# Communication in the Healthcare Organization: The Perceived Use of Rhetoric among Healthcare Professionals

Master's Thesis

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## Abstract

The study of communication was born with the study of rhetoric, and scholars have been examining the creation and reception of messages for thousands of years. However, the term rhetoric often has negative connotations, as we hear people label some statement as “just rhetoric” or we hear them say, “The action doesn't match the rhetoric.” However, rhetoric is a style of communication that takes into account the effective use of both verbal and non-verbal languages, and it is one of the main ingredients in the day to day communication in organizations, healthcare organizations being no exception. It is virtually impossible to communicate without the use of rhetoric. This study focused on healthcare organizations because the delivery of healthcare is built on communication, and there is more to understand about the usage of language and organizational rhetoric in healthcare organizations. To these effects, the study examined communication in healthcare organizations and the perceived use of rhetoric among healthcare professionals; it explored how healthcare professionals perceive communication with their audiences, how the use of rhetoric, as perceived by healthcare professionals, affects communication in healthcare organizations and the contribution of rhetoric, as perceived by healthcare professionals, in motivating healthcare audience in healthcare organizations. The five canons of rhetoric were employed as a theoretical framework, and semi-structured interviews were used as tools for data collection. While contributing to existing literature on health and organizational communication, this study will also contribute in providing both government and private organizations insights into the use of rhetoric in professional communication with the hope of enhancing the quality of communication in the workplace.

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# Chapter 1: Introduction

Organizations cannot exist apart from communication. In fact, some scholars argue that communication is what creates an organization (Core, Taylor, & Van Every, 2006). All organizational activity involves communication. Activities such as leading, motivating, negotiating, decision-making, problem solving, and exchanging information and ideas are all based on the ability of managers and employees to communicate successfully with colleagues, clients, and supply (Lisbeth, 2006), hence, the use of organizational rhetoric as a communication strategy, because it is concerned with how messages are fashioned to meet specific goals (Hoffman & Ford, 2010).

Effective communication is valued at all stages of human life, most especially in healthcare organizations because it enables good relationships between healthcare providers and healthcare seekers and helps them in challenging healthcare choices (Boise & White, 2004; Winn, Cook, & Bonnel, 2004). Effective communication also is linked to improved adherence to treatment and positive healthcare outcomes as well as patients recall of information (Harms, Young, & Amsler, 2004; Roter, Stewart, & Putnam, 1997). Effective communication in healthcare can safeguard against malpractice suits (Levinson & Chaumeton, 1999). Studies have shown that effective communication coupled with mutual sharing of information and collaborative decision making between healthcare professionals and patients are the most essential determining factors of patients' satisfaction in the delivery of healthcare, and also help to develop healthcare professionals' sense of competence and confidence (McCabe, 2004). Although there is a body of research addressing effective communication in healthcare, there are still gaps that need to be filled, particularly, in understanding the usage of language and organizational rhetoric in healthcare organizations; hence, the focus of this study on healthcare

organizations, because the delivery of healthcare is built on communication, and there is more to understand about the usage of language and organizational rhetoric in that sector. Extensive research has shown that no matter how knowledgeable a clinician might be, if he/she is not able to open good communication with the patient, he/she may be of no help (Asnani, 2009). Studies also indicate that a clinician may conduct as many as 150,000 patient interviews during a typical career (Institute of Medicine [IOM], 2003). If viewed as a healthcare procedure, the patient interview is the most commonly used procedure that the clinician will employ. Yet communication training for healthcare professionals historically has received far less attention throughout the training process than other clinical tasks (IOM, 2003).

In the delivery of healthcare, communication is a vital ingredient. The ability to communicate information and ideas effectively is increasingly recognized as critical to the success of the healthcare organizations. Effective healthcare assumes effective communication between the patient and the healthcare professional (Jennifer, Dip, & Nancy, 2010). However, effective communication is required not only for successful interactions between healthcare seekers and healthcare providers but also between healthcare providers themselves. Intuitively, a healthcare organization's success is related to its service quality. Practices such as open communication among staff members and providing patient-centered care have an impact on both patient safety and patient satisfaction (Bontrager, 2012). A healthcare professional's communication and interpersonal skills encompass the ability to gather information in order to facilitate accurate diagnosis and establish caring relationships with patients (Fong, 2010). Fong (2010) explained that effective doctor-patient communication is a central clinical function, and the resultant communication is the heart of medicine and a central component in the delivery of healthcare.

Hoffman and Ford (2010) stated that all communication is situated in a context. Events and conversations that occur prior to an instant of communication have an impact on what is said, how it is said, and the meaning that is assigned to it (Hoffman & Ford, 2010). Language, however, is both a medium of communication and a framework for understanding human experience. In general, communication is improved through the consistent use of plain and unambiguous language (Blundel, Ippolito & Donnarumma, 2013). The late twentieth century saw an increased interest in the way that language influenced healthcare organizations (Blundel et al., 2013).

Sapir and Whorf (2013) argued that language predetermines what we see in the world around us. In other words, language acts like a polarizing lens on a camera in filtering reality—we see the real world only in the categories of our language. Organizational rhetoric, on the other hand, is the strategic use of language and symbols by organizations to communicate, influence and persuade its audience. Organizations are powerful in contemporary society, and they exercise that power through the use of rhetoric (Hoffman & Ford, 2010). When you hurt someone, saying "sorry" may seem like the least you can do. But when the hurt occurs in healthcare organizations, offering an apology is not so easy (O'Reilly, 2010). More than a decade since studies first showed that openness and apology might work, "I'm sorry" is still rarely uttered in medicine (O'Reilly, 2010). One way in which physicians can respond to a medical error is to apologize. Apologies—statements that acknowledge an error and its consequences, take responsibility, and communicate regret for having caused it—can decrease blame and anger, increase trust, and improve relationships (Robbennolt, 2008). Robbennolt (2008) further stated that incorporating apology into conversations between healthcare professionals and patients can address the needs of both parties and can play a role in the

effective resolution of disputes related to medical errors. This is among the reasons as to why it is important to understand the usage of language and organizational rhetoric in healthcare organizations.

The purpose of this research was to explore how healthcare workers perceive communication with their audiences, examine how the use of rhetoric affects the style of communication in healthcare organizations and finally, establish how rhetoric contributes in motivating the audience in healthcare organizations. To that effect, the study reviewed literature on audiences in healthcare organizations, communication in healthcare organizations, rhetorical situations in healthcare organizations, constraints and assets in healthcare rhetoric, and last but not the least motivation in healthcare organizations.

In the following, the key terms and concepts used in this study are defined

***Language:*** Communication of thoughts and feelings through a system of arbitrary signals, such as voice sounds, gestures, or written symbols (American Heritage Dictionary, 2000).

***Rhetoric:*** Rhetorical scholars often debate how to characterize the word. Definitions range from Aristotle's well-known statement that rhetoric is "an ability in each particular case, to see the available means of persuasion" (Aristotle, 2007, p. 37), to rhetorical theorist Barry (2006) who claimed that rhetoric is "the ways in which signs influence people" (p.4). Rhetorician Hikins (1986) suggested that rhetoric is "the art of describing reality through language" (p.62). However, the online Advanced English Dictionary and Thesaurus (2014) defines rhetoric as using language effectively to please or persuade, or the study of the technique and roles for using language effectively.

***Organization*:** One of the most well-known definitions of organization was developed by Barnard (1969). He wrote that "a formal organization is a system of consciously coordinated activities or forces of two or more persons" (p. 73). This definition suggests three characteristics of a given organization: communication, willingness to cooperate, and common purpose. Each of these is important in understanding the role of rhetoric in organizations. Contemporary scholars such as Richmond & McCroskey (2009) define an organization as "an organized collection of individuals working interdependently within a relatively structured, organized, open system to achieve common goals" (p.1).

***Organizational rhetoric:*** Is the strategic use of language and symbols by organizations to influence the thoughts, feelings, and behaviors of audiences important to the operation of the organization (Hoffman & Ford, 2010). To be strategic is to carefully consider the impact of the selection and arrangement of symbols in a message.

***Healthcare:*** Healthcare is the diagnosis, treatment, and prevention of disease, illness, injury, and other physical and mental impairments in human beings. Healthcare is delivered by practitioners in allied health, dentistry, midwifery-obstetrics, medicine, nursing, optometry, pharmacy, psychology and other care providers (Merino, 2012).

***Inter-professional communication:*** Inter-professional communication occurs when healthcare providers communicate with each other; this type of communication builds trust amongst them (Berry, 2007). Schiavo (2007) emphasized that "in professional communication, the concept of peer describes professional with similar education, training, and overall capacity" (p.177). Inter-professional communication can help healthcare providers meet their challenges with peer-to-peer information and tools that contribute to the effectiveness of their medical practices and, ultimately, better health outcome for their patients (Schiavo, 2007).

***Doctor-patient communication:*** Doctor-patient communication encompasses the verbal and nonverbal interactions that form the basis for the doctor-patient relationship (Berry, 2007). Berry (2007) emphasized that effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship, which is the heart of medicine. Doctor-patient communication is important in the delivery of quality healthcare (Berry, 2007; Merino, 2012).

## *Overview of the Thesis*

In order to explore communication in healthcare organizations and the use of rhetoric, this thesis is divided into six main sections. The present chapter provides a background and context for understanding communication in the healthcare organizations. The next chapter examines more closely existing literature pertinent to the current study, and outlines the theoretical framework and research questions posed. Chapter three discusses the methodological approach employed in this study; the collection and analysis of data are then discussed in detail. In chapter four, the findings of this study are reported, followed by discussions in light of the theoretical framework used. Finally, chapter six presents conclusions and implications of the findings, closing with suggestions on potential directions for future research.

## *Chapter Summary*

In the present chapter, the researcher has introduced the subject matter serving as the focus of this study, that is, communication in healthcare organizations and the use of rhetoric. This chapter has provided a brief summary of the importance of communication in healthcare, while underscoring the usage of language and organizational rhetoric.

In chapter two, the researcher will review related literature on rhetoric and communication, audience in healthcare organizations, communication in healthcare organization,

rhetorical situations in healthcare organization and motivation in healthcare organizations, and pose research questions to help guide the study.

# Chapter 2: Literature Review

This literature review seeks to provide context and background to examine communication in healthcare organizations and their key audiences, and also provides a foundation to further identify these audiences and explore their communication style. Accordingly, the literature review is divided into six sections: backdrop into rhetoric and communication, audiences in healthcare organizations, communication in healthcare organizations, rhetorical situations in healthcare organizations, constraints and assets in healthcare rhetoric, motivation in healthcare organizations and the theoretical framework used in this study. In so doing, the review moves from general ideas that provide a conceptual framework to specific areas that affect communication in healthcare organizations.

## Rhetoric and communication

Rhetoric is the art of discourse, an art that aims to improve the capability of writers or speakers to inform, persuade, or motivate particular audiences in specific situations (Allen, 2007). As a subject of formal study and a productive civic practice, rhetoric has played a central role in the European tradition (Thomas, 1991). Its best known definition comes from Aristotle, who considers it a counterpart of both logic and politics, and calls it the faculty of observing in any given case the available means of persuasion (Enos, 2005). Rhetoric typically provides heuristics for understanding, discovering, and developing arguments for particular situations, such as Aristotle's three persuasive audience appeals, logos, pathos, and ethos (Corbett, 1990). The five canons of rhetoric, which trace the traditional tasks in designing a persuasive speech, were first codified in classical Rome: invention, arrangement, style, memory, and delivery. Along with grammar and logic, rhetoric is one of the three ancient arts of discourse (Vican, 2008).

From Ancient Greece to the late 19th century, it was a central part of Western education, filling the need to train public speakers and writers to move audiences to action with arguments (Henry, 1995). The word is derived from the Greek, "oratorical", from "public speaker", related, that which is said or spoken, word, saying, and ultimately derived from the verb "I say, I speak" (Enos, 2005).

Scholars have debated the scope of rhetoric since ancient times. Although some have limited rhetoric to the specific realm of political discourse, many modern scholars liberate it to encompass every aspect of culture (May & Mumby, 2005; Thomas, 1991). Contemporary studies of rhetoric address a more diverse range of domains than was the case in ancient times. While classical rhetoric trained speakers to be effective persuaders in public forums and institutions such as courtrooms and assemblies, contemporary rhetoric investigates human discourse at large (Dow, 2007). Rhetoricians have studied the discourses of a wide variety of domains, including the natural and social sciences, fine art, religion, journalism, digital media, fiction, history, cartography, and architecture, along with the more traditional domains of politics and the law (Nelson, 1998). Many contemporary approaches treat rhetoric as human communication that includes purposeful and strategic manipulation of symbols (Rapp, 2002).

Rhetorically − the communicator gives thought to the intended message and stimulates the receiver in a manner designed to achieve a specific result and the use of verbal and nonverbal messages is frequently required (Burton, 2007). In that way, rhetoric is goal-oriented; it seeks to create a specific meaning in the mind of the audience (Corbett, 1990). In its long and vigorous history rhetoric has enjoyed many definitions and accommodated differing purposes. Yet, for most of its history it has maintained its fundamental character as a discipline for training people to perceive how language is at work orally and in writing, and to become proficient in applying

the resources of language in speaking and writing (Burton, 2007). Rhetoric was a comprehensive art just as much concerned with what one could say as how one might say it (Enos, 2005). Indeed, a basic premise for rhetoric is the indivisibility of means from meaning; how one says something conveys meaning as much as what one says (Burton, 2007). Rhetoric studies the effectiveness of language comprehensively, including its emotional impact, as much as its propositional content. To see how language and thought worked together. Rhetoric requires understanding a fundamental division between what is communicated through language and how this is communicated (Enos, 2005). Corbett (1990) phrased this as the difference between logos (the logical content of a speech) and lexis (the style and delivery of a speech). If we can effectively communicate using rhetorical skills then we increase our chances of success in whatever field we work (Worthington, 2008).

On the other hand, the history of communication dates back to prehistory, with significant changes in communication technologies (media and appropriate inscription tools) evolving in tandem with shifts in political and economic systems, and by extension, systems of power (Heath & Bryant, 2000). Communication can range from very subtle processes of exchange, to full conversations and mass communication. Communication from Latin commūnicāre, meaning "to share" (Barnlund, 2008) is a purposeful activity of exchanging information and meaning across space and time using various technical or natural means, whichever is available or preferred.

Communication requires a sender, a message, a medium and a recipient, although the receiver does not have to be present or aware of the sender's intent to communicate at the time of communication; thus communication can occur across vast distances in time and space (Lester, 2005). Communication requires that the communicating parties share an area of communicative

commonality. The communication process is complete once the receiver understands the sender's message (Lester, 2005).

There are a range of verbal and non-verbal forms of communication. These include body language, eye contact, sign language and haptic communication. Other examples are media content such as pictures, graphics, sound, and writing (Clark, 2013).

Nonverbal communication describes the process of conveying meaning in the form of non-word messages (Ekman, 2003). Some forms of non-verbal communication include haptics, gesture, body language or posture, facial expression and eye contact, object communication, such as clothing, hairstyles, architecture, symbols, infographics, and tone of voice, as well as through an aggregate of the above. Clark (2013) argued that speech also contains nonverbal elements known as paralanguage. This form of communication is the most known for interacting with people. These include voice lesson quality, emotion and speaking style as well as prosodic features such as rhythm, intonation and stress. Research has shown that up to 55% of human communication may occur through non-verbal facial expressions, and a further 38% through paralanguage (Mehrabian, 1971). Likewise, written texts include nonverbal elements such as handwriting style, spatial arrangement of words and the use of emoticons to convey emotional expressions in pictorial form (Krauss, Chen, & Chawla, 2000).

Effective verbal or spoken communication is dependent on a number of factors and cannot be fully isolated from other important interpersonal skills such as non-verbal communication, listening skills and clarification (Butler & Hope, 1996). Spoken communication and pictorial languages can be described as a system of symbols (sometimes known as lexemes) and the grammars (rules) by which the symbols are manipulated. Language learning normally occurs most intensively during human childhood (Barnlund, 2008). Most of the thousands of

human languages use patterns of sound or gesture for symbols which enable communication with others around them (Butler & Hope, 1996). Languages seem to share certain properties although many of these include exceptions.

Oral communication, while primarily referring to spoken verbal communication, can also employ visual aids and non-verbal elements to support the conveyance of meaning (Witzany, 2012). Oral communication includes speeches, presentations, discussions, and aspects of interpersonal communication (Clark, 2013). As a type of face-to-face communication, body language and excellent tone play a significant role, and may have a greater impact upon the listener than informational content. This type of communication also garners immediate feedback, and generally involves the cooperative principle (Tubbs & Moss, 2006).

Effective communication occurs when a desired effect is the result of intentional or unintentional information sharing, which is interpreted between multiple entities and acted on in a desired way (Boise & White, 2004). This effect also ensures that messages are not distorted during the communication process (Winn et al., 2004). Effective communication should generate the desired effect and maintain the effect, with the potential to increase the effect of the message. Therefore, effective communication serves the purpose for which it was planned or designed (Robbins, Judge, & Millett, 2011). Possible purposes might be to elicit change, generate action, create understanding, inform or communicate a certain idea or point of view. When the desired effect is not achieved, factors such as barriers to communication are explored, with the intention of discovering how the communication has been ineffective (Tubbs & Moss, 2006)

## Audiences in healthcare organization

Esman (1972) introduced the concept of audience that plays a vital role in the survival of an organization. Esman (1972) argued that all organizations have enabling audience, functional

audience, normative audience, and diffused audience and each has interests in an organization and its activities.

Hoffman and Ford (2010) defined and explained organizational audiences as follows:

***Enabling audiences*** are made up of people who allow an organization to operate. This group of audience includes individuals who are part of legislative bodies, regulatory groups and stockholders, depending on an organization. Healthcare organizations have a number of enabling audiences. State owned healthcare organizations are accountable to their legislatures, and ultimately, to taxpayers. Private healthcare organizations answer to boards of directors. Healthcare organizations need to consider these groups as they monitor their environments and craft messages.

***Functional audiences*** are made up of individuals or groups that help the organization function on day-to-day basis. They include employees (e.g., doctors, nurses and administrative staff), customers (e.g., patients), and suppliers (e.g., pharmacies and laboratories). A healthcare organization cannot operate without members of this audience group. Functional audiences are often targets for communication in an organization.

***Normative audiences*** on the other hand are composed of individuals in organizations who face similar challenges. This audience includes members of a particular professional industry or are organizational peers. Most healthcare organizations have a number of normative audiences. They may include the administration at other institutions in what is commonly known as mission class (e.g., hospitals and clinics of similar size and healthcare goals). These organizations are audience for healthcare organizational rhetoric because they share similar interests and may learn to handle challenging situations by observing how similar institutions do so. Normative audiences are often secondary.

***Diffused audiences*** are removed further from an organization, yet still have an interest and potential influence. Diffused audiences may include individuals in the surrounding community, in interest groups concerned with human rights or environmental protection, and representatives of the media. For healthcare organizations, diffused audiences certainly include people living in the same community or the geographical area with the organization.

Emphasis is always placed on the functional audience, as the name suggests the activities of this group of audience keep an organization functional and the quality of communication among this audience determines the organization delivery of service (Hoffman & Ford, 2010). Doctor-patient communication, nurse-patient communication and inter-professional communication is very important in healthcare (Schiavo, 2007). Effective communication is a primary clinical skill needed among this audience in the delivery of healthcare, and the final goal is to achieve the best practice outcome and patient satisfaction (Brinkman, Geraghty, & Lanphear, 2007). However, in examining communication in healthcare, the other audiences cannot be totally overlooked (Hoffman & Ford).

## Communication in the healthcare organization

Jennifer, Dip, & Nancy (2010) argued that communication is a vibrant constituent in the delivery of healthcare. Indeed, the ability of healthcare providers and healthcare seekers to communicate effectively is core to the success of the healthcare organizations. Effective communication is needed not only for fruitful interactions between healthcare providers and healthcare seekers but also between healthcare providers themselves (Jennifer, Dip, & Nancy, 2010). Bontrager (2012) argued that intuitively, healthcare organizations wellbeing is connected to the quality of service it provides to patients. Practices such as open communication and the provision of patient-centered care have an influence on both patient welfare and patient

satisfaction (Bontrager, 2012). Healthcare professionals' communication skills start with the ability to collect relevant information regarding their patients' health problems in order to offer quality care (Asnani, 2009).

### *Doctor-patient Communication*

Effective doctor-patient communication is central in building a therapeutic doctor-patient relationship and is very essential in the delivery of quality healthcare (Fong, 2010). Most patient dissatisfaction and patient complaints are due to the breakdown in doctor-patient communication (Schiavo, 2007). Medicine is an art whose magic and creative ability have long been recognized as residing in the interpersonal aspects of patient-physician relationship (Hall, Roter, & Rand, 1981). As earlier stated a healthcare professional's communication and interpersonal skills has to do with his/her ability to gather information in order to carry out correct diagnosis, counsel appropriately, give therapeutic instructions, and establish caring relationships with patients (Fong, 2004). These are the primary clinical skills in the practice of medicine, with the ultimate goal of achieving the best practice outcome and patient satisfaction, are essential for quality healthcare delivery (Brinkman et al., 2007).

Professional and effective communication skills are the basic tools to build and sustain a fruitful therapeutic doctor-patient relationship, and that entails shared perceptions and feelings regarding the nature of a patient problem, goals of treatment, and psychosocial support (Clark, 2003). Respectable interpersonal skills build on these basic tools is the healthcare professional's road map to a successful practice (Duffy et al., 2004). Appropriate healthcare communication integrates both patient and doctor-centered approaches (Brédart, Bouleuc, & Dolbeault, 2005), however, emphases are placed on patient-centered practice because it is associated with

improving patients' health status and increased efficiency of care (Stewart, Brown, & Donner, 2000).

The ultimate objective of any doctor-patient communication is to improve the patient's health and medical care (Duffy et al., 2004). Stewart (1995) argued that studies on doctor-patient communication have demonstrated patient dissatisfaction even when most doctors considered the communication adequate or even excellent and that doctors tend to overestimate their abilities in communication. Tongue & colleagues (2005) reported that 75% of the orthopedic surgeons surveyed believed that they communicated satisfactorily with their patients, but only 21% of the patients reported satisfactory communication with their doctors. Studies on patient have consistently shown that they want better communication with their healthcare providers (Clark, 2003). This is why patient-centered communication is proving to be paramount to successful doctor-patient relations (Stewart et al., 2000).

The principles of patient-centered medicine date back to the ancient Greek school of Cos (Stewart et al., 2000). Until quite recently, patient-centered medicine has not been a common practice (Lee, Block, & Stewart, 2002). For example, a few decades back, doctors were practicing paternal medicine; one of the reasons was that most doctors considered it inhumane and detrimental to patients to communicate bad news because of the unwelcoming treatment prospect for some diseases (Lee et al., 2002). The medical model has more recently progressed from paternalism to individualism. Information exchange is the overriding communication model, and the health consumer movement has led to the current model of shared decision making and patient-centered communication (Henrdon & Pollick, 2002).

Arora (2003) reinforced the point raised earlier that effective doctor-patient communication is a central clinical function and an essential component in the delivery of

healthcare. The main goals of current doctor-patient communication are creating a good interpersonal relationship, facilitating exchange of information, and including patients in decision making (Bredart et al., 2005). Effective doctor-patient communication is determined by the doctors' communication skills, which patients judge as a key indicator of their doctors' general competence (Clark, 2003).

Good doctor-patient communication has the potential to help regulate patients' emotions, enable understanding of medical information, and allow for better identification of patients' needs (Arora, 2003). Patients reporting good communication with their doctor are more likely to be satisfied with their care, and especially to communicate relevant information for correct diagnosis of their problems, adhere to advice, as well as to follow the prescribed treatment (Wanzer, Booth-Butterfield, & Gruber, 2004). Patients' agreement with the doctor about the nature of the treatment and need for follow-up is strongly associated with their recuperation (Stewart et al., 2000).

Henrdon and Pollick (2002) argued that studies have shown connections between a sense of control and the ability to bear pain, recuperation from illness and daily functioning. Some studies have revealed a decline in the length of hospital stay and therefore the cost of individual medical visits and fewer referrals (Wanzer et al., 2004). A more patient-centered encounter results in better patient as well as doctor satisfaction (Brinkman et al., 2007). Satisfied patients are less likely to make formal complaints. Satisfied patients are also advantageous for doctors in terms of greater job satisfaction and less work-related stress (Bredart et al., 2005).

Healthcare professionals' communication skills include both style and content (Chiò, Montuschi, & Cammarosano, 2008). Attentive listening skills, empathy, and use of open-ended questions are some examples of skillful communication because they involve the patient and

allow him/her to express him/herself (Fong, 2010). Improved doctor-patient communication tends to increase patient involvement and adherence to recommended treatment; influence patient satisfaction, healthcare utilization and improve quality of healthcare outcomes (Diette & Rand, 2007).

Communicating bad news to patients is a difficult communication task for healthcare professionals in the practice of medicine (Baile, Buckman, & Lenzi, 2000). Relationship building is essential in communicating bad news to patients (Platt & Keating, 2007). Understanding patients' perspectives, sharing information, and patients' knowledge and expectations are crucial to the development of a positive therapeutic alliance between a doctor and his/her patient (Parker, Clayton, & Hancock, 2007). In contrast, miscommunication has severe repercussions, as it may impede patients' understanding, expectations of treatment, or participation in the treatment design (Baile et al., 2007). In addition, miscommunication may reduce patient satisfaction with medical care and level of confidence (Clark, 2003). Baile and colleagues (2007) reported that patients often regard their doctors as one of their most important sources of psychological support. Empathy is one of the most powerful ways of providing this support to reduce patients' feelings of isolation and validating their feelings or thoughts as normal (Wanzer et al., 2004).

Fong (2010) argued that doctors are not born with excellent communication skills, as they have different innate talents. Instead doctors can understand the theory of good doctor-patient communication as taught in medical school, learn and practice these skills, and be capable of modifying their communication style if there is sufficient motivation for self-awareness and training (Roter, Hall, & Aoki, 2002). Communication skills training have been found to improve doctor-patient communication (Harms, Young, & Amsler, 2004). However, the improved

behaviors may lapse over time (Brown, Boles, & Mullooly, 1999). It is therefore important to practice new skills, with regular feedback on the acquired behavior (Brown et al., 1999) Some have said that medical education should go beyond skills training to encourage physicians' responsiveness to the patients' unique experience (Stewart et al., 2000).

Fong (2010) encourages the call for collaborative communication. Collaborative communication is a mutual and dynamic relationship, involving the two-way exchange of information (Feudtner, 2007). In an ideal world, doctors should collaborate with their patients to provide the best care because doctors tend to make decisions based on quick assessments, which may be biased (Feudtner, 2007). This requires doctors to take time or set up opportunities to offer and discuss treatment choices to patients and share the responsibilities with them (Lee et al., 2002). Successful information exchange ensures that concerns are elicited and explored and that explanations of treatment options are balanced and understood to allow for shared decision making (Minhas, 2007). In this approach, the discussion is facilitated by the doctor, and in the process the doctor negotiates with patients and evaluates treatment options that are available and then tailors the care to fit the patients' situation and desires, rather than the standardized paternalism mode (Arora, 2003). Options for healthcare need to be collaborative work between doctors and patients, making sure that patient' anticipations, outcome preferences, level of risk acceptance and measures to assure the best outcome is taken into consideration (DiMatteo, 1998).

Conflict Management is another issue of which good doctor-patient communication can take care (Fong, 2010). Feudtner (2007) stated that there are situations in pediatric palliative healthcare where the cause of conflicts is usually not articulated. Fong (2010) explained that the root causes of such conflicts are not discussed and most of the time unclear or not notice by

either the doctor or the patient or some cases both partiers which generated feelings of dissonance. Conflict situations between doctors and patients are very challenging and arouse unpleasant condition in most case, such as the feelings of helplessness, frustration, confusion, anger or uncertainty (Lee et al., 2002). Doctors are supposed to be aware of such feelings and develop skills to identify conflict situations in the process of delivering healthcare, so that they can de-escalate such situations should they arise, and if well handled, conflict situations can be turned into clinical success for both doctors and patients (Lee et al., 2002).

In addition to avoiding unpleasant condition, which prevents patients from expressing their opinions, effective doctor-patient communication should be a patient-centered communication, in that case there will be mutual understanding of both parties' viewpoints, and shift away from the viewpoint that is fairly convinced to be the doctors' belief to a more fact-finding approach that strives to understand the situation from both the doctor and the patient viewpoint (Feudtner, 2007). The reorganization of the effect of patient sharing of information through communication and the effect it has on their medical visit is very essential, it may assist in creating a positive conversation to resolve the negative situations that is possible to arise (Roter et al., 2002).

Personal beliefs and values affect doctor-patient relationship and communication (Tongueet al., 2005). Beliefs and values held by individuals (both healthcare professionals and healthcare seekers) can affect healthcare delivery over competing therapies among doctors and anxiety of healthcare organizations or mistrust of prescribed therapies on the side of patients (Diette & Rand, 2007). Perceptions arising from individual beliefs and values have the potential to negatively influence treatment decisions and consequently may affect patient healthcare outcomes even if the suitable therapy is adapted (Platt & Keating, 2007). Doctors may be using

biomedical model in understanding illness, patients' beliefs and values are subjective to social and behavioral factors as well as biology or body composition (Platt & Keating, 2007).

In doctor- patient communication, it is essential for both parties to identify and discuss openly any potential barriers perceived by the patient, as well as the benefits of treatment. This may in turn improve patient compliance to medical plans by making sure that the benefits and importance of treatment are very well understood (Clark, 2003). It is the doctors' call to understand the patients' functional meaning of disease, as well as the relationship and symbolic meaning, followed by a summary of this information and making sure that the patient is very well informed of the problem from the doctor's standpoint, finally, the doctor may ask the patient to explain what was communicated to him/her (Asnani, 2009). Proper understanding between doctors and patients is a key factor that influences successful healthcare outcome (Platt & Keating, 2007).

Patients with their own personal world view and social norms will usually create their version of compliance to healthcare, which most times result in different expectation of compliance in the process of delivering healthcare, for example, if a doctor assumes, and not communicate very well the importance of completing a medication, a patient may stop taking that medication if her/she feels better halfway that medication (Sawyer & Aroni, 2003). There is no doubt that effective doctor-patient communication is the oil that lubricates doctor-patient relationships, and presents an opportunity for doctors to gain insight into patients' beliefs and expectations in healthcare (Tongue et al., 2005). Patient-centered communication allows for opinions from a both parties perspective, as a result it creates attention for correct diagnosis and the subsequent treatment on a particular condition, (Feudtner, 2007). In this alliance model, an

effective doctor acknowledges is created, hence the doctor respects the patients' rights to make decisions (Sawyer & Aroni, 2003).

### *Nurse-patient communication*

McCabe (2004) argued that on the whole, communication is a complex process, and now more than ever is requisite to successful nurse-patient relationships, patient satisfaction, and positive clinical outcomes. Understanding the complexity of communication is critical to recognizing diverse influences that promote and impede healthy nurse-patient interactions (McCabe, 2004). Communication is often seen as a natural process, but complex biological processes mediated by psychosocial and cultural influences within a changing society and healthcare organization place inordinate pressure and challenges on today's nurse-patient communication (Attree, 2001).

The communication process becomes more significant during distressful situations because they often require health education, appreciation of diversity, partnerships with the patient and family, and accurate explanations of procedures and their psychological and physical ramifications (DiMeglio, Lucas, & Padula, 2005). The nurse must also take into account educational level, language, and literacy when communicating with patients and families from diverse cultural and ethnic backgrounds (Munet-Vilaró, 2004).

Online communication has the capacity to increase access to healthcare, promote patients involvement in their own care, improve outcomes, and reduce healthcare costs. Online interactive health communication involves the patients or healthcare professionals using electronic technologies to access or transmit health information or receives guidance on a health-related issue, for instance, telemedicine (Eng, 2001). Although this approach seems like a logical extension of the nurse-p relationship, it raises legal and ethical concerns. Some researchers assert

that electronic client-clinician communication may disrupt the balances in that relationship and create wider gaps in clinical status outcomes for different segments of the population and impede access to healthcare (Mandl, Kohane, & Brandt, 1998; Hamvas, Wise, & Yang, 1996). Despite these concerns, most research indicates that email and other electronic technologies can enhance nurse-patient relationships if implementation strategies are planned ahead of time to ensure secure channels for health communication sites and maintain confidentiality and patient privacy (Spielberg, 1999).

Nurse-patient transactions involving email may be more effective and practical when a quality relationship already exists. Prior to establishing email or other Internet nurse-patient transactions, certain parameters must be established to negotiate boundaries, ensure privacy and informed consent, specify the limitations of the relationship, response times, and subject matter and determine message or information storage and management methods (Eysenbach & Diepgen, 1999; Spielberg, 1999). Another benefit of email is that it is a very efficient method of communication, particularly when the nurse uses it to provide test results, give information about the next appointment, imparts healthcare education, follow up on data obtained from home monitoring devices, or consult with patients or refer them to specialty clinics.

Knowing the significance of nurse-patient holistic care across the health continuum, efforts to understand patients experiences, improve communication, and foster trust among diverse cultures and ethnicities must be a priority (McCabe, 2004). Openness, nonjudgmental, and honest communication offers the nurse a way in which to interact with diverse cultures to identify and evaluate their needs and preferences (Mandl et al, 1998). Nurse-patient encounters provide forums to understand the meaning of patient's experiences, concerns, preferences, and healthcare practices through cross-cultural communication (McCabe, 2004). Compelling

evidence demonstrates that positive clinical outcomes, patient satisfaction, and adherence to treatment may be a result of cross-cultural communication in which the patient's needs, preferences, and wishes are respected and integrated into treatment (Cooper-Patrick et al., 1999; Institute of Medicine [IOM], 2001; Laine & Davidoff, 1996; Stewart et al., 1999). Unresolved language barriers result in poor access to preventive services, higher rates of chronic disease, poor disease management, and negative clinical outcomes (Lieu et al., 2002; Povlsen, Olsen, & Ladelund, 2005).

Patient-centered communication is a basic component of nursing and facilitates the development of a positive nurse-patient relationship which, along with other organizational factors, results in the delivery of quality nursing care. According to Arnold & Boggs (1995) and Balzer-Riley (1996), communication is a reciprocal process of sending and receiving messages using a mixture of verbal and nonverbal communication skills. However, Sheppard (1993) suggests that, in the nurse–patient relationship, communication involves more than the transmission of information; it also involves transmitting feelings, recognizing these feelings and letting the patient know that their feelings have been recognized. Attree (2001) and Thorsteinsson (2002) support this view and indicate that communication is a fundamental part of nursing and that the development of a positive nurse–patient relationship is essential for the delivery of quality nursing care.

The quality of communication in the nursing setting depends on several factors as studies show. From the patient’s view, the following behavior of nurses is accountable for a rather negative communication experience with nurses: stereotyping, rule enforcement, lack of intimacy, lack of friendliness and caring (Cleary and Edwards 1999). From the nurses’ view, the quality of communication is influenced by the attention a nurse pays to the details of sending a

message (Usher and Monkley 2001). A shared perspective of patients and nurses is the claim to truth and claim to truthfulness in communication (Sumner 2001).

### *Inter-professional communication*

The healthcare team is a resourceful concept, often defined as a group of people coming together and pooling their resources for the benefit of the patient (Reeves, Russell, & Zwarenstein, 2007). One immediately gets the impression of an interacting network of healthcare professionals, each sharing the belief that no one person can provide totally for any patient's complex physical and mental needs (Kohn, Corrigan, & Donaldson, 1999). A team effort with a variety of professional expertise and of personalities complements one another's observations and cancelling out one another's blind spots and misconceptions. Within this team framework there is no room for para or sub professionals — each person has a special knowledge and skill and should be treated as a peer (Schiavo, 2007). Hence, the idea of a healthcare team promises optimum healthcare for the patient together with prime working conditions for healthcare professionals.

Inter-professional communication occurs when healthcare professionals communicate with each other; this type of communication builds trust amongst them (Berry, 2007). As Schiavo (2007) emphasized, that in professional communication, the concept of peer describes professional with similar education, training, and overall capacity. Inter-professional communication can help healthcare professionals meet their challenges with peer-to-peer information and tools that contribute to the effectiveness of their medical practices and, ultimately, better healthcare outcome for their patients (Schiavo, 2007).

Healthcare professionals all agree on the importance of effective communication among the members of a healthcare team (Varpio, Hall, & Lingard, 2008). To support effective and

timely collaboration within and across teams, healthcare professionals should use good communication skills and be aware of scopes of practice, roles and responsibilities, and applicable policies and procedures (Reeves et al., 2007). Common goals, shared mental models and appropriate accountability also help healthcare teams to communicate effectively and build trust (Lingard, Espin, & Evans, 2004).

Operating rooms have long histories of healthcare professionals' hierarchies and limited communication, but this is changing (Varpio et al., 2008). Surgical safety checklists and other initiatives are now used to expand teamwork and communication, and to improve culture. Physicians are reminded to use checklists and structured tools to give a voice to all members of the surgical team and to ultimately contribute to the culture of patient safety (Varpio et al., 2008).

Establishing and maintaining effective communication between physicians and pharmacists is essential since both parties have responsibility to work together with the patient to optimize drug therapy (Varpio et al., 2008). Physicians may consider establishing a system where pharmacists with whom they have established a collaborative relationship prioritize communication when prescriptions are changed, renewed or initiated without first consulting the physician (Manojlovich & Decicco, 2007). This may include specifying that any communication in this regard be in writing and sent within a defined period of time. It is also prudent to clarify in advance the expectations regarding follow up healthcare, and who will typically be responsible for conveying healthcare and information to the patient (Lingard, 2007). Physicians should also consider documenting discussion with the pharmacist and/or the patient regarding treatment decisions in the medical record.

Nurses and other healthcare professionals are trained to document their observations and their efforts to communicate with physicians, including noting when they have called a physician (Lingard, 2007). It is the duty of physicians to review the notes of nurses and other healthcare professionals. Healthcare team communications regularly involve the participation of different professionals at different times. Many researchers have investigated how inter-professional communication is linked both directly and indirectly to issues of patient safety and medical error (Varpio et al., 2008).

### *Verbal and nonverbal communication*

Communication during medical interviews plays a large role in patient adherence, satisfaction with care, and health outcomes (Ngo-Metzger, Telfair, & Sorkin, 2006). Both verbal and non-verbal communication skills are central to the development of rapport and trust between patients and healthcare professionals (Hall, Harrigan, & Rosenthal, 1995). In addition, it is suggests that there may be a positive association between physician cultural sensitivity and patient perceptions of quality of healthcare (Collins, Hughes, & Doty, 2002)

A few previous studies have documented the central role of non-verbal communication skills in the medical encounter (Gordon, Street, & Scharf, 2006). Non-verbal communication allows doctors and patients a way to gauge responses, to contextualize the meaning of verbal utterances, and to communicate a hidden agenda (Ishikawa, Hashimoto, & Kinoshita, 2006). Non-verbal behaviors, such as body lean, head movements, and eye contact, have been shown to convey interest, intimacy, and balance of power (Griffith, Wilson, & Langer, 2003). A few studies have shown that non-verbal communication predicts patient satisfaction (Griffith et al., 2003; Ambady et al., 2002). However, clarifying the impact of non-verbal communication on patient outcomes has been a challenge. Ishikawa and colleagues (2006) argued that studies on

non-verbal communication often rely on a global assessment or impression of non-verbal communication and few studies have assessed non-verbal communication based on a measure of specific behaviors. In addition, few studies have correlated non-verbal communication with verbal checklists or placed non-verbal communication within the context of the doctor–patient relationship (Krauss, Chen, & Chawla, 2000). More recently, it has become clear that the role of non-verbal communication must be examined in evaluation of verbal communication skills and interview quality (Ishikawa et al., 2006).

Both verbal and non-verbal communication skills are central to the development of rapport between patients and healthcare professionals. Researchers have long focused on the verbal components of the medical interview and in doing so, neglected non-verbal communication between doctors and patients (Clark, 2003; Wanzer et al., 2004). Emotional behavior however, cannot always be verbally perceived (Collins et al., 2002). Although touch can be used to communicate friendliness, warmth, and appreciation in all types of service encounters, the manner in which touch affects customer evaluations can best be illustrated with healthcare services (Roter, Frankel, & Hall, 2006).

A typical healthcare service involves multiple encounters, including contact with a receptionist, nurse, physician, and possibly a pharmacist. The physician-patient encounter, where touch is highly relevant, involves well defined activities, including gathering information, giving a medical examination, and providing recommendations for treatment (Gordon et al., 2006). The medical examination stage involves task touch, meaning that the physician touches the patient as a part of the medical examination. Because task touch is a required part of the interaction, it will not necessarily be associated with warmth and friendliness. However, if the physician engages in voluntary touch (e.g. pat on the back, holding arm while verbally comforting the patient) while

making treatment recommendations, the touch will be perceived as an indication of warmth, empathy, and friendliness (Roter et al., 2006).

## Rhetorical Situations in healthcare Organizations

Situation or context has long been a key component of the study of communication (Hoffman & Ford, 2010). Just as context is important in understanding communication in everyday life, it is also important in understanding how rhetoric works in healthcare organizations (Tubbs & Moss, 2006).

Probably the best-known perspective on context and rhetoric is that of Bitzer (1968), who coined the term rhetorical situation.

Bitzer first introduced the concept of the rhetorical situation in 1968, and his work has been instrumental in how rhetorical critics analyze and understand the circumstances in which rhetoric is created and received. Vatz in 1973 suggested a new way of understanding rhetorical situations. Each of these viewpoints, although are different philosophically, they offer important insights for the creation of organizational rhetoric. First, we would review Bitzer's take on rhetorical situation, and then explore Vatz's.

Bitzer's primary argument was that situations employ the use of rhetoric. In other words, situations exist in the physical and social world, and rhetoric is required to address them. He also argued that a situation determines what a suitable and effective response will be. It is the responsibility of the person creating the rhetoric to determine what kind of response will be able to resolve the situation.

In order to understand Bitzer's (1968) viewpoint, it would be helpful to look at how he defined a rhetorical situation. He defined rhetorical situation as "a complex of persons, events, objects and relations presenting an actual or potential exigency, which can be completely or

partially removed if discourse, introduced into the situation, can so constrain human decision or action as to bring about the significant modification of the exigency" (p. 6). This definition is easier to understand if explored one idea at a time.

Bitzer (1968) began by stating that situations are composed of "persons, events, objects and relations" (p. 6). All of these things combine to create what he calls an exigency, or "an imperfection marked by urgency" (p. 6). This part of the definition is perhaps easiest to understand when illustrated with an example. When a doctor or a nurse carries out an operation and makes a mistake, the situation leaves the patient at risk. This example is clearly an imperfect situation marked by a sense of urgency because of the risk to which the patient is exposed. People (e.g., both the patient and healthcare professionals), events (e.g., the operation, and recovery efforts), objects (e.g., buildings, equipment, and medication), and relations (e.g., family, friends and sympathizers) when put together, as illustrated in the example, will likely create a situation that requires rhetoric in order to resolve it. In short, the mistake or situation created an exigency.

Bitzer (1968) also argued that in order for a situation to be considered rhetorical, rhetoric must be able to solve or at least attempt to solve the problem present in the situation. In other words, a situation is not rhetorical if communication cannot somehow solve the situation. From Bitzer (1968) viewpoint, if rhetoric cannot make a difference in the situation, the situation should not be considered rhetorical.

Although he explicitly used the term exigency in the above definition, Bitzer (1968) only implied the other two constituents that he argued make up any rhetorical situation—audience and constraints. Bitzer (1968) was very specific about the meaning of the term audience in a rhetorical situation. Because the purpose of rhetoric in a situation is to create change in the

exigency, the audience has to be capable of responding to the rhetoric in a way that can create that change.

The final constituent addressed by Bitzer (1968) was constraints. He explained that they are "made up of persons, events, objects, and relations which are part of the situation because they have the power to constrain decision and action needed to modify the exigency" (p. 8). Constraints are things that might get in the way of the rhetoric overcoming the exigency. Bitzer (1968) indicated that constraints may include "beliefs, attitudes, documents, facts, traditions, images, interests, and motives" (p. 8). For healthcare organizations, constraints might include patients' past experiences with a healthcare professional or organization, prior rhetoric issued by a healthcare professional or organization, or previous media coverage of a healthcare professional or organization.

Bitzer's (1968) viewpoint on rhetorical situations has important implications for organizational rhetoric. It suggests that organizations operate in an environment that presents them with an ongoing parade of situations marked by an opportunity to address an imperfection. If they wish to be successful, organizational communicators (e.g., doctors, nurses and other healthcare professionals) must monitor the situation around them in order to recognize situations that invite a response. They also need to be aware of who their rhetorical audiences are, and what beliefs, attitudes, and previous knowledge and experiences those audience members bring to the discourse.

Vatz (1973) tested Bitzer's (1968) basic assumption that situations employ the use of rhetoric, and argued that rhetoric gives meaning to situations. Vatz (1973) argued that, "No situation can have a nature independent of the perception of its interpreter or independent of the rhetoric with which he chooses to characterize it" (p. 145). In other words, events have no

objective meanings in themselves for Vatz. Rather, they come to have meaning only when they are filtered through the perceptions of a communicator and the rhetoric that the communicator uses to share his/her perceptions. For Vatz (1973), meaning is not located in the events that make up what Bitzer (1968) calls a situation; instead, meaning is created through how rhetoric selects and names events as situations.

Vatz (1973) viewed this creation of meaning as a two-step process made up of selection and naming. In the first step, a communicator chooses which elements to emphasize from all of the possible choices that are perceived by the communicator. Rather than viewing events as discrete objects, Vatz (1973) argued that communicators are faced with a stream of ongoing elements that can be punctuated in a variety of ways. Communicators select elements out of that stream to label as events. By selecting particular elements, communicators call attention to some elements in the stream while distracting, or at least omitting attention to others.

The second step in this meaning-making process is to name the elements that have been selected. Vatz (1973) viewed this as a creative process. From this viewpoint, there is no single possible meaning for a series of events; rather, the communicator selects a meaning and then shares that meaning with an audience. Vatz (1973) argued that, "To the audience, events become meaningful only through their linguistic depiction" (p. 157).

From Vatz (1973) viewpoint, healthcare organizations may have slightly more rhetorical power than they do from Bitzer (1968) viewpoint. If, as Vatz (1973) suggested, the environment is a stream of facts or events that are not given meaning until they are communicated; healthcare organizations can influence which facts are emphasized and what those facts mean for their audiences. Healthcare organizations can define events in their environments. A very simple example of this can be found in the terms used to describe some organizational actions. In the

current economy, employees are no longer "fired" or even "laid off;" they are "downsized." Some organizations use the term rightsizing, which strives for an even less negative connotation.

Vatz (1973) viewpoint offers a more proactive approach to considering how events and communications interact. If communicators select and name events in order to create meaning, it becomes critical that healthcare organizations (e.g., hospitals and clinics) carefully monitor their environments in order to be able to identify those elements that should be selected and labeled in particular ways to create effective and ethical organizational rhetoric (e.g., how a doctor should apologize or break a bad news to a patient). By acting early, healthcare organizations can shape perceptions of upcoming events.

### *The phenomenon of language in healthcare*

Although communication extends beyond spoken words or speech, language is an integral part of this process (Desilet, 1999). Speech is the motor act of communicating through articulation and verbal expression, whereas language is the primary venue of communicating ideas and thoughts (Richards & Rodgers, 2001). It links nations, societies, cultures, communities, individuals, and history and is the foundation of human intelligence (Partida, 2007). Language involves both production and comprehension (Mohan & Beckett, 2003). It is governed by cerebral hemispheric dominance, which is associated with handedness, a trait that seems to be genetically determined (Klee, Carson, & Gavin, 1998). Right-handed individuals show an overwhelming bias towards left-hemispheric speech lateralization (Flagg, Cardy, & Roberts, 2005).

Language is more than just a means of communication. It influences our thought processes. Theorist Burke (1966) argued that language reflects, selects, and deflects reality. If healthcare organizations are systems of consciously coordinated activities, communication is

essential if all of the interdependent parts and practices of any group are going to work together (Heath& Bryant, 2000).

Events and conversations that occur prior to an instant of communication have an impact on what is said, how it is said, and the meaning that is assigned to it (Hoffman & Ford, 2010). For example, there are at least three options in addressing others in a business encounter: simple first name, in many North American meetings; title plus first name, for instance in Brazil; and title plus last name, as in Asian cultures (Pan, Scollon, and Scollon, 2002). Language is both a medium of communication and a framework for understanding human experience (Lustig & Koester, 1996). In general, organizational communication is improved through the consistent use of plain and unambiguous language. The late twentieth century saw an increased interest in the way that language influenced healthcare organizations (Blundel et al., 2013).

### *Organizational Exigencies in Healthcare organizations*

Exigency is described as an imperfection marked by urgency; the term imperfection may tempt communicators to think of rhetorical situations as only negative (Cheney, 1991). The phrase "opportunity marked by urgency" better incorporates the range of reasons why healthcare organizations may create rhetoric (Boyd, 2004). Certainly healthcare organizations do respond to problems through the use of rhetoric—explaining diagnosis, treatment, operation and health risk to patients. Furthermore, accidents and disasters happen, and employees (e.g., doctors, nurses or other healthcare professionals) sometimes need to be laid off. Healthcare organizations also use rhetoric to address positive situations— finding cure for patients, operational success or medical research finding (Boyd, 2004).

All exigencies facing organizations can be described as somewhere between fully anticipated and fully unanticipated (Czarniawska-Joerges, 1995). For example, healthcare

organizations may have some advanced information about whether some ailments are curable or not. In addition, they may be able to anticipate the retirement of a key executive medical office. Other types of exigencies cannot be anticipated ahead of time. For example, a healthcare organization usually cannot anticipate that a doctor will make a mistake during an operation (Crable, 1990).

All exigencies facing healthcare organizations can also be described as having the potential to enhance or threaten perceptions of the organization (Harrison, 1995). For example, if a healthcare organization is releasing an innovative new drug or treatment which has the potential to save lives or make significant contributions to community programs; the organizations' communication professionals (e.g., doctors or other healthcare professionals) have an opportunity to produce messages that will help enhance positive patients or public perceptions of the organization. On the other side are events that have the potential to cause audiences to have negative thoughts or feelings, or to exhibit negative behaviors toward the organization (Heath, 1990). For example, if healthcare professionals mistakenly caused the death of a patient, audiences may begin to view it negatively.

## Constraints and Assets in Healthcare Rhetoric

According to Bitzer (1968), "Every rhetorical situation contains a set of constraints made up of persons, events, objects, and relations which are part of the situation because they have the power to constrain decision and action needed to modify the exigency" (p. 8). He included "beliefs, attitudes, documents, facts, traditions, images, interests and motives" in his description of constraints (p. 8). He also suggested that not only do these potential limitations exist in the situation, but the communicator can also add constraints in the construction and delivery of response. Much like his use of the term imperfection, Bitzer's use of the term constraints

suggests that a communicator only have challenges and have nothing working in his/her favor. It is important to also recognize that beliefs, attitudes, documents, facts, traditions, images, interests and motives also make the communicator's job easier in some situations (Johnson & Sellnow, 1995). Rowland (2008) used the term advantages to describe factors that might work in a communicator's favor.

In simple terms, a constraint is anything that may have an impact on the likelihood that a communicator's message will be able to address the situation in the desired way (Jordan, 2003). Rowland (2008) introduced the concept of rhetorical barriers that helps clarify the idea of constraints and adds specificity to the types of barriers that may occur in rhetorical situations. Rowland (2008) defined a rhetorical barrier as "an attitude, belief or other problem that a communicator must overcome in order to persuade an audience to accept a given position" (p. 42). He argued that a barrier may be related to the audience, the situation, the occasion, or the reputation of the communicator.

Several scholars have written about rhetorical constraints (Bitzer 1968; Rowland, 2008), so it is important to recognize how these concepts might play out in rhetorical situations in healthcare organizations. There are a number of constraints that are likely to recur in healthcare organizations because of their nature as public entities (Lair, 2003). All healthcare organizations need to be aware of potential limitations that fall under the categories of reputation and legal issues (Legge, 1995). Both of these types of constraints are influenced by past occurrences and rhetoric. Statements such as 'I am so sorry' or other apologies made by a physician to his/her patient following a complication or unexpected outcome can be taken as an admission of negligence or a sign of professionalism, depending on how it is communicated (Woods, 2004).

## Motivation in healthcare organization

Leaders of healthcare organizations are increasingly interested in ways to attract, retain, and gain commitment from their employees (Morrison, George, & Green, 2007). It is rare to have a discussion with healthcare leaders or corporate executives, for that matter, without the topic of employee commitment becoming part of the conversation (O'Malley, 2000). The motivation for continued productivity and high morale must come from a sense of meaning and purpose from organizations (Morrison et al., 2007). O'Malley (2000) argued that leaders must examine their sources of fundamental motivation, provide a culture that encourages this level of exploration for all employees, and develop methods that assess and sustain this approach. Healthcare organizations that practice any component of this approach must be committed to increasing commitment in engagement through an improvement in the inner lives of employees (Morrison et al., 2007).

A technical definition for motivation given by some social scientists suggests that motivation is the psychological process that causes the arousal, direction, and persistence of voluntary actions that are goal directed (Mitchell, 1982). The two factors of greatest importance have been the arousal (activating energizers) and direction (choice) of behavior (O'Malley, 2000). The question of persistence has been of minor importance, partly because the issue of maintenance of behavior has received less attention and partly because persistence simply is seen as the reaffirmation of the initial choice or factor (Fox, 1994).

Fox (1994) stated that the arousal question has focused on what gets people motivated. What are the circumstances that arouse healthcare professionals to want to do well? The question of choice deals with the pressure on the individual to engage in desired behaviors (Coombs, 2002). Given that the person is aroused, what gets them going in a particular direction?

Motivation has traditionally been assumed to be an individual phenomenon (Morrison, 2007). Each individual is unique; that is, different people have different needs, expectations, values attitudes, reinforcement histories, and goals (Fox, 1994).

Motivation is also usually described as intentional because healthcare professionals have control over motivation (Coombs, 2002). Most behaviors that are influenced by motivation are viewed as voluntary actions chosen by the individual. Initially, it must be recognized that the purpose of motivational theories is to predict behavior (O'Malley, 2004). The behavior is the criterion; the motivation is merely implied. Motivation becomes the degree to which an individual wants and chooses to engage in certain specified behaviors (George, 2014).

### *Motivation and the role of rhetoric in healthcare*

What makes an employee so willing to uphold the values of an organization, even when his supervisors are thousands of miles away? Experiences have led to asking questions about the role of rhetoric in influencing the thoughts, feelings, and behaviors of employees, volunteers, and others we might think of as being inside the healthcare organization (Legge, 1995). Hoffman and Ford (2010) argued that organizations create rhetoric aimed at functional audiences. When healthcare organizations produce orientation and training materials or in-house newsletters, or when they display an employee-of-the-month plaque or sponsor a picnic, they are creating organizational rhetoric. Each of these symbolic creation attempts to influence how members (or potential members) think, feel, and behave toward the organization (Sproule, 1990).

George (2014) pointed out that motivation is critical to maintaining productivity. He argues that there are several factors that influence motivation, including pay, career opportunities and positive relationships with colleagues. Nevertheless, hospitals and clinics owners and managers also need to understand the role of communication in employee motivation, as it can

sometimes be the most basic communication errors that lead to employee dissatisfaction. Facilitating effective communication can help improve employee motivation in several ways (Harrison, 1995).

The concept of organizational socialization provides a helpful framework for understanding the role of rhetoric in meeting the goals outlined above. Organizational socialization is the process an individual experiences in becoming part of an organization (Bullis, 1993). The process is generally described as taking place in three stages. Although the stages are labeled in a variety of ways, we will refer to them as anticipatory socialization, organizational entry, and metamorphosis (Jablin, 2001). Organizational communication scholars have been particularly interested in the communication processes that happen as new members gather information, accept and test new roles, and learn the culture of organizations (May & Mumby, 2005). Although socialization is an individual and largely interpersonal experience, rhetoric created by healthcare organizations also plays a key role in influencing members' thoughts, feelings, and behaviors at each step in the process (Desilet, 1999).

All healthcare organizations, whether large or small, face similar challenges, or exigencies, in dealing with functional audiences (e.g., doctors, nurses and administrators). They need to recruit, retain, and motivate individuals to do the work of the organization. They also need to encourage organizational members to change when needed, and to represent the organization to external audiences in a variety of rhetorical situations (Hoffman & Medlock-Klyukovski, 2004).

Once a communicator has persuaded individuals to associate with an organization, the next step is to introduce newcomers to the organization and to persuade them to begin making decisions with the interests of the organization in mind (Lair, 2003). Legge (1995) argued that

almost any new job begins with at least a few hours, and even up to a week, of orientation. Employee orientation serves both a task function and a rhetorical function. The task function simply means that newcomers need to learn how to do the job, whether that involves learning to operate new equipment or becoming acquainted with procedures. The rhetorical function is a bit more challenging. The rhetorical function in the entry phase is to persuade newcomers to behave like other members of the organization (Legge, 1995).

Newcomers need to adopt the decision premises of the organization and begin thinking, feeling, and behaving in ways that uphold the organization's best interests (Harrison, 1995). After studying the orientation program at a company producing healthcare equipment, Pribble (1990) argued that "During socialization, differences between personal values and ethics of newcomers and those of an organization are most salient, as would be rhetorical efforts to convince newcomers to embrace the organization's ethical stance" (p. 255).

Hoffman and Ford (2010) stated that the final stage in the socialization process is often referred to as metamorphosis and is accomplished when the newcomer is accepted as, and feels like, an insider. At this point, it may seem that all of the organizational rhetoric in the anticipatory and entry phases has done its job. In reality, though, rhetoric remains of central importance long after a newcomer has been socialized into the organization and identifies with it (Lair, 2003).

Healthcare organizations cannot simply create identification and assume their rhetorical work is finished. Identification is an ongoing process. The level of connection an individual may feel with an organization can increase and decrease over time. Competing demands for identification, a change in values of the individual, or a change in the perceived values of the organization can all strain organizational identification (Hoffman & Medlock-Klyukovski,

2004). These sorts of changes require healthcare organizations to demonstrate that they are worthy of employee loyalty. The audience for this type of rhetoric is current organizational members, and the constraints may include cynicism; changes in beliefs, attitudes, or values; and threats to organizational reputation (Rowland, 2008).

After building and reinforcing organizational decision premises through identification, organizational leaders often find themselves in the challenging position of asking employees to participate in a change that may alter or threaten some points of identification (Hoffman & Ford, 2010).

### *Motivation as therapy*

Healthcare professionals motivate patients to change their lifestyles and improve their health (Schwartz, Lowe, & Sinclair, 2010). Much of healthcare today involves helping patients manage conditions whose outcomes can be greatly influenced by lifestyle or behavior change (Mitchell, 1982). A number of theories of health-behavior change provide important perspectives on the factors that promote behavior change and maintenance, including Social Learning Theory, which posits that learning is a cognitive process that takes place in a social context and can occur purely through observation or direct instruction, even in the absence of motor reproduction or direct reinforcement (Bandura, 1986), The Health Belief Model, which is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals (Janz & Becker, 1984), The Theory of Reasoned Action is also a model for the prediction of behavioral intention, spanning predictions of attitude and predictions of behavior. The subsequent separation of behavioral intention from behavior allows for explanation of limiting factors on attitudinal influence (Ajzen & Fishbein, 1980), and The Transtheoretical Model, which is an integrative, biopsychosocial model to conceptualize the

process of intentional behavior change. Whereas other models of behavior change focus exclusively on certain dimensions of change (e.g., theories focusing mainly on social or biological influences), the transtheoretical model seeks to include and integrate key constructs from other theories into a comprehensive theory of change that can be applied to a variety of behaviors, populations, and settings (e.g., treatment settings, prevention, policy-making settings, and so on) — hence, the name transtheoretical. (Prochaska & Di Clemente, 1983; Prochaska, Di Clemente, & Norcross 1992). All of these theories recognize the importance of motivation to change behavior, and highlight the importance of strengthening the factors or processes that prompt behavior change.

Behavior change research in the seventies and eighties focused on the application of these theoretical models for the development of the skills needed to change behavior of patients (Rollnick, 1996). In the past decade, the importance of motivation for health-behavior change, in addition to skills, has been recognized, and efforts to enhance motivation have received increased research attention (Mitchell, 1982).

In contrast, there is evidence that more patient-centered approaches produce better outcomes (Stewart & Roter 1989). The essential features of these patient-centered approaches are that the patient does most of the talking, and that there is a ‘meeting between experts’ (Tuckett, Boulton, & Olsen, 1985), with the concept of reciprocity in the consultation (Roter, 1987; Bates & Ahmed, 2012). However, patient-centered counselling has not been developed into a replicable method specifically geared towards negotiating behavior change in healthcare consultations (Rollnick, 1996).

Motivational interviewing, which evolved from Miller’s experience with the treatment of problem drinkers (Miller, 1983), and was later elaborated by Miller & Rollnick (1991), is a

patient-centered approach that has been gathering increased interest in healthcare organizations (Rollnick, 1996). Miller (1983) conceptualizes motivation as a state of readiness for change, rather than a personality trait. As a state, motivation may fluctuate over time or from one situation to another, and can be influenced to change in a particular direction (Miller, 1994). Thus, lack of motivation (or resistance to change) is not seen as inherent within the patient but rather something that is open to change. The main focus of motivational interview is facilitating behavior change by helping patients to explore and resolve their ambivalence about the behavior change (Rollnick & Mille, 1995).

This conceptualization of motivation as a state which is open to change is a sharp contrast to traditional approaches which view motivation as an attribute of personality, and denial or resistance as something to be dealt with through aggressive confrontation (Yablonsky, 1989). In fact, Miller and Rollnick (1991) suggest that adopting an aggressive and/or confrontational style (as in traditional approaches) is likely to produce responses from the patient (such as arguing) which may then be interpreted by the practitioner as denial or resistance, thus creating a "self-fulfilling prophecy" (p. 10) Motivation is not a fixed thing—be it trait, stage, or any other fairly static entity. Rather, motivation waxes and wanes as a function of shifting personal, cognitive, behavioral, and environmental determinants (Bandura, 1986).

## Theoretical Framework

The five canons of classical rhetoric are important in the mastery of oral and written communication, and critical to the success of contemporary organizational communication (Vican, 2008). The canons are used in this study to help in understanding the usage of language and organizational rhetoric in healthcare organizations. A growing number of scholars have developed diverse theoretical frameworks for the analysis of communication (Wiseman & Horn,

1995). The five canons of rhetoric are rooted in the ideas of Aristotle, but refined and labeled by early Roman scholars of rhetoric, the five canons of rhetoric describe the five basic ingredients of any speech—the most traditional form of rhetoric. The five canons are as follows:

- *1. Invention*—the development of ideas and support
- *2. Arrangement* —the order in which ideas appear
- *3. Style*—the use of language
- *4. Memory*—how rhetoric is committed to memory
- *5. Delivery*—the way that verbal and nonverbal actions contribute to the speech

Over the years, authors have built on the five canons of rhetoric and the ideas of Aristotle to develop systems for describing rhetorical strategies found in traditional rhetoric (Campbell, 1996; Campbell & Burkholder, 1997; Rowland, 2008). Although scholars have been studying rhetoric for thousands of years, some of the oldest concepts still provide the best framework for understanding how communication work. Whether your purpose is to decide if a particular piece of rhetoric meets its persuasive goal or to determine how a piece of rhetoric reveals the use of power by an organization, learning to see the rhetorical strategies in a piece of communication is the first step in becoming an informed consumer of rhetoric (Campbell, 1996). Being able to identify fundamental rhetorical strategies is an important step in any analysis of organizational rhetoric (Campbell & Burkholder, 1997). Rowland (1999) explains that the goal of this descriptive analysis "is to see clearly what is being said and how the rhetoric is saying it" (p. 9). We see and hear so many communications each day that we often accept them at face value. The five canons of rhetoric would be the guiding theoretical framework in this study.

The five canons of classical rhetoric, first introduced to the world in Cicero's De Inventione, are important in the organizational communication particularly in healthcare

organizations (Vican, 2008). Although the Roman statesman Marcus Cicero was only nineteen when he wrote his original work on the subject, he spent his remaining life re-inventing the ideas about how to master rhetoric through the five canons he identified in this first work (Enos 2005). In today's work environment, many manifestations of the original classical canons can be clearly seen. Some examples of the work that would be subject to the utilization of the canons would be speeches, presentations, company memos, meeting outlines, mission statements, and everyday work environment communication (Fahnestock, 2001). In the history of rhetoric, Marcus Cicero's introduction to the idea of organizing ideas to form a better structure and more common outline to a speech and in communication was a foreign idea (Enos, 2001). That is because writers during Cicero's lifetime had so far used rhetoric for persuasion, and most communicators worked without planning for the purpose of tailoring speeches to their audience (Griffin, 2006). Cicero's intention in developing the canons as they are known today was to make communication easier (Vican, 2008).

Cicero had many strong opinions about the use of rhetoric. One of his most famous ideas about rhetoric was that the tongue, which represents speech and the brain, which represents analyzing and planning should come together and act as one force (Mendelson, 1997). In the real world of contemporary organizations are often the first environments in which communicators are able to put to use their knowledge of rhetoric (Vican, 2008). One of the strength of Cicero's canons is that they transcend time in their importance (Enos, 2005). They are seen at work throughout history in many different types of rhetoric, and healthcare organizations consistently refer to them when conducting interviews and consultation, engaging in team brainstorming sessions, and in the day to day interaction. Healthcare organizations and its audience seek

methods to make communication easier in the workplace, and the rhetorical canons of rhetoric accomplish that.

The first canon is invention. Cicero's idea of invention was divided into either topics or stopping points. The most used method in the workplace is topics, which is most often used to brainstorm or generate multiple ideas on a subject, Sloane (1989) believes that the process of invention is most crucial during the process of coming to agreement at stopping point- the point at which the pros and cons of the subject must meet in the middle at an agreed-upon basis, before the interaction can continue successfully. Invention can be thought of most easily as brainstorming. The second of Cicero's canons is arrangement, is a six-part method of putting together compositions either oral or written (Vican, 2008). Arrangement was the central idea to Cicero's composition of any communication and was the key to begin the processing of ideas from simple realization and creation to concrete actions and thoughts. If the end result of communication is for the audience to understand commands, share information, be motivated or persuaded, arrangement of the composition should be organized to ensure maximum results (Enos, 1985). Arrangement must include an introduction, a statement of facts, a division between ideas if there is one, proof or evidence supporting all ideas, refutation of ideas, an optional digression, and conclusion (Jasinski, 2001).

The third canon is known as style. This is an extremely influential canon which employs the communicators' personal style for the most optimal result. Invention and arrangement are concerned more with what is being said, style is concerned with how it is being said (Mendelson, 2001). Style is something that is encouraged in the workplace. A speaker cannot recite ideas and expect people to listen. Instead, they must accompany their ideas with the proper expression to help convey them (Vican, 2008). The fourth canon, memory, has less to do with what is

considered as memorization. Memory can be utilized in a modern workplace for many outcomes, but it is particularly useful when communicating knowledge of a topic and it allows the speaker to react to various types of feedback from their audience (McKeon, 1975).

The fifth of Cicero's five canons of rhetoric is delivery. Delivery is somewhat similar to the canon of style in that it concerns how something is communicated, but it is different because its focus is more on nonverbal behaviors which accompany speaking such as gesturing, vocal training, and emphasis (Agnew, Barrett, & Caplan, 1997). Delivery, unlike arrangement, cannot be specifically taught or learned, it should also be tailored to fit the audience of the speaker. Delivery can be incredibly subjective to an audience- people react differently depending on how much authority the speaker appears to have and how confidence they seem (Griffin, 2006). Delivery can be crucial in attaining the end goal in communication and is also the most lasting impression left with the audience (Vican, 2008).

Cicero wrote his canons of rhetoric based on the idea that a communicator should seek to be eloquent and wise above all else. Eloquence consisted of delivering powerful and effective language to persuade people or to express oneself. Classical rhetoric has been and will continue to be, a dominant theory for instruction and information sharing both in the workplace and beyond (Sloane, 1989). By using the classical rhetorical canons in the aspects of delivering verbal and non-verbal communication in the workplace, and by carefully tailoring them to specific audiences, organizations can effectively persuade, influence, and express opinions in a manner that is well-organized and defined. Learning the major goals of the canons will allow speakers to represent their ideas confidently at work, and allow the workplace audiences to appreciate and value the efforts (Vican, 2008).

The above discussion on the five canons of classical rhetoric indicates that these five canons are essential in understanding the usage of language and organizational rhetoric in healthcare organizations. For that reason, the canons are adopted to guide this study. The five canons were taken into account in drafting the interview guideline and they also informed the data analysis and discussion, especially in terms of facilitating the understanding of the usage of language and organizational rhetoric in healthcare organizations.

## Research Questions

The above literature review focused on rhetoric and communication, audience in healthcare organizations, communication in healthcare organizations, rhetorical situations in healthcare organizations and motivation in healthcare organizations. It shed light on the effectiveness of communication in healthcare organizations and the use of rhetoric. However, given the fact that understanding the use of language and organizational rhetoric in healthcare organizations is of significance and that there is room for more reflection on the topic of communication in healthcare organization and the use of rhetoric, three research questions are posed to help guide this study:

- How do healthcare professionals perceive communication with their audience?
- How can the use of rhetoric, as perceived by healthcare professionals, affect the style of communication in healthcare organizations?
- How does the use of rhetoric, as perceived by healthcare professionals, contribute in motivating the audience in healthcare organizations?

### *Chapter Summary*

Chapter two provided a review of relevant literature on the topic of communication in healthcare organizations and the use of rhetoric. The literature review also discussed Marcus Cicero's five canons of rhetoric and explained the canons in the theory, and argued for using it as a theoretical framework for this study. Based on the literature reviewed, the research questions guiding this thesis were posited.

In the following chapter, the methodology to carry out this study is described

# Chapter 3: Methodology

A qualitative approach is interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world (Merriam, 2009). This study employed a qualitative approach, mainly, semi-structured in-depth interviews to understand communication in and the use of rhetoric in healthcare organizations. A qualitative approach enables the researcher to "study selected issues in depth and detail" (Patton, 1990, p. 13). Kvale (1983) defines qualitative research interview as "an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretation of the meaning of the described phenomena" (p.174). Semi-structured interview is well suited for the exploration of the perception and opinions of participants regarding "complex and sometimes sensitive issues and enable probing for more information and clarification of answers" (Barriball & White, 1994, p. 330). At first, it seemed case study was fruitful to employ as the principal research method, it is an empirical inquiry that investigates a contemporary phenomenon and its real- life context (Yin. 2009). However, due to limited time and the unwillingness of the healthcare organizations in Ottawa (which were contacted) to provide information and release documents, it became impossible to find multiple sources to build a case study database. Therefore, this study integrated semi-structured interviews to better and further understand communication in a healthcare organization and the use of rhetoric.

## Sampling and Participants

Criterion and expert sampling were integrated to select participants. Criterion sampling is a type of purposive sampling technique that involves searching for cases or individuals who meet a certain criterion, e.g., age, site, location, years of experience, and so on (Patton, 2001). Expert sampling is also a type of purposive sampling; this technique is used when a researcher needs to

glean knowledge from individuals who have particular expertise (Patton, 2001). Interview participants in this study were recruited using criterion and expert sampling. Thirteen healthcare professionals in Ottawa were recruited for this study; they were 4 doctors (General physicians with at least 10 years of practice experience), 5 nurses (Registered nurses with at least 5 years of practice experience), and 4 administrative staff (with at least 5 years of work experience). All thirteen healthcare professionals agreed to participate in the one-to-one recorded interviews, except for two participants, who did not consent to the recording of their interviews.

The study was approved by the Research Ethics Board (REB) of the University of Ottawa. The participants were told that their participation was completely voluntary and that they would not receive any compensation. Participants were also informed that their Personal information such as names, address and place of work will not be used in this study.

## Data Collection

Data reported in this study was generated through participants completing one-to-one semi-structured interviews, ranging from 20 to 45 minutes (see Appendix A for the interview guide). Upon REB approval, participants were assigned to interviews at their convenient times and places. Informed consent forms were gained from each participant before conducting the interviews (Keyton, 2006) (see Appendix B for the informed consent form). Eleven interviews were recorded with a digital voice recorder and two interviews were recorded by writing notes. Interviews covered general communication experience at workplaces; participants' mode of communication, perception and style of communication, the use of rhetoric and motivation. Open-ended questions were used to gather the perspectives of participants (Baxter & Babbie, 2004; Patton, 1990; Seidman, 1998). The interviews were conducted in English to reflect the participants' language competencies. After conducting the interviews, the researcher transcribed

the interviews verbatim using a computer-based word-processing program (Seidman, 1998). The researcher verified the interviews by playing it back for participants to confirm and agree to what they have said. To protect the anonymity of the participants, participants' identities were kept private, and professional titles were used in the final report (Hoffman, Novak, & Peralta, 1999; Seidman, 1998). During the data collection process, the researcher kept a journal of ideas and thoughts as an on-going log of the interview process.

## Data Analysis

Data analysis consists of examining and recombining evidence to draw conclusions (Yin, 2009). In this study, thematic analysis was employed to analyze the interview data (Howitt & Cramer, 2008). As one of the "most commonly used methods of qualitative analysis," thematic analysis can help the researcher to identify a certain number of themes which "adequately reflect their textual data" (Howitt & Cramer, 2008, p. 333).

After the researcher had completed data collection, the data were subjected to thematic analysis (Langdridge, 2004). The researcher examined the interview transcripts in detail by performing a thorough reading of the data several times to obtain a general sense of the information and its overall meaning (Baxter & Babbie, 2004; Creswell, 2009). Then, participants' responses that were related to research questions and interview questions were highlighted on the computer with a different colour (Howitt & Cramer, 2008), and coded into categories and subcategories according to their different themes (Creswell, 1998; Deng, 2008; Seidman, 1998). After that, the researcher identified themes on the basis of those codes, for instance, perceptions of communication in healthcare, rhetoric and communication in healthcare and, rhetoric and motivation in healthcare. Direct quotations were employed to reflect participants' perceptions, thoughts, and experiences (Patton, 1990).

## Validity

Validity, also known as credibility, is very important to qualitative research (Keyton, 2006). According to Creswell (2009), validity in qualitative research means that "the researcher checks for the accuracy of the findings by employing certain procedures" (p. 190). Accordingly, in this study, the researcher employed two methods to ensure validity.

The first method was data triangulation (Keyton, 2006). The researcher compared and cross-checked the consistency of data from different sources, interview transcripts and research journal, to assure consistency of the findings (Creswell, 2009). The second method employed was member-checking, or member validation (Patton, 1990). Recorded interviews were playback to each participant to allow them an opportunity to verify what they have said (Baxter & Babbie, 2004).

## Limitations

There are several caveats that need to be taken into consideration in evaluating the study. First of all, the size of the sample may be relatively small since all participants are from specific health care organizations (Hospitals and Clinics) in Ottawa, hence, the generalizability of the study is limited (Wang, Rosenbeng, & Lo, 2008). Secondly, participants do not cover all the special areas in healthcare, which is quite restrictive to the findings of the study. It is likely this study would not reflect other areas of healthcare communication and the use of rhetoric. Third, in this study, participants' experiences were assessed mainly through face-to-face semi-structured in-depth interviews. This research design has its own natural flaws and it is possible that could have some effects on the data collected. These flaws may include the interviewer not having a real way of knowing if the respondents are being biased or even telling the truth, interviewer

giving out unconscious signals or clues that may guide respondents to give answers expected by the interviewer and the interviewing skills of the interviewer, among others.

### *Chapter Summary*

This chapter outlined the methodology employed to conduct this study. By describing the specific procedures, data collection and analysis methods, and the limitations, a clearer understanding of the research design has been presented.

All thirteen participants in the study were healthcare professionals in Ottawa. They were recruited using an integration of criterion and expert sampling techniques. By discussing the pros and cons of the procedures, data collection, and data analysis, the chapter provided a justification for adopting semi-structured interviews.

In the following chapter, the results of this study will be reported and analyzed.

## Chapter 4: Results and Analysis

Thirteen participants were recruited for this study. Out of the thirteen participants, four were doctors, five were nurses and four were hospital/clinic administrative staff. All of them were residents of Canada residing in Ottawa (Ontario). The four doctors were all general practitioners, and each one of them had at least 10 years of practice experience; three of them were working in hospitals and one in a clinic. With regard to the nurses, all of them were registered nurses with at least 5 years of work experience; three were working in hospitals and two in clinics. The last group was the hospital/clinic administrative staff, they all had at least 5 years of work experience in healthcare organizations and out of the four, one was a director at a clinic, two were office managers at clinics and the last one was a human resource manager at a hospital. All the participants in this study were full time employees in their various fields and organizations. To respect the anonymity of participants, they are identified in this study by their fields of specialty and nomenclatures, such as of Doctor 1,2,3, Nurse 1,2,3 and Administrator 1,2,3.

This study focused on healthcare organizations because the delivery of healthcare is built on communication, and there is more to understand about the usage of language and organizational rhetoric in that sector. To that effect, the study reviewed literature on rhetoric and communication, audiences in healthcare organizations, communication in the healthcare organization, rhetorical situations in healthcare organization, constraints and assets in healthcare rhetoric, and last but not the least motivation in healthcare organizations.

Semi-structured interviews were conducted, which ranged from 20 to 45 minutes. The data were subjected to the thematic analysis method (Langdridge, 2004). The data were coded into thematic categories and subcategories (Creswell, 1998). Accordingly, the data was examined

in detail to acquire a general sense of the information and its various themes (Baxter & Babbie, 2004). These themes emerged in the process of examining the data. Finally, three leading themes were identified, perception of communication in healthcare; rhetoric and communication in healthcare; and rhetoric and motivation in healthcare. The theme perception of communication in healthcare includes two sub-themes, patient-centered communication and therapeutic alliance. The theme rhetoric and communication in healthcare includes three sub-themes, use of language, verbal and non-verbal communication and effective communication. The theme rhetoric and motivation in healthcare includes two sub-themes, psyche communication and motivation as therapy.

## Perception of communication in healthcare

Doctors, nurses, and the administrative staff who participated in this study perceived communication in healthcare as their number one tool for work. They all agreed on the importance of effective communication among the members of a healthcare team. Participants' responses to the question as to whether they think they were effective communicators unearthed a tall regard for communication in healthcare organizations.

One of the doctors who works in a general hospital with 15 years of practice experience (Doctor 1) said that effective communication is an important part of life, but even more important when seeing a doctor. He highlighted that effective communication in healthcare is important for correct diagnosis and quality treatment.

The participants believed that it is very important that both healthcare professionals and patients communicate very clearly in their interactions during the delivery of healthcare. Doctor 1 stated that, "when a patient is unclear, inconsistent or limited in the information he or she

provides regarding his or her symptoms and experiences, the diagnosis we will carry out may be inaccurate, leading to mistreatment of his or her condition."

It is important to note that the doctors in this study were more particular about their communication with patients. Doctor 1 advised as follows:

> Patients must ask questions about their treatment if they are unclear on the instructions, and communicate adequate information to doctors and nurses, for certain information help in advancing medical progress.

A participant who was an administrative staff at a hospital with 16 years of work experience (Administrator 1) shifted the issue from diagnosis and treatment to some legal processes. She explained how effective communication is important for legal issues pertaining to treatment; she said that a thorough understanding of diagnoses and treatments must be established before a healthcare delivery can proceed. Citing that documentation of all communications can become important should something go wrong. She stated that, "documentation of communication that has taken place between a doctor and a patient can provide a defense for the hospital or ammunition for the plaintiff." That was the extent to which she perceived communication in healthcare.

Communication among healthcare professionals was also perceived to be a catalyst for the delivery of healthcare by all participants. Doctor 1 mentioned that interactions should be polite and show respect for fellow healthcare professionals. He also mentioned that active listening on the part of healthcare professionals is a helpful technique. He further explained that the understanding of each healthcare team member's role in the process of deliver healthcare is very important.

### *Patient-centered communication*

The concept of a patient-centered approach in healthcare has gained prominence in contemporary health communication (Bredart et al., 2005). Participants' have the view that communication should be patient-centered, they mentioned that effective patient-centered communication is key to quality healthcare, emphasizing that good communication between healthcare professionals and patients is ethical imperative, necessary for informed consent and achieving better healthcare outcomes. Participants complained that is sometimes difficulty to get patients to effectively communicate their medical experiences.

Doctor 1 explained that the goal of a patient-centered communication is to help them provide care that matches with their patient's values, needs and preferences, and that allow patients to provide input and participate actively in decisions regarding their health. He stated that it is widely endorsed as a central component of high-quality healthcare and somehow blamed the lack of input from some patients on poor communication skills on the part of some healthcare professionals. He asserted that "acknowledging the patient's emotions and values demonstrates recognition of their individuality and statements such as that must have been painful are crucial to establish rapport." He elaborated as follow:

> We tend to be uncomfortable relating to our patients' emotions. Remember that a little human kindness could make that patient your best advocate.

Participants mentioned that patient-centered care starts with the healthcare professionals' communication. They explained that healthcare professionals must listen to and honor patient perspectives and choices. Doctor 1 further explained that patient knowledge and cultural backgrounds must be incorporated into the planning and delivery of care. He stated the following:

> Healthcare professionals should communicate and share complete and unbiased information with patients in ways that are affirming and useful, and patients must receive timely, complete, and accurate information in order to effectively participate in the care delivery process.

### *Therapeutic alliance*

The hierarchical perception of healthcare professionals being in complete charge of healthcare delivery and the patient being passive is by far reducing. Participants viewed communication in healthcare to be a team work, team work not only among healthcare professionals but with patients as well. Unlike some time back when paternalism was perceived to be the order of communication in healthcare organizations, participants indicated that the perception is changing and that communication in healthcare organizations is today seen more as therapeutic alliance.

A nurse at a hospital with 5 years of nursing experience (Nurse 1) stated that therapeutic communication is a concept that is essential to nursing and the art of healing. She stressed that the quality of interpersonal relationships must be nurtured because of their importance to both the healthcare professionals and patients. Studies show that effective communication between healthcare professionals and patients, improves treatment adherence, and leads to better healthcare outcomes (Stewart, 1996).

A doctor with 17 years of practice experience in a hospital (Doctor 2) explained that therapeutic alliance extends beyond the doctor-patient relationship and involves interactions with other healthcare staff, patients' families, and stakeholders. This supports Hoffman and Ford`s (2010) description of enabling, normative and diffused audiences. Doctor 2 indicated that stakeholders of therapeutic alliance include individuals or organizations with a vested interested

in healthcare issues and policies, such as communities, higher learning and teaching institutions, government officials, advocacy groups, and financial supporters. He further stated that "the provision of quality healthcare is a team work, is not a one man show, all hands are needed in creating the alliance for quality healthcare."

Participants emphasized that communication is particularly significant in today's fast-paced, information-driven; Poor communication among healthcare professionals creates a gap in the continuity of care and threatens patient's safety. A nurse with 7 years of nursing experience in a clinic (Nurse 2) stated that, as agents of healthcare, they use interpersonal relationships and cooperating with one another, including the patient and his or her relatives, to ensure holistic healthcare and also to facilitate best healthcare outcomes among all interest.

Doctor 2 elaborated on therapeutic alliance as follows:

> Therapeutic interactions require mutual respect. A caring environment helps healthcare professionals to embrace and value the patient's experience.

Participants indicated that therapeutic alliance is an important element in the discharge of their duties; they stated that team work among healthcare professionals and with patients will promote quality healthcare delivery and patients' satisfaction. For instance, Doctor 1 stated that therapeutic alliance will close the gaps that sometimes exist between healthcare professional and with patients, and will provide a holistic approach to the delivery of quality healthcare.

**Rhetoric and communication in healthcare**

The study of communication was born with the study of rhetoric (Aristotle, 2007). Participants' responses indicated that they use rhetoric in their communication at work with both patients and colleagues.

Rhetoric was defined to participants as using language effectively to please or persuade (Advanced English Dictionary and Thesaurus, 2014), while language was defined to them as communication of thoughts and feelings through a system of arbitrary signals, such as voice sounds, gestures, or written symbols (American Heritage Dictionary, 2000).

Participants asserted that they use both verbal and non-verbal modes of communication, where verbal means voice sounds and nonverbal meaning the use of gestures and written symbols. When participants where asked about the effectiveness of these modes of communication, they said both modes very effective. One of the doctors with 12 years of practice experience in a hospital (Doctor 3) stated as follows:

> They [verbal and non-verbal modes of communication] are very effective, that is why I use them, so every doctor is taught communication in medical school; how to communicate with a patient with verbal and non-verbal languages. Because you can be an excellent doctor but if you cannot communicate, it leads to many problems. So for example, you may know your stuff when it comes to medicine, but if you cannot communicate the message to the patient, the patient may not understand.

He further explained that lack of effective communication can lead to many problems, citing that patients may ignore a doctor's advice because it was not well understood, which can lead to a break down in doctor-patient relationship. He again stated "it is important that communication is at the professional level in healthcare delivery, however, every physician has different abilities and capabilities."

A nurse at a clinic with 11 years of nursing experience (Nurse 3) pointed out that doctors, nurses and other members of healthcare organizations conduct countless patient interactions in

the course of their career. She stated that "when we think of communicating, we often envision ourselves talking, but actual communication means listening, thinking and responding appropriately." She explained further that it means understanding from another person's perspective and interpreting and responding based on personal experiences. She believes that the nurse-patient or nurse-doctor interaction requires the nurse's attention to analyze behavioral and emotional responses within the context of the interaction. Nurse 1 expounded that a nurse mode of communication is influenced by his/her skill to create rapport and use active listening as a means of facilitate healthy nurse-patient or nurse-doctor relationships.

All participants settled that rhetoric is a part and parcel of communication in healthcare. A nurse who works at a hospital and has 14 years of nursing experience (Nurse 4) explained as follows:

> I think, depending on who you are using it with, like if the person has the ability to make their own decisions then you should be upfront and honest for sure, but if you are working with someone who has a type of dementia or Alzheimer's, it is for their best interest, you have to use rhetoric, because you want them to take their meds or influence their behavior positively.

Participants agreed to the use of rhetoric in their communication at the workplace, they indicate that they use it in its verbal and non-verbal forms. For example, Doctor 3 stated that healthcare professionals use rhetoric depending on the audience and situation they are addressing.

### *Use of language in healthcare*

As mentioned in the earlier chapters, Sapir and Whorf (2013) argued that language predetermines what we see in the world around us. In other words, language acts like a polarizing lens on a camera in filtering reality. Participants indicated that they use both plain and medical professional languages; plain language was explained to participant as the everyday words or language used by people whereas professional language was explained to them as the jargons or language used by medical professionals.

With a unanimous response all participants agreed to the use of both plain and professional languages. It was explained that, the use of a particular language is dependent on the person they were communicating with at a given time. They said it was easier using the professional language among healthcare professionals and much better using the plain language with patients. When asked how comfortable they were using the languages, they said they were very comfortable using both languages. Doctor 3 stated as follows:

> We don't really want to use professional language with a patient because they do not understand what you are talking about. So you want to break it down to their own language, to what they understand. So we don't really use medical terminology for patients. When you do, you are increasing their fear because they think the problem they have is unsolvable by using these kinds of big medical jargons. So we don't really use medical jargon in front of the patient, but when we are discussing issues among ourselves, medical colleagues, we can use medical terminology. Because that way is a fast way of communicate with each other.

Participants were asked whether they faced any form of challenges using plain or the professional languages at work, participants' response indicated that there were no challenges, they explained that the right language is always used for the right audience. However, Doctor 2 said that there were some common challenges among colleagues. He explained as follows:

> I guess another point that could lead to some breakdown in physician-physician communication is the use of abbreviations. Because sometimes one abbreviation in medicine could mean different things, for example, "OCD" in sports medicine refers to a condition which can occur in various joints, often in the knee, so if orthopedic writes OCD to another orthopedic surgeon, he will immediately know that it means osteochondritis dissecans, a type of joint condition. But if a psychiatrist sees the same thing, who is also a medical doctor, they will mean obsessive-compulsive disorder. So the use of abbreviations in medicine can be a challenge that is why physicians are always advised to try and stay away from abbreviations when communicating.

Participants were asked if there were any form of language or words they were not allowed to use in their line of duty. Participants answered that swear words and foul language were the only words they were not allowed to use. Participants asserted that it was regulations at their work places not to use swear words and foul languages.

Doctor 2 elaborated on the issue as follows:

> I don't want to use the word controlled but it is advised always to follow the best rules of ethics- medical ethics. So in terms of language, we are not allowed to use any type of language which may be offensive or may be in

> any way, shape or form discriminatory whether it's on the basis of sex, of religion, etc. so that sort of thing we have to stay away from, obviously. But I use "I am sorry" many times, a practical example is that sometimes a patient waits for a long time, which happens once in a while, it is very common for a physician to say I am very sorry for your wait. Yes, we do say sorry, I would say pretty, quite often.

Participants mentioned the important role that language plays in communicating at their work places. Participants stated that they use plain language when communicating with patients; on the other hand, they indicated that it was more easy using professional language when communicating with colleagues. Participants stated that they were not allowed to use unfriendly language for moral and regulatory reasons. Participants, however, stated that they use apologetic language with both colleagues and patients when necessary. An administrative staff at a clinic with over 33 years of work experience (Administrator 2) stated "we say I'm very sorry I did this, and I'm thinking of doing this or that to fix it."

### *Effective communication*

The ability to communicate information and ideas effectively is increasingly recognized as critical to the success of healthcare systems. Effective communication is required not only for successful interactions between healthcare professionals and their patients but also between healthcare professionals themselves (Schwartz, Lowe & Sinclair, 2010).

Participants' responses to the question as to whether they are effective communicators revealed their high respect for communication in healthcare. Participants asserted that they strive to be effective communicators. They affirm that communication play a significant role in the discharge of their duties. For instance, one of the administrative staff at a clinic with 6 years of

work experience (Administrator 3) indicated that communication means everything in healthcare organizations; she stated “I cannot imagine life in the healthcare without communication.”

In attempt to highlight their practice of effective communication skills, participants described themselves as attentive listeners, good speakers, empathizers and motivators. They pointed to the fact that effective communication is their first tool in their line of duty.

The question on effective communication did not end at how effective communicators they think they were. Participants were asked to explain what made them describe themselves as effective communicators. Most participants stated that they were effective communicators because they were taught how to communicate in medical and nursing schools. Administrator 2 stated as follows:

> I think I am an effective communicator, because if I wasn’t, I would not be at this job very long. My employer would have let me go many years ago. I think I am okay when I communicate with the staff, with the patients, and the doctors.

She mentioned that she communicates with doctors, nurses and other management staff every day and no one has ever complained about her style of communication. A doctor at a clinic with over 40 years of practice experience (Doctor 4) stated as follows:

> I tend to explain yes, whatever is going on to the patients, I try to use analogies in a practical sense, and I have never been accused of not explaining well enough to people both patients and colleagues here. I would say yes; I think I convey the message to the patients effectively.

Participants stated that effective communication is a very important component of quality healthcare delivery; participants indicated that they strive at all times to be effective

communicators, for example, Administrator 1 stated, “For me effective communication is very important so I work hard on being a good communicator.”

### *Verbal and non-verbal communication*

Communication extends beyond that borders of the use of sound, it includes gestures and written symbols. Participants agreed to the use of both verbal and non-verbal modes of communication, when they were asked about their mode of communication. Doctor 1 stated that “effective communication in healthcare goes beyond talking, our facial expression, body movement and gesture counts.”

Participants emphasized that effective communication is not just verbal. Participants stated that there are other tools that can be used to enhance the communication process and can help patients remain informed for the duration of their stay in a healthcare facility. Administrator 1 stated that

> An easy and cost effective way to help patients and their loved ones remain involved and informed is through the use of patient and family communication boards. These boards, usually in the form of dry erase boards, allow the care team to post their names for patient and families, and include some basic information, such as the room number and patient room telephone number.

## Rhetoric and motivation in healthcare

Healthcare delivery includes helping healthcare seekers manage problems whose outcomes can be greatly influenced by change in their behavior, therefore, healthcare professionals have a vital role in the process of motivating patients and colleagues. When talking about rhetoric and motivation, the responses of participants’ revealed that they use rhetoric in motivating one another as well as motivating patients, for instance, Doctor 3 stated as follows:

> This is the objective of physicians especially when it comes to preventative healthcare, where physicians are taught that you are supposed to try and get people to do things to prevent future problems from occurring. So a key element of preventative healthcare is to motivate the patient to engage in those behaviors that will prevent future medical problems. So it is absolutely essential for the physician to be able to motivate the patient. It could be preventative healthcare, it could be motivating a patient to lose weight, and it could be motivation to have the patient quit smoking or quit alcoholism etc. so that's absolutely vital and essential in healthcare.

Doctor 2 shared a personal experience with a patient he saw recently as follows:

> Just today I had a patient who came in very happy, but he came a few weeks ago complaining of severe headaches at the back of his head, and his face was red what we call in medical terminology erothermunus, so I knew something was quite wrong. What I found upon examining him was his blood pressure was very high- very high, and he was overweight. And I told him, you are at a risk of a sudden stroke and sudden death. So what I told him is that, you got to lose your weight, and I'm going to start you on blood pressure medications right away. So I did and I aggressively treated him. I just saw him today; he has already lost 15 pounds.

He explained that the patients' first case was about two months ago and the last time he saw the patients he had already lost 15 pounds, his blood pressure has come down to basically a normal range and his face was  normal colored. He further shared:

> So today I had to motivate him, he asked, do I have to keep taking my medication? I said yes, you have to keep taking them; you look great, you look fabulous, you look very healthy now, you are doing all the right things, and I need you to keep doing what you are doing. So I had to motivate him. So it's vitally important to motivate patients.

Most of the participants' believed that motivation is medicine by itself and sometimes it is motivation that keeps them going after long hours of work. Doctor 3 stated that they motivate each other to bring out the best in them and to always do what they think is best for their patients. He went further saying that every hospital has its goals and believes. He stated that the motto of the hospital he works is "motivate others in doing the best for the patient" and through motivation they treat patients as their own family members. He elaborated: "If you are treating your family members you motivate them as well, you don't want anything wrong to happen to them. You always want to provide them with the best care you have."

When participants were asked how often they motivated each other and patients, Doctor 2 stated as follows:

> Oh every opportunity that I have, I always motivates people to be able to do what is right, to be able to help in the management, to be able to make things work fast, because I believe in motivation. I believe motivation is part of treatment. I do it all the time and every opportunity I have because I believe motivation is an important aspect of healthcare.

In the same vein, other participants' stated that they use every opportunity they get to motivate both colleagues and patients. Administrator 2 stated as follows:

> I like to be happy, so I need happy people around me. So I will do all my best at all times to motivate and excite people around me. And I'm talking about the staff with who I'm working, the patients that are coming and the doctors.

Most participants smiled when they were asked to cite examples of the common phrases or sentences they often use when motivating people. Responses included; "great job", "fantastic", "excellent", "thank you", "keeps it up", "you did not have to do that", "thanks a lot", "you did a superb job", all the way to non-verbal expression such as smiles and taps on the shoulders. Administrator 2 expressed her love for taps on the shoulder, she said that she becomes motivated when she receives a tap on her should after a good job. She shared, "I like people to give me taps on the shoulder, so I like to do it to other people too"

Participants' responses to the question, why they believe in the use of rhetoric in motivating each other and patients revealed their affection for rhetoric and motivation. Participants described motivation as therapy, and rhetoric a vehicle they use when motivating colleagues and patients. For instance, Nurse 4 explained that people sometimes believe what they hear, so when someone uses rhetoric in motivating people, it works.

### *Psyche communication*

Motivation is psyche. Psyche is that which is responsible for human thoughts and feelings; the seat of the faculty of reason (Coppin & Nelson, 2005). Healthcare professionals influence the thoughts and feeling of colleagues and patients in some cases to improve the process of quality healthcare delivery. Doctor 3 explained that motivating patients can be very helpful in the treatment process, he stated as follows:

> It's a good way of communicating because it's psyche. When you say psyche, for example, if patient says, 'I'm going to die' you motivate that patient by telling him 'you're not going to die because we are taking care of you.' That is a psyche communication.

Doctor 2 also stated that sometimes they need to use psychological tactics with patient. He explained that in some cases patients need to take psychotherapy to get them motivated before a treatment or an operation. This doctor's thoughts were shared by most participants. A nurse at a clinic with 12 years of nursing experience (Nurse 5) shared a story about psychological tactics that she uses to motivate an inmate who did not like taking her bath. She narrated:

> We have a patient on the floor, this woman when it comes to the issue of bath, she never want to have a bath. She will tell you she had one in the morning and it's not true, if she refuse to bath for the whole week, how will she feel? She will smell. So, I discovered at the end that there is a way I can get her to bath; there's a cream I put on her hair, after putting the cream on her hair, I say, you see the cream I put on your hair? I have to wash it. If you don't wash it, your hair will fall off. And I am not trying to scare you, but you have to wash it. After that, she will have her bath. So ever since I discovered that trick we never had any issue with her.

Nurse 2 shared her psyche moments when she starts her shift; she said that she would always go around and greet the patients before she would start the day. She narrated her psyche interaction as follows:

> I say: hey, good morning, my name is this, I'm going to be your nurse for the next twelve hours and I hope we will have a nice time together, how was your night,

> did you have a good sleep, do you have any pain. This is how you approach and convince them that you are there for them, not for yourself.

Administrator 1 indicated that they use psychological tactics with each other as medical professionals. She explained that they always have common goals and objectives, so everyone needs to be motivated to get on the same wavelength. She further explained that she normally gets one on one with doctors and nurses. She also narrated the *psyche* style she uses: "I will tell them, this is what we did this month, this is what we need to work on, this is how we want to get there, and this is what we're looking at. Remember we are on the same team."

### *Motivation as therapy*

Motivation is the process of stimulating people to actions to accomplish a goal (Mackay, 2007). Many participants indicated that they have offered some degree of motivation during treatment for a successful outcome. Doctor 3 stated that one of the biggest things one can give to someone who is sick is hope. In the same vein, Doctor 2 stated that every treatment starts with motivation; he narrated an encounter with a patient as follows:

> I had a patient with a very difficult case this morning, she came in looking really distraught, down and depressed, even though she was quite healthy. She had a bad diagnosis given to her a number of years ago and now she was getting similar symptoms after her treatment, so I had to motivate her and build a therapeutic alliance between us in order to get her interested in treating herself, because there is an antidote to her diagnosis. With that motivation she left my office felling somehow better than when she came.

Nurse 4 pointed out that in their field, they motivate patients all the time and they do it because treatment always starts with their communication with patients. "Sometimes they will

not take their meds; you have to kind of really use persuasive language to make them take it," she elaborated.

Doctor 3 mentioned that there are several types of motivation that he has adopted over the years to help patients recover faster. He mentioned active and reward motivations; he explained that active motivation is a form of motivation that involves physical therapy. He said that it has to do with taking patients for walks around the wards and allow them to hold interactions with rehabilitating patients; he said it helps them to ambulate sooner than they think they can. On the other hand, he explained that sometimes when he interacts with patients he gives them the idea that others have done it before, and that they can also do it, and that motivation is called reward motivation, he indicated that both active and reward motivation help patients to heal faster. He stated that there are other techniques that healthcare professionals adopt in motivating their patients with regard to communication, which helps very well in healthcare organizations. "We have seen the results of motivation and when something produces results, we always follow it up," he affirmed.

Participants explained that motivation can sometimes serve as therapy in the process of delivering healthcare. Participants indicated that motivating colleagues and patients is very helpful; they explained that it allows colleagues to put in their best and give patients hope in the process of delivering healthcare. For instance, stated that on several occasions she has chatted with patients, and during the chat they [patients] say, "oh you just made my day, I'm so happy you came in to talk to me."

## *Chapter Summary*

This chapter explored the results of the semi-structured interviews conducted with thirteen participants in this study. The results revealed themes and sub-themes related to

communication in healthcare organizations and the use of rhetoric. The first theme was perception of communication in healthcare which had two sub-themes under it: patient centered communication and therapeutic alliance. The second theme, rhetoric and communication in healthcare had three sub-themes, namely, use of language, effective communication and verbal and non-verbal communication. Rhetoric and motivation was the final theme and the sub-themes under it included psyche communication and motivation as therapy.

In the chapter which follows, a discussion will take place on these results and their analysis employing Marcus Cicero's five canons of rhetoric. At the same time, the three research questions posed in chapter two will be discussed.

# Chapter 5: Discussion

Although the findings of this study have uncovered a number of themes and sub-themes emerging from participants' responses with regard to their experience with communication in healthcare organizations and the use of rhetoric, these themes and sub-themes must also be examined through a theoretical lens for further understanding. Accordingly, the study findings are discussed in relation to the research questions using the five canons of rhetoric in order to shed further light on participant's experience of communication in healthcare organizations and the use of rhetoric.

The first question asked how healthcare professionals perceive communication with their audiences. In response to this question, participants answered in ways which suggested that they perceive communication as a vital tool in healthcare organizations. Quality healthcare delivery assumes effective communication between the patient and the healthcare professional and also among healthcare professional themselves (Jennifer et al., 2010). Participants indicated that communication in healthcare organizations should be more patient centered and therapeutic alliance. Participants stated that it is important that both healthcare professionals and patients be clear in what they say to one another to avoid poor healthcare delivery, for instance, if patients are not clear or limited in the information they provide regarding their symptoms and experiences, their diagnosis may be inaccurate, leading to mistreatment of their conditions. Participants emphasized that it is very important that the patients be very clear in communicating their medical history to doctors and nurses and it is equally important that healthcare professionals listen attentively and also pay attention to the information that the patients communicate to them.

In a patient-centered communication, healthcare professionals respect and respond to patients' wants, needs and preferences, so that patients can make choices in their care that best fit their individual circumstances (Arora, 2003). Participants have the view that communication should be patient-centered; they asserted that effective patient-centered communication is key to quality healthcare, emphasizing that good communication is both an ethical imperative, necessary for informed consent and effective patient engagement, and a means to avoiding errors and achieving better healthcare outcomes. These findings support what other scholars found regarding patient-centered communication, that it has the potential to help regulate patients' feelings, it facilitates comprehension of medical information, and allows for better identification of patients' needs and preferences (Jennifer et al., 2010; Brinkman et al., 2007; Arora, 2003). A more patient-centered medical encounter thus results in better patient as well as doctor satisfaction (Brinkman et al., 2007; Arora, 2003).

Additionally, participants in this study perceived communication in healthcare to be a team work, team work not only among themselves but with patients and their families or relatives. Unlike a couple of decades ago where communication was perceived in the mode of paternalism (Arora, 2003), participants indicated that communication in healthcare should be a therapeutic alliance and that they were striving to adopt that mode of communication. Participants admitted that sometimes there are poor and incoherent communications among healthcare professionals that create gaps in the continuity of healthcare and threaten patient's safety. Scholars have argued that collaborative communication between healthcare professionals and patients reduces malpractice suits, improves treatment adherence, and leads to quality healthcare outcomes (Stewart, 1996; Platt & Keating, 2007).

The second research question asked how the use of rhetoric, as perceived by healthcare professionals, affects the style of communication in healthcare organizations. Participants' responses revealed that they use rhetoric, and it has some positive effects in their style of communication. For example, they mentioned that rhetoric helps them use the right language for the right audience, help them make effective use of verbal and non-verbal languages when communicating with their audiences and also help them to persuade and motivate colleagues and patients during their interaction encounters. These findings support other existing literature regarding the effective use of rhetoric; scholars have argued that rhetoric helps in delivering clear and persuasive communication (Berry, 2007; Hoffman & Ford, 2010; Blundel et al., 2013). However, the researcher had to define rhetoric to most participants to help them answer questions with regard to the use of rhetoric in their communication. This suggested that either participants were using rhetoric in their communication not knowingly, or they were using rhetoric without taking into account its significance in their communication. To provide a better understanding, in the following, study participants' style of communication and the use of rhetoric will be examined within the context of Roman statesman, Marcus Cicero's five canons of rhetoric (Enos, 2005).

To reiterate, the five canons of rhetoric, describe the five basic ingredients of any communication which include invention, arrangement, style, memory, and delivery. Invention refers to the development of ideas and support or discovering the available means of persuasion. Arrangement refers to the order in which ideas appear or to select and assemble the speech effectively. Style refers to the use of language or to present the speech cogently and eloquently. Memory refers to how rhetoric is committed to memory or to speak extemporaneously, and delivery refers to the way that verbal and non-verbal actions contribute to the speech or the

effective use of voice, gestures, text, and images (Vican, 2008). Accordingly, participants' responses in this study can be discussed in relation to these five canons.

***Invention***

Supporting Bitzer's (1968) arguments that, situations call for rhetoric, participants indicated that there are events in healthcare organizations that required their invention; for example, when a patient visits a doctor for consultation or treatment. The doctor has to listen and develop support mechanism that would remedy the patient problem, and that remedy always starts with communication; the way doctors talk to patients during consultation, the way in which they explain diagnosis to patients or the way they communicate treatment process to patients require suitable development of ideas that will reduce the patient anxiety. In healthcare organizations invention can sometimes be thought of most easily as thinking and seeing the negative aspects of a subject, for example, a doctor communicating to patients his/her diagnosis results or treatment process; (e.g., your results show that you have cancer and the treatments will be chemotherapy, but do not worry other patients have gone through that treatment successfully). In this case, the doctor is trying to discover the available means to reduce the anxiety of the patient and persuade him/her for the chemotherapy, and this is where rhetoric plays an important role. Invention could also come in a form of motivation. Participants stated that most times they motivate patients before operation or in order for them to take their medication. For example, a doctor may offer a praise to boost the self-esteem of a patient in order to for him to keep taking his medication.

The finding also identified invention in the communication among healthcare professionals. Participants indicated that they communicate with each other as healthcare professionals, especially when clarifying an understanding of each healthcare member's

responsibilities for patient care. For example, when nurses or doctors end their shifts they brief those taking over from them about patients situations.

***Arrangement***

Invented ideas must be arranged in a way that will make sense to the audience. The second canon, arrangement, is a six-part method of putting together compositions either oral or written. Arrangement must include the following: introduction, statement of facts, division between ideas if there is one, proof or evidence supporting all ideas, refutation of ideas and conclusion (Vican, 2008). For the canon of arrangement, we can use several healthcare basics such as consultation procedures, and operation procedures, among many. At its most basic, the canon of arrangement is the structure by which it's previous step, invention is arranged. Participants stated that communication must follow a logical pattern to make sense; most participants explained that without structure, communication can take any number of routes beyond the immediate dialogue. The findings revealed that arrangement of ideas can be neatly divided into ways that best fit the healthcare audience and situation. For example, when a nurse is starting her shift, she will not be going around the wards asking patients to bring their hands for her to examine their blood pressures as her invention. The nurse has to arrange her invention of communicating to the patients before examining their blood pressures; (e.g., my name is Mary, am going to be your nurse for the day, how was your night, may I take your blood pressure to see how you are doing). Participants indicated that the end result of communication in healthcare is for the patients and healthcare professionals to understand each other in order to take right diagnosis and give the quality care; therefore, arrangement of the composition should be organized to ensure quality healthcare outcomes. Participants indicated that during the process of arrangement, they use logical ideas to support their information.

***Style***

The third canon is known as style or sometimes as expression. This is an exceptionally influential canon; it employs the use of healthcare professionals communication skills, while invention and arrangement are concerned more with what healthcare professionals communicate, style is concerned with how they communicate (Vican, 2008).

Upon reflection of the responses provided by the participants, it is obvious that participants perceived themselves to be careful users of language. All participants indicated that they use of both verbal and non-verbal language within the right parameters of the "seven C's" of communication; complete, courteous, consideration, clear, concise, concrete, and correct (Stull & Baird, 1993). Participants stated that they were very courteous at all times in their communication, participants explained that they have different styles of language considering the audience they are addressing at a given time; they indicated that they use plain or everyday English language when communicating with patients, however, when communicating with peers, they use the medical language or terminologies. Participants further stated that they use clear and concise language regardless of the audience they are communicating with. This finding supports Blundel and colleagues' (2013) arguments that, the use of plain and unambiguous language improves and gives better meaning in communication. Correct and concrete use of language was considered by participants as very important in communicating with audiences in healthcare organizations, most especially with patients.

Participants asserted that they were not limited to the use of any style of language but they were encouraged to always use decent and respectful language when communicating with their audiences. With regard to the use of apologetic language by healthcare professionals, participants dismissed the notion that they were not allowed to use it, this was in line with the

use of language; there is a common phrase from the Miranda warning. It essentially advises a person accused of a wrongdoing to say nothing until he speaks with an attorney. Traditionally, the advice given a medical professional who may be a potential defendant in a civil action for medical negligence is similar. The use of language such as "I am sorry" or other apologies made by healthcare professionals to their patients following an unanticipated outcome can be presented as an admission of negligence in an ensuing malpractice trial (Morrow, 2010). Participants reiterated that they were very courteous and concise in the use of language. The findings revealed that the doctor who makes a mistake will not necessarily be sued and that healthcare professionals' potential adversary is their patient to whom they owe ethical and moral obligations. As earlier mentioned, style is concerned with how communication is presented. For example, how healthcare professionals communicate inventions to their audiences. This makes style a yard stick for measuring the effectiveness of communication. The findings revealed that participants could not give reasons why they considered themselves to be effective communicator. Most of the participants pointed to the communication skills they were taught in medical and nursing schools, and the fact that they had no complaints with how they communicate with their audiences. This finding leaves room for further study into whether the communication skills taught at medical and nursing schools can be enough to make healthcare professionals effective communicators.

***Memory***

The fourth canon, memory, has less to do with what is considered as memorization, it is more of an innate knowledge to communicate extemporaneously. For example, it has to do with speaking without having to prepare or memorize a speech. In the delivery of healthcare, communications are tailored towards individual patients. The canon of memory allows

healthcare professionals to react to various types of interactions with their audiences. The canon of memory suggests that there is no need for a healthcare professional to memorize one consultation procedure for patients with the same ailment; patients may have different emotion or psychological needs. The findings revealed that participants are aware of the individual communication needs of their audience and there is no particular communication pattern that they have memorized to work with patients. Participants indicated that what they communicated to patients in their encounters with them is very vital in ensuring quality healthcare outcomes.

***Delivery***

The fifth of Cicero's five canons of rhetoric is delivery. Previous studies have found that delivery is fairly similar to the canon of style in that it concern with how communication is delivered, but it is different because its focus is more on non-verbal behaviors which accompany communication such as gesturing and emphasis (Vican, 2008). Scholars have argued that this canon is sometimes referred to as elocution because that word is derived from the Latin word elocutio (Agnew, Barrett, & Enos, 1997). Elocution, however, is more associated with style, and that is not its original function. Delivery is the way that verbal and nonverbal actions contribute to the way people communicate. Participants stated that verbal and non-verbal actions contribute to the way they communicate with both colleagues and patients. Most participants indicated that they often use images to explain diagnosis to patients, for instance, x-ray photos. Participants also indicated that they use non-verbal action during inter-professional communication, especially in operation rooms. Participants revealed that in some cases patients also use gesture in communicating pain or discomfort during examinations and treatments. Delivery unlike the other canons cannot be specifically taught or learned meanwhile it contributes to effective communication (Griffin, 2006). This finding again questions participants' claims for being

effective communicators because of the communication skills they were taught in medical and nursing schools.

Participants stated that delivery is always tailored to fit different audience. For example, while they deliver smiles to communicate happiness to some patients, they may have to show serious faces to communicate confidence to other patients. Scholars have argued that delivery in verbal format should be natural; similar to a rough draft of a written format, and both types of delivery should be careful to capture the logic of the interaction (Wood, 1979; Jasinski, 2001; Wanzer, Booth-Butterfield, M. & Gruber, K. (2004). Previous studies have found that delivery can be crucial in attaining the end goal in communication and that it is also the most lasting impression left with the audience of healthcare organizations (Vican, 2008). Participants indicated that it is very important that both healthcare professionals and patients be clear in their delivery.

The third research question asked how the use of rhetoric, as perceived by healthcare professionals, contributes in motivating the audience in healthcare organizations. In response to this question, participants answered in ways which suggest that they perceive motivation to be a therapy.

This finding supports scholars arguments that healthcare professionals motivate patients to improve their health, scholars further argued that many of healthcare services today involves helping patients manage conditions whose outcomes can be influenced by lifestyle (Bandura, 1986, Janz & Becker, 1984; Ajzen & Fishbein 1980; Prochaska et al., 1992; Schwartz et al., 2010). Participants indicated that they offer motivation to some patients during treatment which help a lot in the process. Most participants were quite familiar with healthcare motivational concepts such as motivational interview, intrinsic motivation and extrinsic motivation.

Participants believed that every treatment starts with motivation. Moreover, many health problems are related to lifestyle factors such as diet, exercise and smoking, and changing such behaviors require considerable effort and motivation. This finding supports previous studies with regard to motivation in healthcare organizations, an example is motivational interviewing, which evolved from Miller's (1983) experience with the treatment of problem drinkers and was later elaborated by Miller and Rollnick(1991) Miller conceptualizes motivation as a state of readiness for change (Mille & Rollnick, 1991; Miller, 1983).

On the other hand, participants stated that motivation in healthcare is not for patients only; they asserted that healthcare professionals need motivation as well, so therefore, they motivate each another to keep up their performances. Scholars have argued that contrary to the motives of a financially oriented system, money does not always translate to the central need of most healthcare professionals. They describe intrinsic motivation as deep absorption and full involvement in an activity. To some healthcare professionals, motivation is influenced by expectant rewards such as praise, attention and approval. Scholars (Ryan & Deci, 2000; Frey & Jegen, 2001; Keller & Bless, 2008) defined intrinsic motivation as the innate property of an individual to pursue an activity or seek out optimal challenges based on one's interest and personal capacity. They further argued that autonomy (by encouraging empowerment), competency (by the inherent need to improve one's self by gaining skill through experience) and relatedness (the sense of belonging to a particular group and adhering to an ethical set of social and cultural norm) are criterions central to an individual's psychological needs (Ryan & Deci, 2000; Frey & Jegen, 2001; Keller & Bless, 2008). Participants indicated that they sometime need that tap on the shoulder or acknowledgement to be motivated in the workplace.

### *Chapter Summary*

This chapter discussed participants' responses using the research questions. Marcus Cicero's five canons of rhetoric were used as the theoretical framework. The five canons; invention, arrangement, style, memory, and delivery were applied to guide the discussion. The discussion indicated that participants perceive communication as a vital tool in the delivery of quality healthcare, the five canons of rhetoric helped shed further light in understanding participants' usage of language and organizational rhetoric.

The concluding chapter will first provide a summary of the findings. Second, limitations of this study will be presented. Then, directions for future research will be discussed followed by implications.

# Chapter 6: Conclusion

This study has examined communication and the use of rhetoric in healthcare organizations in Ottawa. To this end, semi-structured interviews were conducted with thirteen participants. The study aimed to: explore the audience of healthcare organizations, examine how the use of rhetoric affects communication in healthcare, and understand the contribution of rhetoric in motivating healthcare audience.

The findings show that participants perceive communication as a fundamental component in healthcare. Participants indicated that effective communication is very important not only among healthcare professionals but between healthcare professionals and patients, as well as other stakeholders. Although most of the participants claimed that they were effective communicators, they could not give reasonable explanation for their claim. For example, some participants claimed they were effective communicators because people did not complain about their communication skills while others pointed to the communication skills they were taught in medical and nursing schools.

Participants in this study believed that communication in healthcare is more of therapeutic alliance and that healthcare workers should adopt a patient-centered style of communication; in this way, they can help patients to openly communicate with healthcare professionals and thus together they can form resilient teams to help each other achieve their goals.

Participants in this study revealed that they used rhetoric when communicating with colleagues and patients at work. They indicated that the use of rhetoric plays a helpful role in their style of communication. Participants stated that rhetoric helped them communicate effectively when using both verbal and non-verbal languages; they also indicated that it helped

them to persuade and motivate their audiences during their interaction encounters. The theoretical framework for this study, Marcus Cicero's five canons of rhetoric, shed some insights into participants' style of communication and their usage of rhetoric. Although participants' responses revealed that rhetoric was a catalyst in their communication, there was a concern regarding the use of rhetoric in participants' communications from the researcher's notes. Participants responded to some questions in a way which suggested that they were not aware of the usage of rhetoric in their communication or they were not taking into account the importance of rhetoric in their communication before the interviews. The findings show that participants perceive motivation to be a therapy. Participants indicated that motivation is very helpful in healthcare delivery, for example, they stated that motivation helps healthcare professionals put in their best performance at work and also help patients recover faster.

## Limitations and Directions for Future Research

Although this study has shed some light on how some healthcare professionals in some healthcare organizations in Ottawa use language and organizational rhetoric when communicating with their audiences, still, there are several limitations that need to be taken into consideration while interpreting the findings. First of all, the size of the study sample is relatively small. The thirteen participants were from specific areas in healthcare organizations and did not represent all the areas of healthcare organizations. Participants' ranged from doctors, nurses to administrative staff (four were doctors, five were nurses and the other four were administrative staff). Therefore, the participants in this study do not represent all doctors, nurses and administrative staff in other healthcare organizations in Ottawa. There were other equally good research designs that could be used for this study, for example case study, At first, it seemed case study was fruitful to employ as the principal research method, it is an empirical inquiry that

investigates a contemporary phenomenon and its real-life context (Yin. 2009). In this study cases and/or documents of communication in healthcare organizations in Ottawa could be used, however, due to limited time, unavailability of cases and the unwillingness of healthcare organizations that were contacted to release documents, this design could not be used. Even with this research design there were challenges recruiting the participants for interviews, participants did not have time to spare out of their busy schedules. For example, initially, the study proposed to recruit 15 participants (5 doctors, 5 nurses and 5 administrative staff); however, due to the unavailability of participants for interviews, the study had to settle for 13 participants (4 doctors, 5 nurses and 4 administrative staff).

Time for that matter is one of the major limitations in conducting research in areas like healthcare organizations, where relevant organizational document collection is a challenge. With regard to this study, the researcher had a tough time recruiting participants, because most of them had tight schedules for several months. For example, the researcher is yet to receive responses to some interview invitations that were sent out to some potential participants and organizations.

Future research can look into the communication in healthcare organizations and the use of rhetoric in specialty areas such as dentistry, optometry, gynecology, cancer, child healthcare among others in Ottawa. Other research designs such as case studies can be utilized if the resources are available. However, in a situation where case study is to be used as a research design, the researcher must have in mind the particular document or documents needed (e.g., films, newspapers, photographs, policy documents, meeting minutes, memorandum of understanding, partnering agreement, reviews and Web literature). This study focused on understanding the usage of language and organizational rhetoric in some healthcare organizations only in Ottawa. Future studies can focus on other cities and provinces in the

country. Last but not the least, patients views were not taken into consideration, which leaves room for future research to complement the findings of this study.

## Implications

Aside from the above caveats, the findings of this study provide important insights into examining ways in which healthcare workers perceive communication with their audiences, how the use of rhetoric affects the style of communication in healthcare organizations and also how rhetoric contributes in motivating the audience in healthcare organizations. As mentioned in the earlier chapters, there is a body of research addressing effective communication in healthcare organizations, however, there are still gaps that need to be filled, particularly, in understanding the usage of language and organizational rhetoric in healthcare organizations; hence, this study provides some insights to help understand the usage of language and organizational rhetoric in healthcare organizations because the delivery of healthcare is built on communication and rhetoric is a tool that can improve communication. Broader implications for doctors, nurses, and administrative staff members suggested by these insights are discussed below.

### *Implications for Doctors*

The findings of this study show that good doctor-patient communication is important and has multiple impacts on various aspects of healthcare outcomes. The impacts include better healthcare delivery, compliance to therapeutic treatments in patients, higher patient satisfaction and a decrease in malpractice risk (Shukla, Yadav, & Kastury, 2010). These findings have implications for designing interventions to enhance the teaching of effective communication skills at medical schools, because most of the responses from doctors in this study indicated that they rely on the communication skills there were taught at medical schools. Interventions for teaching effective communication skills at medical schools should be broad based, focusing on

verbal and nonverbal languages and also organizational rhetoric (Cegala, Marinelli, & Post, 2000). Interventions should also be designed to periodically evaluate doctors' improvement in communication skills (Zoppi & Epstein, 2002).

The finding shows that doctors in this study were more concerned with their communication with patients more than colleagues. Extra effort from the side of doctors to improve communication and relationship with colleagues would help to increase quality healthcare outcomes in healthcare organizations (Schiavo, 2007). The concept of doctors using rhetoric to motivate patients and colleagues should be encouraged (Lair, 2003).

### *Implications for Nurses*

According to the study findings, the task-centered approach to patient care that is associated with nursing appears to be active. The findings show that communication and the use of rhetoric form a major part of the care that nurses give to patients. However, nurses have ethical and professional responsibilities to effectively communicate not only to patients but also to colleagues and other professionals (DiGioia & Greenhouse, 2011). Nurses must be able to clearly communicate the patient's condition to doctors. If they are not able to effectively communicate such information, serious medical errors can occur (Burke, 2004).

The use of rhetoric has influence on the communication style of the nurses in this study. To ensure the effective use of rhetoric in their communication with patients, nurses must consider each patient as an individual instead of approaching them in a one-size-fits-all way (McCabe, 2004). For example, some individuals may not speak openly about private health matters, so nurses might have to be more prudent. Also, some individuals may disapprove of physical contact between strangers, so if a nurse pats a patient's hand to comfort him/her, he/she may take offense (Sheets, 2001).

The findings have implications to initiate interventions for consistent retraining of nurses in the usage of both verbal and non-verbal languages and organizational rhetoric (McCabe & Timmins, 2006). Nurses are the pivots and agents of communication in healthcare organizations, holding the power to understand and be understood. Nurses are given a huge responsibility to communicate effectively and relay all important information accurately and efficiently. When communication breaks down from the side of nurses, so does the delivery of quality healthcare (Anderson & Mangino, 2006).

### *Implications for Administrative staff*

The take-home message from this study for administrative staff members is clear: Administrative staff of healthcare organizations around Canada should make an initiative to make themselves the advocates for effective communication across all audiences in healthcare organizations (Lowe, 2002). Effective interpersonal and communication skills may be more critical for administrators among other professional groups in healthcare organizations. For example, they manage all the activities of doctors and nurses, as well as the patients. They also serve as an official mouthpiece for their organizations, so they have the responsibility to act as motivators and promoters of effective communication (Ashkanasy, Wilderon, & Peterson, 2000). The findings have implications for organizational wide training, to teach all employees effective communication and conflict resolution skills in healthcare organizations (Garman, Leach, & Spector, 2006).

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## Appendix A: Interview Guide

1. What is your mode of communication?
2. How effective do you think that mode of communication is?
3. How comfortable are you using professional language in your communication at work?
4. Does the use of plain language help you in communicating effectively at work?
5. Do you think you are an effective communicator, as in listening attentively to others and addressing them in manners they understand easily? Why?
6. Which language are you comfortable using at work? Are you comfortable using the medical jargons or the lay man's language? Why?
7. Does it pose a challenge in the way you communicate with others?
8. Is there any form of language that you are not allowed to use in your line of duty? the use of apologetic language when you make a mistake in the cause of carrying out your duties
9. Do you motivate other people in your communication as in making them happy and doing what you want them to do? How?
10. Do you believe in the use of language as a method of motivation?
11. Do you think that method of motivation is effective? Why?
12. Do you believe in the effective use of language to please or persuade patients and colleagues? For example making others feel better with a situation? Why?
13. How often do you motivate others in your communication? how often do you use nice words to make patients or colleagues feel better
14. Do you find it helpful in your line of duty? How?

15. Do you praise others for their good work or efforts? For example, do you say thank you or show appreciation when a nurse help out in an operation or a doctor helps serve a serious medical situation in the hospital. How?
16. What are your methods of motivating patients and colleagues in your communication?
17. Do you believe in the use of rhetoric (persuasion and motivation) when communicating at work with patients and colleagues? Why?
18. Do you find the use of rhetoric real, flattery or deceptive? Why?

## Appendix B: Informed Consent Form

**Title of the study:** Communication in the Health Care Organization: The Use of Rhetoric

**Name of researcher:** Mr. Jibril Yahuza
Graduate Student
Department of Communication
Faculty of Arts
University of Ottawa
Ottawa, ON

**Name of supervisor:** Dr. Rukhsana Ahmed
Associate Professor
Department of Communication
Faculty of Arts
University of Ottawa
Desmarais Building
55 Avenue Laurier East, Room 11147
Ottawa, ON K1N 6N5, Canada

**Invitation to Participate:** I am invited to participate in the above mentioned research study conducted by Mr. Jibril Yahuza and supervised by Dr. Rukhsana Ahmed as part of Mr. Yahuza's Master's thesis.

**Purpose of the Study:** The purpose of the study is to examine how participants use rhetoric in strategic communication, how they use rhetoric in motivating people, examine how the use of language affects rhetoric in organizational communication and finally, establish to what extent are they aware of the use of rhetoric in professional communication

**Participation:** My participation will consist essentially of attending a one-time audio-recorded interview of 30 minutes scheduled at my convenient date, time and place, during which I will be interviewed about my professional communication at the work place.

**Risks:** My participation in this study will entail that I volunteer personal information, and this may cause me some inconvenience. I have received assurance from the researcher that every effort will be made to minimize this inconvenience; I am under no obligation to answer any questions that will inconvenience me

**Benefits:** My participation in this study will contribute to existing literature on health and organizational communication and also contribute in providing both government and private organizations insights into the use of rhetoric in professional communication with the hope of enhancing the quality of communication in the workplace.

**Confidentiality and anonymity:** I have received assurance from the researcher that the information I will share will remain strictly confidential. I understand that the contents will be used only for purposes for which the collected data will be used and that my confidentiality will be protected as no other person except the researcher and his supervisor will have access to the information I provide.

**Anonymity** will be protected in the following manner: My personal details and that of my organization will not be revealed at point in the research or in any publication.

**Conservation of data:** The data collected, audio recordings of interviews, transcripts, and notes will be stored in a secured locker at the thesis supervisor's office at University of Ottawa campus (Desmarais Building, 55 Avenue Laurier East, Room 11147) and electronic data will be safeguarded on a password protected computer for the period of the research and only the researcher and his supervisor will have access to it.

**Voluntary Participation**: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be deleted or shredded.

**Acceptance:** I,……. agree to participate in the above research study conducted by Jibril Yahuza of the Department of Communication, Faculty of Arts, University of Ottawa, which research is under the supervision of Dr. Rukhsana Ahmed

If I have any questions about the study, I may contact the researcher or his supervisor.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON K1N 6N5.

There are two copies of the consent form, one of which is mine to keep.

Participant's signature: Date:

Researcher's signature: Date:

# Appendix C: REB Approval

**File Number:** 09-14-13 **Date (mm/dd/yyyy):** 10/29/2014

Université d'Ottawa
Bureau d'éthique et d'intégrité de la recherche

University of Ottawa
Office of Research Ethics and Integrity

## Ethics Approval Notice

### Social Sciences and Humanities REB

**Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

| First Name | Last Name | Affiliation | Role |
|---|---|---|---|
| Rukhsana | Ahmed | Arts / Communication | Supervisor |
| Jibril | Yahuza | Arts / Communication | Student Researcher |

**File Number:** 09-14-13

**Type of Project:** Master's Thesis

**Title:** Communication in the Health Care Organization: The Use of Rhetoric

| Approval Date (mm/dd/yyyy) | Expiry Date (mm/dd/yyyy) | Approval Type |
|---|---|---|
| 10/29/2014 | 10/28/2015 | Ia |

**(Ia: Approval, Ib: Approval for initial stage only)**

**Special Conditions / Comments:**
N/A



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**File Number**: 09-14-13 **Date (mm/dd/yyyy)**: 10/29/2014

Université d'Ottawa University of Ottawa
Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement (2010) and other applicable laws and regulations in Ontario, has examined and approved the ethics application for the above named research project. Ethics approval is valid for the period indicated above and subject to the conditions listed in the section entitled "Special Conditions / Comments".

During the course of the project, the protocol may not be modified without prior written approval from the REB except when necessary to remove participants from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the project (e.g., change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, including consent and recruitment documentation, should be submitted to the Ethics Office for approval using the "Modification to research project" form available at: http://www.research.uottawa.ca/ethics/forms.html.

Please submit an annual report to the Ethics Office four weeks before the above-referenced expiry date to request a renewal of this ethics approval. To close the file, a final report must be submitted. These documents can be found at: http://www.research.uottawa.ca/ethics/forms.html.

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5387 or by e-mail at: ethics@uOttawa.ca.

Kim Thompson
Protocol Officer for Ethics in Research
For Barbara Graves, Chair of the Social Sciences and Humanities REB



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## Appendix D: Recruitment Text

Dear Dr. Board

I am currently carrying out a research titled “Communication in the Health Care Organization: The Use of Rhetoric” and your participation in this research will be very much cherished.

I would appreciate the opportunity to meet with you briefly and discuss the practice of your specialty. I am especially interested in your views regarding communication in the health care organization and the use of rhetoric. Any further insights you have would be greatly appreciated.

I know that you must be quite busy, so I assure you I will be brief -- taking up no more than 45 minutes of your time.

I will contact your office next week to inquire about a convenient time for scheduling this informational meeting.

Thank you very much for considering this request.

Sincerely,

Jibril Yahuza

## Appendix E: Thematic Analysis – Data Chart

| Code | Themes | Findings/Evidence | Conclusions/Thoughts |
|---|---|---|---|
| Communication in healthcare | Perception of communication in healthcare | The doctor with 15 years of practice experience stated that "Patients must ask questions about their treatment if they are unclear on the instructions, and communicate adequate information to doctors and nurses, for certain information help in advancing medical progress. Information gathered at a hospital or doctor's office can help track things like outbreaks of airborne or other communicable diseases."<br><br>The administrative with 16 years of work experience explained that "documentation of communication that has taken place between a doctor and a patient can provide a defense for the hospital or ammunition for the plaintiff." | Participants perceive communication as a fundamental component in healthcare. |
| The role of healthcare audience | Therapeutic alliance | The doctor with 17 years of practice experience stated that "the provision of quality healthcare is a team work, is not a one man show, all hands are needed in creating the alliance for quality healthcare."<br><br>The nurse with 5 years of nursing experience stated that "therapeutic communication is a concept that is essential to nursing and the art of healing." | Participants view the delivery of healthcare as team work. |
| Communication among audience of healthcare | Patients-centered communication | The doctor with 15 years of practice experience "We tend to be uncomfortable relating to our patients' emotions. Remember that a | Patients participate actively in decisions regarding their health. |

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| organizations | | little human kindness could make that patient your best advocate."<br><br>He further explained that "acknowledging the patient's emotions and values demonstrates that you recognition of their individuality." | |
| Style of communication in healthcare organizations | Rhetoric and communication in healthcare | The doctors with 12 years of practice experience stated that "it is important that communication is at the professional level in healthcare delivery, however, every physician has different abilities and capabilities."<br><br>The nurse with 14 years of nursing experience elaborated "I think, depending on who you are using it with, like if the person has the ability to make their own decisions then you should be upfront and honest for sure, but if you are working with someone who has a type of dementia or Alzheimer's, it is for their best interest, you have to use rhetoric, because you want them to take their meds or influence their behavior positively." | Participants use rhetoric in their communication. However, participants use rhetoric unconsciously or use without taking into accounts its importance in their communication. |
| Modes of communication in healthcare | Verbal and non-verbal communication | The doctor with 15 years practice experience explained that "effective communication in healthcare requires all the healthcare professionals' senses, attention, interest, and competence to analyze behavioral and emotional responses within the context of a given interaction."<br><br>The administrative staff with 16 | Participants communicate with both verbal and non-verbal actions |

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| | | years of work experience stated that "An easy and cost effective way to help patients and their loved ones remain involved and informed is through the use of patient and family communication boards. These boards, usually in the form of dry erase boards, allow the care team to post their names for patient and families, and include some basic information, such as the room number and patient room telephone number. " | |
| Plain and medical language | Use of language | The doctor with 12 years of practice experience stated that "We don't really want to use professional language with a patient because they do not understand what you are talking about. So you want to break it down to their own language, to what they understand. So we don't really use medical terminology for the patient. When you do, you are increasing their fear because they think the problem they have is unsolvable by using these kinds of big medical jargons. So we don't really use medical jargon in front of the patient, but when we are discussing it among ourselves, medical colleagues, we can use medical terminology. Because that way is a fast way of communicate with each other"<br><br>The administrative staff with over 33 years of work experience explained that "we say I'm very sorry I did this, and I'm thinking of doing this or that to fix it." | Participants use both plain and medical language when communicating with their audiences; they use both languages with respect. |

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| Understanding the usage of language | Effective communication | The administrative staff with 16 years of work experience asserted that, "For me effective communication is very important so I work hard on being a good communicator."<br><br>The doctor with over 40 years of practice experience expressed that "I tend to explain yes, whatever is going on to the patients, I try to use analogies in a practical sense, and I have never been accused of not explaining well enough to people both patients and colleagues here. I would say yes; I think I convey the message to the patients effectively." | Participants are striving to be effective communicators; however, there is no proof that they are effective communicators. |
| Actions taken to improve delivery of quality healthcare | Rhetoric and motivation in healthcare | The administrative staff with 33 years of work experience expressed that "I like to be happy, so I need happy people around me. So I will do all my best at all times to motivate and excite people around me. And I'm talking about the staff with who I'm working, the patients that are coming and the doctors."<br><br>The doctor with 12 years of practice experience explained that "If you are treating your family members you motivate them as well; you don't want anything wrong to happen to them. You always want to provide them with the best care you have." | Participants believe that motivation serves as therapy |
| Action taken to create hope in healthcare | Psyche communication | The doctor with 12 years practice experience explained that "It's a good way of communicating because it's psyche. When you say psyche, for example, if patient says, 'I'm | |

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| | | going to die' you motivate that patient by telling him 'you're not going to die because we are taking care of you.' that's a psyche communication."<br><br>The nurse with 7 years of nursing experience stated that "I say; hey, good morning, my name is this, I'm going to be your nurse for the next twelve hours and I hope we will have a nice time together, how was your night, did you have a good sleep, do you have any pain. This is how you approach and convince them that you are there for them, not for yourself." | |
| A form of treatment using communication | Motivation as therapy | The nurse with 14 years of nursing experience indicated "Sometimes they will not take their meds; you have to kind of really use persuasive language to make them take it."<br><br>The doctor with 12 years of practice experience stated that "We have seen the results of motivation and when something produces results, we always follow it up." | |