suggest that the health sector is having a hard time in The Netherlands. In 2003, for example, media reported that a large inquiry had shown that about 19.000 people end up in hospital because of medical errors (NICTIZ, 2003). These errors are explained by a lack of communication and coordination between health care professionals (Witmer & De Roode, 2004). Dutch government hopes to decrease the number of medical errors by improving the exchange of medical information between health care professionals. The electronic health record (EHR) is one way of realizing this. However, that’s not the only (formal) objective of the EHR. Other objectives frequently mentioned are more patient centered health care and increased efficiency. The here described research project reflect upon the meanings and possibilities of more patient centered health care.

Research objective and research questions

The proposed research project hopes to open up new possibilities for creating relational responsibility through the use of the electronic health record. Within the present thought style research is seen as intervention and so the research project will also be seen as a piece of field work or change work (see also Hosking, 2004).

On the basis of the above, the following central research question can be formulated.

What can an electronic health record mean for the process of relational responsibility within health care relationships and what could the file look like when studied from the perspective of relational responsibility?

In order to be able to answer this central research question, the following questions need to be answered:

- ✓ How is the (objective and usefulness of the) EHR constructed by various people and/or communities (e.g. policy makers, health care professionals, patients) in The Netherlands?
- ✓ How can an EHR be constructed in different communities?
- ✓ What are the (ethical and practical) advantages and disadvantages of these different EHR’s as constructed by people within different communities?
- ✓ How can relational responsibility be stimulated within health care relationships?
- ✓ What can an EHR mean for the construction of identities and negotiation of responsibilities?

Ingredients of the research project

This research project can broadly be seen as consisting of five ‘research ingredients’. I consider change ongoing and I will be open to the voices of others participating in the research project. Therefore, these ingredients can change or be supplemented.

1. Desk research
2. Reflexive interviews on the construction of ethics and identities, on responsibilities and the potentials of an EHR
3. Discourse analysis of texts and interview transcripts
4. Focus groups
5. Reflexive ethnographic research within health care communities in which the EHR is introduced

Below these five ingredients, which need not take place in this order, are briefly described.

Ingredient 1. Desk research

a) Texts on the use of EHR's

In order to show how the (objectivity and usefulness) of the use of the EHR is constructed by various people or groups in The Netherlands, I will study different texts written by amongst others policy makers, patients, health care professionals. This will also involve research into the way in which the EHR is related to current legislation on for instance informed consent. In addition, I will study the stories of people who have already been working with the EHR.

b) Texts that explicitly use the language of relational responsibility

If we want to explore how the EHR can stimulate relational responsibility it is interesting to look at literatures discussing the ways in which relational responsibility can be stimulated within (health care) relations.

c) Texts on the use of EHR's in other countries.

The increasing usage of information- and communication technology within the health care sector is not restricted to The Netherlands. Different forms of EHR's have been introduced in different ways in different countries. For instance, in the USA patients have been given the opportunity to build an online health report in which they report on their symptons. It is possible to study the 'practical theories[1]' (Shotter, 1993) of people who have participated in the process of introducing the EHR. Practical theories that might be of use in other contexts if people find relevant analogies (Gergen & Thatchenkery, 1996). In addition, through the analysis of these texts I will explore potentials for relational responsibility and distributing responsibilities that are opened up by EHR's.

Ingredient 2. Reflexive interviews

During reflexive interviews I will reflect on the usefulness of the electronic health record, the idea of relational responsibility and the way in which the EHR could stimulate relational responsibility and can be constructed from this perspective. I intend to interview:

- ✓ Scientists
- ✓ Health care practioners
- ✓ Patients
- ✓ Policy makers
- ✓ Software developers
- ✓ Health care managers
- ✓ Medical students

[1] Practical theories can be seen as contextualized knowledges and skills, developed by all forms of practitioners. They can also be called forms of 'knowing-from-within'.

Ingredient 3. Discourse analysis

With the word discourse I refer to a system of written or spoken statements that construct a phenomenon (adapted from Parker, 2003, p.5). I will do a discourse analysis of the studied texts and interview transcripts. Through this analysis I will distinguish different constructions of the EHR and will study how these relate to different constructions of responsibility, identities and ethical health care. These discourses can be seen as the context within which the EHR can be constructed and used.

Ingredient 4. Focus groups

A focus group can be seen as a form of research in which a group of people are asked about their attitude towards for instance a product, program, concept or idea. Participants are asked questions in an interactive group setting where participants are free to talk with other group members. In this way reflexive dialogues can emerge.

During the research project it is possible to construct focus groups in which for instance only patients participate or in which both doctors, patients, policy makers and others participate and reflect on each other's contributions. This depends on the stage of the project en thus on the objective of the focus group.

Focus groups are a useful complement to interviews, because they make it possible to create a multilogue, in which various voices reflect upon the possibilities of an EHR for the doctor-patient relationship.

Ingredient 5. Reflexive ethnographic research within particular health care communities

Reflexive research can be discoursed in different ways. Reflexivity can be seen as an activity that aims at minimizing bias, checking objectivity, or it can be constructed as a relational process that is concerned with, among other things, local pragmatics and relational ethics (Hosking & Pluut, In writing). The latter approach is taken in this research project.

I will participate in relational processes within different health care communities in which the electronic health record is introduced and/or in use. In this way we can develop practical theories of using the EHR and stimulating relational responsibility with it. These practical theories can then be used by other communities by discovering relevant analogies. This is consistent with a relational constructionist thought style that assumes context dependent (i.e. local and historical) social realities (see e.g. Gergen, 1995; Hosking, 2002; Pluut, 2006). During my participation in these communities I will initiate reflexive interviews in which there is a communal reflection on 'good' and 'ethical' health care, the way in which the EHR can contribute to this and the way in which the EHR needs to be constructed and used.

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