

HEALTH PSYCHOLOGY**The Social Psychology of Health Care:
Consumerism, Technology and The "Public Good"**

Rory Coughlan, PhD.

ABSTRACT

The manufacturing of desire in industrial society has implications not only for the economy but for how we view each other and how we plan important social services such as healthcare. Our belief in innovation, particularly the application of expensive technological and pharmacological advances, has far reaching effects on the provision and management of health institutions with limited budgets. Our cultural beliefs concerning the value of innovation, combined with political and administrative goals, may also lead us to denigrate the importance of front-line staffing and the value of the care they provide to patients. Research demonstrates the important role that one-on-one clinical care and clear communication has on the satisfaction ratings of vulnerable people experiencing illness. This paper discusses the social-psychological, political and administrative roots of the dilemma facing modern healthcare systems and their infringement on the advancement of humane practices and the "public good."

There is something wonderfully compelling about new technology, whether it comes in the shape of new cars, kitchen appliances or technological advancements in the modern clinic. I want to explore briefly how our cultural attachment to consumerism, innovation and technology may contribute to problems in medical practice with some negative consequences for health care and "the public good."

In western democracies dependent upon exponentially increasing economic activity, the advertising industry has been extremely successful in contributing to the manufacture of desire. We are cajoled by cultural messages to internalize and identify with a more consumerist outlook, not fully realizing that embracing novelty for its own sake changes the way we see ourselves and the value of everything around us. For instance, in social-psychological research people termed as "high self monitors"¹ are more influenced by the views of others and tend to be easier targets for conforming to the latest socio-cultural messages. They are socially rewarded for conforming to popular beliefs and the consumption of novel items but tend to be both more anxious and depressed because their locus of control is external to themselves and

this external locus is always changing.² The acceptance of consumerism and market economics also tends to promote individual competitiveness as well as a redefinition of social relations in terms of the metaphor of economic activity.^{3,4} In other words, we may tend to generalize instrumental economic models concerning profit and loss in relation to how we structure our institutions and how we treat each other in terms of consolidating power for net gain. This can lead to some awkward and dehumanizing consequences. A culture of consumerism tends to promote innovation and technological advancement but too strong a belief can negatively affect us, our relations, how we define care and the way we organize social institutions such as healthcare. Market economics has the power to distort social institutions that depend upon the relatively smooth interaction of many stakeholders with different interests, advantaging the most powerful stakeholders and creating imbalances that may undermine fundamental goals. The core values of publicly funded healthcare revolve around promoting "the public good" but our attachment to innovation and technological advancement has presented the corporate sector with a distinct advantage to further its agenda with consequences that

exacerbate existing problems in preserving these values.

Technological innovation, whether in the form of pharmacology, surgical interventions or new medical appliances, can have positive effects but only if we can demonstrate an improvement in outcomes over previous ways of doing things. With many innovative medical interventions, manufacturers demonstrate both effectiveness and safety through research trials and, generally, patients, clinicians and the health system have been reasonably well served. Lately however, we have been forced to admit that the procedures for evaluation have sometimes been seriously undermined as some companies have attempted to hide damaging information because they feel that their competitive lust for profits outweighs the public's right to safe products. Examples include silicone breast implants for cosmetic reasons, the Dalcon Shield, the use of certain pharmaceuticals for depression in children, and the extensive marketing of Cox 2 Inhibitors to name just a few. To further their business goals, certain manufacturers have developed cosy relationships with governmental organizations charged with overseeing the safety of medical products and appliances. Since the mid 80's, and especially in the United States, this has resulted in the evolution of a more corporate-friendly evaluative system committed to the fast-tracking of approvals.⁵ In some cases clinical trials are ghost written with senior medical researchers accepting rewards for adding their names as authors.⁵ Some corporate interests have attempted to bully scientific clinical assessors into silence concerning dangerous side effects or negative results from trials. Occasionally, pharmaceutical corporations attempt to bully universities and hospitals into admonishing or firing employees for their moral stance to continuing failing trials or publicly reporting negative results. The case of Doctor Olivieri, a research scientist at the University of Toronto, is one notorious example.⁶

Pharmaceutical corporations attempt to increase their market share by providing information, free samples and other perks. In the United States \$13.2 billion was spent promoting pharmaceutical products to physicians in 2000 and an additional \$ 2.4 billion was spent by pharmaceutical corporations using public media where direct to consumer marketing is almost ubiquitous.⁷ Recent research demonstrates that this has a major effect on physicians' prescribing behaviours,⁸ and this impact is much greater than many clinicians realize.^{9,10} Since the strengthening of copyright laws in most industrial economies, this more aggressive marketing has meant steadily rising prices for prescription medicines, soaring profits and rising costs to health systems. In Canada, the total expenditure on drugs climbed from 8.4% of total healthcare expenditures in the late 1970's to 15.7% in 2001 and is expected to rise to 16.2% this year.¹¹ In 1997 the amount spent on pharmaceuticals surpassed the amount paid for physician services and is expected to continue to be the

second most important health spending behind costs for hospitals.¹² The last 15 years have seen an explosion in the number and costs of pharmaceuticals but without a proportionate rise in the health of the population.^{13,14} The corporate sector, driven by the structure of market economics, invests heavily in public relations campaigns to convince both professional and public audiences that technological innovation contributes to the public good. Such messages, however, fail to disclose that, while the corporate sector has much to gain, the public interest may be jeopardized by inferior outcomes, accelerating costs to limited budgets and painful restructuring.

Many so called "innovative" advances are really nothing more than an attempt to circumvent generic competition by marginally changing popular copyrighted products and advertising them as "new and improved." Another major direction for the corporate sector is what is euphemistically referred to as "me-too" drugs: variations of already existing profitable pharmaceuticals already in circulation that increase profits with little in the way of development costs.¹⁵ Thus, we can readily appreciate that, in healthcare, acquiescence to the marketing of novelty and instrumentally-oriented market relations may not always be in the public interest.

In addition to pharmaceuticals, the corporate sector also furthers their interests by innovation in other areas such as diagnostic testing and screening machinery. We tend to have faith in diagnostic machinery to provide accurate assessments and some commentators have argued that this faith can often be uncritical.^{16,17} The purchases (often at increasingly extraordinary costs) may produce better pictures or estimates of possible problems but are rarely evaluated in terms of actual health outcomes.¹⁸ In the case of some technologically-dependent screening programmes, evaluations have thrown their worth into considerable doubt.¹⁹ For instance, mass breast mammography and prostate screening programmes have often been criticized by many health commentators. In the case of breast mammography for women, the rationale that benefits outweigh harm has been discussed for women aged 50-69²⁰ but others disagree, citing needless anxiety and false-positive results, especially for women outside this age range.^{21,22} For some people, aggressive early screening may result in timely treatment but for others it may lead to invasive surgical procedures that put them at significant risk for no good reason.^{16,17} The routine use of newer \$2 million 64 detector CT scanners by cardiologists in emergency departments in the United States is lauded by some as a possible breakthrough in diagnostic technique whereas others see such expenditures as leading to serious budgetary problems and, perhaps, bankruptcy for some institutions. Newer, expensive technology is sometimes capable of greater "technical" sensitivity but, even in the best circumstances, their use actual-

ly increases the chances of false-positive interpretations, leading to both unnecessary psychological distress and increased costs.^{16,17}

Governments and funding agencies also approve of innovation and seem willing to fund projects linked to the newest technological solutions. In a qualitative investigation concerning the closure of one long-term care facility and the movement of the patients to a brand new, much heralded "high tech" facility in Central Ontario, the initial findings give cause for concern.²³ The Ontario Ministry of Health provided funding for a new facility, partly because the majority of the placements would provide revenue from private patient fees (making it much more problematic for less wealthy seniors to access long term care), and partly because it could also function as a demonstration project for the latest technological nursing innovations. However, many staff report that the digital systems are extremely intimidating and resent their deleterious effects on the available time spent directly caring for patients: something exacerbated by a reduction in staffing that accompanied the move to this "high-tech" facility. In addition, some patients felt somewhat disappointed when they arrived because they were led to believe by the promotional messages, and almost expected, that the new facility would resemble a facility from "Star Trek." Staff and patients interviewed expressed that the real value and quality of their lives is highly correlated with caring interactions rather than an innovative facility or any technological advancements.²³ Unfortunately, the current funding formula mandated by the Provincial government in Ontario has led to administrative policies that structure staff shortages as an everyday reality.²⁴ Residents and staff alike report that current funding formulas have resulted in "caring interactions" being both too short and too few to provide a good quality of life for residents.²³

While we seem increasingly willing to spend money on technological innovation, we seem less willing to offer high quality care via the more traditional medium of well-trained clinical personnel. The problems of insufficient staffing levels are not limited to long term care facilities. Although partial blame can be laid with the aging population (leading to increased health care and increased retirements of medical personnel), other more controllable aspects are exacerbating the situation. From the point of view of many clinical staff, there is often a sense that administrations are distant and disengaged from their needs. Nurses report that they are spending increasing time contributing to the maintenance and care of the record-keeping systems⁴ when they see their job as caring for patients in a more immediate form.³⁰ In addition, we are seeing changes in the make-up of the hospital workforce that are affecting front-line "care" workers' morale while downgrading overall proficiency and experience levels.²⁵ Increasingly, the hiring of part-time or casual nurses and other clinical staff has become de rigeur. In Canadian

hospitals the number of licensed practical nurses has fallen almost 40% whereas the proportion of nurse aides and orderlies has increased by 50% between 1987 and 2003,²⁵ even though research demonstrates that a higher proportion of more highly-trained nurses reduces patient mortality, medical errors and the number of patient falls.²⁶ Only 54% of nurses in Canadian hospitals worked full-time whereas 33.8% were part-time employees and 11.8% were casual.²⁷ While many nurses have requested flexible employment schedules for various reasons, others (including recent graduates from nursing programmes), require full-time positions to provide economic security. Nurses' inability to find suitable full-time employment in Canada has led to an exodus to the United States.²⁴ In addition, the frequent relocation of nurses between units leads to problems in continuity of care and patient dissatisfaction.^{4,28} The current low morale of nursing staff here in Canada (which is also widespread among many European nations) is linked to increasing time spent responding to many administrative dictates for record keeping and monitoring complex machinery, and away from patient care. Patient satisfaction is closely linked to the socio-emotional aspects of care²⁹ and communication but this is made problematic because increased work-loads result in reduced contact time with patients.^{28,30} All these aspects tend to increase the probability of complications, adverse events, the increased use of services and readmissions, all resulting in further cost escalations.^{28,31,32}

In Canadian hospitals and throughout many western medical systems, administrators are becoming increasingly powerful in setting institutional goals.³³ The application of administratively-driven economic cost-benefit models can have some awkward effects in terms of providing quality clinical care. Health administrators decide how best to spend the available budget and an increasing proportion tends to be spent on pharmaceuticals and new technology. Such products are aggressively, and often successfully, marketed but any increase in spending on these items is highly likely to jeopardize important services affecting budgets for frontline staff. There are many reasons for this, including a general societal belief that technology is positive in and of itself,³⁴ but there are other additional values of importance to administrators. In the manufacturing sector, the increased use of technology (in addition to all its reputed labour cost efficiency aspects) also allows the creation of reliable records but can further function as an efficient means to increase surveillance of staff work processes and protect the institution in the case of malpractice accusations. The surveillance and record keeping aspects of the routine use of technological interventions reinforce the power of administrations in medical institutions and these are compelling reasons for hospital administrators to encourage their proliferation.³⁵ However, the more health institutions utilize technology to mediate care, with consequences for reinforcing existing

hierarchical power relations, the greater the tendency for depersonalized interactions.³⁶ Any increase in depersonalization in medical relationships is deleterious to clinicians and patients and, consequently, health care values that support “the public good.” As outlined, technology can be a double-edged sword but it is most problematic for medical outcomes when it interferes with communication.³⁶

Another related aspect of our belief in novel technology that affects clinical communication, and increases the probability of depersonalization, concerns the use of standardized templates including chronic disease management software. While there are many positive aspects to utilizing patient data software, including improvement in patient record-keeping and in reminding clinicians to discuss pertinent points, there are also some drawbacks. Such systems mediate the communication process and may over-structure clinical conversations using the template of the standard or “normal” case, when most individual patients “deviate” from abstract averages, and often substantially. Important aspects regarding individual experiences may remain undiscussed or glossed over, and in worst case scenarios lead to “cookbook” medicine.³⁷ Different management programmes abound but in some cases software is designed by or with the help of the corporate sector (including subsidiaries of pharmaceutical companies) to further commercial aims by incorporating elements that promote information pertinent to corporate interests.^{38,39}

Technological interventions that distort communication in health settings are problematic, but all the more so because common models of diagnostic encounters have already been subject to critiques. It is argued that they tend to render the living patient, contextualized by socio-psychological variables, economic aspects, beliefs and values, to merely a collection of biological systems. Clinical interactions often translate patients’ “lifeworld” into a more abstract language consistent with the biochemical paradigm of scientific medical testing technology.⁴⁰ Critics charge that many of our medical diagnostic systems and diagnostic interactions are more congruent with understanding the person as a “corpse” rather than as a conscious and multifaceted social being.⁴¹ Such abstraction of patients’ lived experience to conform to standardized and impoverished templates has the effect of making clinical interaction all the more disempowering for the patient and will interfere with patient strategies of self-care and behaviour change.⁴² Research has suggested that patient satisfaction with clinical interactions is highly correlated with open, two-way communication,^{28,30} and with communication that is less authoritarian and distorted by unequal power relations.⁴³ Augmented patient compliance to treatment protocols and improved health outcomes have also been associated with a more equal and “democratic” style of interaction.^{40,43} Thus, while such chronic disease management templates may act

as handy tools for physicians to monitor patients and improve record-keeping, they may also standardize interactions with a possibility of problematic outcomes.

The powerful cultural messages that encourage our commitment to consumerism, and thus an appreciation for innovation and technological advancement, are bitter-sweet. While medicine has gained immeasurably by advances in diagnostic testing and disease management, problems have been created in other critical components linked to humane, quality care in planning for, and adapting to, technological innovation. We have been socialized to believe that increasing our dependence on technology will improve our lives and different stakeholders in the health sector have been keen to support technological innovation for reasons linked to their self-interests. While the aims of clinicians and administrators for utilizing tools that will improve medical outcomes and institutional efficiency are often supportable, those of the corporate sector are less so. Spending substantial proportions of health budgets on increasingly expensive innovative interventions would seem to be an arrangement that suits a plethora of interests. However, the implementation of technological innovation advantages the most powerful stakeholders while simultaneously undermining frontline healthcare workers and patients, with implications for outcomes. A more critical approach towards our commitment to consumerist cultural values would focus attention on the manner in which such beliefs have consequences for policies and practices in our health system. Without serious attention to such issues we may inadvertently undermine the ability of clinicians to provide humanitarian care, and consequently undercut the aims of healthcare to promote “the public good”. †

REFERENCES

- Lippa, R. & Donaldson, S. I. (1990). Self-monitoring and idiographic measures of behavioural variability across interpersonal relationships. *Journal of Personality*, 58, 165-88.
- Gonnerman, M.E., Jr., Parker, C.E., Lavine, H, et al. (2000). The relationship between self-discrepancies and affective states: The moderating roles of self-monitoring and standpoints on the self. *Personality & Social Psychology Bulletin*, 26, 810-19.
- Harvey, D. (1996). *Justice, Nature & the Geography of Difference*. Blackwell, Oxford
- Coughlan, R. (2002). *General medical and birthing Experiences of New Mothers in the Capital Health Region: An Empirical and Socio-Historical Investigation into the Concept of Personal Agency*. Unpublished Dissertation. University of Victoria.
- Healy D. (2003) *Let Them Eat Prozac: The Unhealthy Relationship Between the Pharmaceutical Industry and Depression*. James Lorimer & Co Toronto.
- Thompson, J. Baird, P. & Downie, J. (2002). *The Olivieri Report*. James Lorimer & Co. Toronto.
- IMS Health. (2004). U.S. promotional spending by type. Retrieved December 9, 2004 from World Wide Web: <http://www.imshealth.com/public/structure/discontent/1,2779,1343-1343-143223,00.html>
- Kravitz, R.L., Epstein, R. N., Feldman, et al (2005) Influence of patients Requests for direct to consumer advertised antidepressants. *JAMA*, 293:1995-2000
- National Institute for Health Care Management, Research and Educational Foundation. Prescription drugs and mass media advertising, 2000 (online) Retrieved November 23, 2004 from the World Wide Web: www.nihcm.org
- Caudill, Ts, Johnson, MS, Rich, EC, et al (1996) Physicians, pharmaceutical sales representatives and the cost of prescribing. *Arch.Fam. Med* 5:201-6

11. Canadian Institute of Health Information (2005). Retrieved March 18, 2005 from the World Wide Web: releases@cihi.ca. and http://secure.cihi.ca/cihi-web/home_e.html
12. Canadian Institute of Health Information (2003). Retrieved March 18, 2005 from the World Wide Web: releases@cihi.ca. and http://secure.cihi.ca/cihi-web/home_e.html
13. Townson, M. (1999). *Health and Wealth: How Social and Economic Factors Affect our Well-Being*. Toronto. Canadian Centre for Policy Alternatives.
14. Duncan, B. Miller, S. & Sparks, J. (2000). Exposing the myth-makers. *Family Therapy Newsletter*, 13, 28-35.
15. Angell, M. (2004) Excess in the pharmaceutical industry. *CMAJ*, 171 (12),1503
16. Lomas, J. (1998). Social capital & health: Implications for public health and epidemiology. *Social Science & Medicine*, 47, 9, 1181-89.
17. Rachlis, M. & Kushner, C. (1989). *Second Opinion: What's Wrong with Canada's Healthcare System*. Toronto. Harper Collins.
18. Feeney, D. Guyatt, G. & Tugwell, P. (1986). *Healthcare Technology: Effectiveness, Efficiency and Public Policy*. Montreal. The Institute for Research on Public Policy.
19. Gotzsche, P.C. & Olsen, O. (2000). Is screening for breast cancer with mammography justifiable? *Lancet*, 355, 129-34.
20. Barratt, A. Howard, K. Irwig, L. et al (2005) Model of outcomes of screening mammography: Information to support informed choices. *BMJ*, 330, 936-7.
21. Barratt, A.L. Trevena, L. Davey, H.M. et al (2004). Use of decision aids to support informed choice about screening. *BMJ*, 329,507-10.
22. Drossaert, C.H., Boer, H., & Seydel, E.R. (2001). Does Mammographic Screening and a negative result affect attitudes towards future breast screening. *Journal of Medical Screening*, 8, 204-12.
23. Coughlan, R & Ward, L. (2006). Experiences of Recently Relocated Residents of a Long-Term Care Facility in Ontario: Assessing Quality Qualitatively. *International Journal of Nursing Research*. In Press
24. Browne, P. L. (2000). *Unsafe Practices: Restructuring and Privatization in Ontario Health Care*. Ottawa: Canadian Centre for Policy Alternatives.
25. Statistics Canada (2004). *Perspectives on Labour and Income, Vol 5, No. 11(75-001-XIE)*
26. Malone, B. (2005). *Fragile Future of Nursing*. Deans Speech, St. Bartholemews School of Nursing, March 9 2005.
27. Canadian Nurses Association (2003). *Highlights of 2002 Nursing Statistics*. Health Policy Division. Canadian Nurses Association
28. Stephenson P. & Holmes, C. (2000). *The Elders Listening Project: Elder Friendly Hospital Initiative of the Capital Health Region*. Victoria, B.C. Capital Health Region/ University of Victoria.
29. Leiter, M. Harvie, P. & Frizzel, C. (1998). The correspondence of patient satisfaction and nurse burn-out. *Social Science & Medicine*, 47, 1611-17
30. Charles, C.A., Gauld, M., Chambers, L.W., O'Brien, B.J., Haynes, R.B. & Labelle, R.J. (1994). How was your hospital stay? Patients reports about their care in Canadian hospitals. *CMAJ*, 150 (11), 1813-22.
31. Dinsdale, P. (2004). Information technology is not meeting nurses' needs. *Nursing Standard*, 19, 7, 8
32. Bartholemew, K. & Curtis, K. (2004). High-tech, high-touch: Why wait. *Nursing Management*, 35, 9, 48-54
33. Saul, J. R. (1999). Opening address. *Future of Healthcare Conference*. Ottawa.
34. Davis-Floyd, R. (1992) *Birth as an American Right of Passage*. Los Angeles. University of California Press.
35. Jordan, B. (1993) *Birth in Four Cultures* (4th ed.) Prospect Heights Ill.: Waveland.
36. Alexander, J., Beagle, C., Butler, P., Douerty, D. Robards, K. & Velotta, C. (1989) *Madeleine Leininger*. St. Louis, MO. Mosby.
37. Timmermans, S. & Berg, M. (2003). *The Gold Standard: The Challenge of Evidence Based Medicine and Standardization in Health Care*. Philadelphia. Temple University Press.
38. Kesterloot, K. (1999) A new technology in need of critical assessment. *International Journal of Technology Assessment*, 15 ,3, 506-519
39. Bloor K. & Maynard, A. (1998) The art of the obvious or an industry conspiracy? In R. Lilley (ed). *Disease Management* (p. 89-110). Chichester: Wiley & Sons
40. Clarke, J.A. & Mishler, E.G. (1992). Attending to patients' stories: Reframing the task. *Sociology of Health and Illness*, 14(3), 344-72.
41. Leder, D. (1992). A tale of two bodies: The Cartesian corpse and the lived body In D. Leder (Ed.). *The Body in Medical Thought and Practice. Philosophy & Medicine*, 43. (17-35). London. Kluwer Academic Publishers.
42. Kutner, N. G. (2003) Paradigm tension in management of chronic disease. *Research in the Sociology of Health Care*, 21, 107-123
43. Mullett, J. & Coughlan, R. (1998). Clinician and seniors' views of Reference Based Pricing: Two sides of a coin. *Journal of Applied Gerontology*, 17, 3, 296-317.

Author Biography

Rory Coughlan holds a PhD and is an Assistant Professor of Health Psychology at Trent University.

ATTENTION DOCTORS



DNA
Doctors Nurses Associates Inc.

HEALTH
CONSULTANTS



"Streamlining Our Health System"

• OHIP Billing

• Clinic Setup

• EDT (Electronic Data Transfer) Billing

• Payroll

• Exam Preparation (Foreign Doctors)

• Income Tax

• Training & recruiting Foreign Doctors & Nurses

Mohsin Samdani 1 (877) DNA-2646

Email: dna@bellnet.ca • www.doctorsnursesassociates.ca