

## ***Discussion paper***

### ***Relational responsibility within the doctor-patient relationship The potentials of electronic health records***

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Place and time: Utrecht, October 2008

#### ***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, the empirical 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**

##### ***Electronic Health Records as stabilizations of relational processes***

When we are relating we are constantly (re)constructing what we experience as 'real and good' (Gergen, 1999). Within things like buildings, clothes, organizational structures we stabilize such relational constructions. ICT can also be seen as such a stabilization (Chia, 1999). Once norms and values are stabilized through ICT it will be harder to improvise and to have other norms and values validated as 'good or acceptable'. An example of this is automation and thus stabilization of ideas of a 'good' role division between doctor and patient in Electronic Health Records (EHRs). Within my PhD I explore and study the processes by which ethical and practical conceptions of good health care are (un)stabilized in EHRs. Relational Responsibility can be considered the ethical point of departure from which this is studied.

##### ***Relational responsibility***

Interactions between doctor and patient can be seen as an exchange and construction of various knowledges. A patient generally draws upon knowledges of his physical symptoms, 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, the responsibilities of patient and doctor are distributed. So for instance, the knowledges of one participant (e.g. the doctor) can be constructed as more valuable or more important. Here we can distinguish between people who would prefer an egalitarian doctor-patient relationship and those who prefer a more traditional role division, in which the doctor is more in charge (Bensing et. al., 2004). The same person

can prefer a different role division, depending on the particular context. In every medical encounter doctor and patient need to decide on these relational qualities of their interaction processes. Within this PhD the concept of relational responsibility is used to study these processes (McNamee & Gergen, 1999), a concept that follows from a relational constructionist thought style (see e.g., Gergen, 1994, 1999; Hosking, 2002). 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'. However, at other times 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.

### *Electronic health records*

An electronic health record (EHR) can be considered a general concept that refers to a collection of electronically stored and electronically accessible health information (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 or a person's general well-being. In addition, different people can be given the right to add information to the EHR. Available software packages by Google and Microsoft, for example, focus on the use of health records by patients<sup>1</sup>. Other EHRs are more oriented towards the use by health care professionals. These different EHR-designs have different implications for communication between doctors and patients and the way they participate in health care process (Eysenbach, 2000).

### *A reflexive research project*

When we consider EHRs stabilized effects of relational processes, we need to pay careful attention to these processes. To be more precise, two types of processes become particularly interesting:

- relational processes during which EHR's are developed, designed and 'put to work'
- relational processes during which we reflect upon that what is being stabilized in EHR' and what this implicates. These reflection then make it possible to redesign EHRs

My PhD is storied *within* such processes. In other words, I explore how processes of stabilization and de-stabilization can be created and studied in a relational reflexive way (Pluut, 2006). The PhD can be characterized by a relational constructionist thought style, which assumes that all acts contribute to the (re)construction of multiple social realities and thus need to be seen as interventions (see e.g. Hosking, 2007; McNamee, 2004). This means I will position myself, as a researcher, as a participant in the very processes that I'm studying. The research project is constructed as a social intervention process in which ethical and local pragmatic issues are centered. I will focus on the use-value of research findings (Pluut and Hosking, in writing), which means issues of how research findings can be absorbed into organizational and research practices are seen as of major importance (Gergen & Hosking, 2006).

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<sup>1</sup> Sometimes such records initiated by patients are referred to as Personal Health Records Tang et. al., 2006). [www.healthvault.com](http://www.healthvault.com) and [www.google.com/health](http://www.google.com/health).

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**

In the last ten to fifteen years we have witnessed an increasing popularity of participatory approaches to health care in Western countries (Todres et al., 2007). Generally speaking there are two explanations for this. The first is that patient participation is considered 'ethical' (see e.g. Stilgoe and Farook, 2008). When patients have an active role in considering and deciding about possible treatments together with their doctor, patients tend to be more satisfied. Sometimes this also leads to better health results (Jahng et al., 2005). In addition, patient participation and emancipation fit with democratic values that are associated with western culture. The second argument for patient participation or empowerment lies in the demographic and labour market developments in western countries (see e.g., Commission of the European Communities, 2000). Because of an ageing population it is argued that a significant amount of health care tasks need to be carried out by patients and/or their family members (Van den Eerenbeemt and Mulder, 2005). Despite these arguments, patient participation can also be 'unethical'. For instance, patients can be emotionally or mentally unable or unwilling to decide about their treatments (Bensing et al., 2004). In addition, many people simply don't want to be actively involved in their health care process.

The above 'multiplicity' poses doctors and patients for an interesting challenge when communicating. A challenge that I myself, as a patient, have often experienced as stressful, when doctors were not responsive to my preference of having an open dialogue on possible treatments. 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 through the use of Electronic Health Records.

An empirical study into three national Electronic Health Records suggests that policy makers in western countries emphasize the importance of patient participation, but have not given priority to translating this into the design of their EHR (Pluut and Zuurmond, submitted). However, on the longer term they would like to design EHRs that support and empower patients to actively participate in their health process. Discussions on EHRs and PHRs, initiated by policymakers (see e.g. [www.patientenepd.nl](http://www.patientenepd.nl)) as well as researchers (e.g. Van der Ploeg et al., 2005, 2006), show there is a need for research into the relational and ethical aspects of electronic health records. In addition, policy makers generally seem to believe that health informatics in general, and health records in particular, will lead to more patient participation (e.g. Commission of European Communities, 2000). However, the precise ways in which Electronic Health Records can help doctor and patient in the health care process are not yet clear (Van der Ploeg et al., 2005, 2006), which also shows the scientific and societal relevance of this research project.

### **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 records. 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.

*How can different EHR services contribute to relational responsibility in doctor-patient relationships and how can research on this topic be an intervention towards EHR policy makers?*

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

- How can we stimulate reflections on ethical and practical aspects of doctor-patient relationships in relation to the design of EHRs?
- How can relational responsibility be stimulated within health care relationships?
- What can different services of EHRs mean for the construction of identities and negotiation of responsibilities between doctors and patients?

### **Ingredients of the research project**

This research project can broadly be seen as consisting of three '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.

- a) Desk research
- b) Ethnographic study of reflexive processes around the ethical and practical potentials and consequences of EHRs
- c) Reflexive case studies

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

#### Ingredient a. Desk research

The desk research will focus on the central themes of this thesis:

- Relational responsibility
- Doctor-patient communication
- Electronic health records (as stabilized effects)
- Reflexive research, i.e. research as intervention

The literature on Relational Responsibility will be combined with literatures on doctor-patient communication, leading to an analytical framework from which to study the potential meanings of EHRs for doctor-patient relationships.

In addition, existing studies on the consequences of EHRs for doctor-patient relationships are analyzed.

In addition, policy documents and journalistic writings on the ethical and practical consequences of EHRs are studied. In this way it becomes clear in which ways various communities construct the practical and ethical consequences of different EHRs and how policy objectives are translated into the design of an EHR.

#### Ingredient b. Ethnographic study of reflexive processes

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). In this research project I will story myself as a participant in the processes that I'm studying. My entire PhD can in this way be seen as an ethnography that is aimed at stimulating reflexive dialogues on the reflexive and practical aspects of EHRs. Articles published in various journals and on various websites can be seen as examples of ways in which reflexive dialogues are stimulated, just as face-to-face conversations with people that are involved in the implementation of EHRs in different settings.

The above makes reflections on the following themes important:

- how are identities constructed? (e.g. of myself as an organizational consultant/researcher, of dialogic partners)?
- what languages do we use and how do we communicate about the research project? (e.g. meta-theoretical<sup>2</sup>, theoretical, practical)
- how do we increase the use-value of research findings?
- how do we address the ethical aspects of the research project?

Because case studies form the easiest to identify 'unit of reflexive processes', below I will discuss them in more detail.

#### Ingredient c. Reflexive case studies

Two types of case studies will be performed:

- Reflexive case studies in health care communities that are working with an EHR
- Reflexive case studies in health care communities that are developing an EHR

The above implies that I will participate in relational processes within different health care communities in which the electronic health record is introduced and/or in use. In some cases I'm asked to be a consultant who facilitates these processes, in other cases my role is constructed as a researcher<sup>3</sup>. In each case we will explore how reflexive dialogues on the practical and ethical aspects of doctor-patient relationships can be translated into designs of EHRs. And how a particular design enables or disables Relational Responsibility in doctor-patient relationships. This can then lead to practical theories (Shotter, 1993) of how to design and work with an EHR, depending on contextual factors like type of health care, community setting and user groups.

#### **References**

- Bensing, J.M., Verhaak, P.F.M., Van Dulmen, A.M. and Van den Brink-Muinen, A. (2004). Communication in GP consultations. In: Van den Brink-Muinen, A., Van Dulmen, A.M., Schellekens, F.G. and Bensing, J.M. (eds.), Second national study into illnesses and activities in the GP-practice, p. 14-35. Utrecht: NIVEL.*
- Eysenbach, H. (2000). Consumer health informatics. In: BMJ, 320, p.1713-16.*

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<sup>2</sup> As said, this PhD is written from a relational-constructionist thought style. Such a thought style has its own discourse, its own language use. For some this way of thinking and talking might seem 'unpractical' and in some cases this might deter people. This dilemma will be addressed in this thesis.

<sup>3</sup> Reflections on these different identities will be an important part of this thesis (see ingredient c).

- Gergen, K. J. (1994). *Realities and Relationships: soundings in social construction*. Cambridge: Harvard University Press.
- Gergen, K. J. (1995). *Relational theory and the discourses of power*. In D. M. Hosking & H. P. Dachler & K. J. Gergen (Eds.), *Management and Organization: Relational Alternatives to Individualism* (pp. 29-51). Aldershot: Avebury.
- Gergen, K. J. (1999). *An invitation to social construction*. London: Sage Publications.
- Gergen, K. J., & Hosking, D. M. (2006). *If You Meet Social Construction Along the Road: A Dialogue with Buddhism*. In M. Kwee, Gergen, K.J., and Koshikawa, F. (Ed.), *Horizons in Buddhist Psychology*. (pp. 299-314). Chagrin Falls, Ohio: Taos Institute Publications.
- Gergen, K. J., & Thatchenkery, T. J. (1996). *Organization science as social construction: postmodern potentials*. *The journal of applied behavioral science*, 32(4), 356-378.
- Hosking, D. M. (2002). *Constructing changes: a social constructionist approach to change work (and beetles and witches)*: Tilburg: Katholieke Universiteit Brabant.
- Hosking, D. M. (2004). *Change works: a critical construction*. In J. Boonstra (Ed.), *Dynamics of Organizational change and learning*. Chicester: Wiley.
- Hosking, D. M. (2007). *Can constructionism be critical?* In J. Holstein & J. Gubrium (Eds.), *Handbook of Constructionist Research*. New York: Guilford Publications.
- Hosking, D. M., & McNamee, S. (2006). *Subject-object relations: knowledge and power*. In D. M. Hosking & S. McNamee (Eds.), *The social construction of organization* (pp. 86-90). Malmö: Liber & Copenhagen Business School Press.
- Hosking, D. M., & Pluut, B. (In writing). *Discoursing reflexivity: a relational constructionist approach*.
- McNamee, S. (1994). *Research as Relationally Situated Activity: Ethical Implications*. *Journal of Feminist Family Therapy*, 6(3), 69-83.
- McNamee, S. (2004). *Therapy as social construction: back to basics and forward toward challenging issues*. In T. Strong & D. Pare (Eds.), *Furthering Talk: Advances in the discursive therapies*. New York: Kluwer Academic/Plenum Press.
- McNamee, S., & Gergen, K. J. (Eds.). (1999). *Relational responsibility: resources for sustainable dialogue*. Thousand Oaks, California: Sage Publications.
- Pluut, B. (2006). *Responsive and reflexive researching: exploring the potentials of a social constructionist thought style*. Tilburg University, Tilburg.
- Pluut, B. and Hosking, D.M. (in writing). *Discoursing reflexivity: a relational constructionist approach*.
- Shotter, J. (1993). *Conversational realities: constructing life through language*. London: Sage Publications.
- Tang, P.C., Ash, J.S., Bates, D.W., Overhage, J.M., Sands, D.Z. (2006). *Personal Health Records: Definitions, Benefits, and Strategies for Overcoming Barriers to Adoption*. *Journal of the American Medical Informatics Association*, 13, 2.

- Treichler, P. A., Frankel, R. M., Kramarau, C., Zoppi, K., & Beckman, H. B. (1984). *Problems and problems: power relations in a medical encounter*. In C. Kramarae & M. Schulz & W. M. O'Barr (Eds.), *Language and Power*. California: Sage Publications.
- Witmer, J. M., & De Roode, R. P. (2004). *Implementation of the WGBO: from law to practice*. Utrecht: KNMG.