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Ethics of Patient Records: Understanding the Tool of Electronic Medical Records in a Clinical Setting and How They Impact the Patient-Physician Relationship

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ETHICS OF PATIENT RECORDS: UNDERSTANDING THE TOOL OF ELECTRONIC MEDICAL RECORDS IN A CLINICAL SETTING AND HOW THEY IMPACT THE PATIENT-PHYSICIAN RELATIONSHIP

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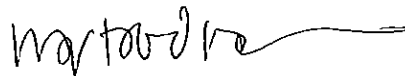
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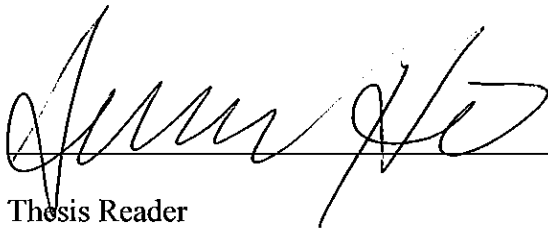
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    "Wherever the art of Medicine is loved, there is also a love of Humanity."

       – Hippocrates

PREFACE AND ACKNOWLEDGEMENTS

My thesis idea stemmed from my own experiences with healthcare where many physicians were concerned with my quality of life and meaning in the world predominantly to my medical conditions. The medical attention I received from these physicians impacted me and made me feel whole and filled with possibilities the world could offer me. On the other hand, there were many instances in my life where I felt as though I was part of a stack of papers that was shuffled from one appointment to the next and I never developed a meaningful relationship with these physicians. This did not necessarily have a negative impact in my life, but it raised my awareness to a system that is primarily focused on revenue, efficiency, and rapid turnovers rather than quality of care for all life. From this I sought to answer the question of how technology's role in medicine impacts the patient-physician relationship and treatment of patients as people.

I would like to acknowledge my thesis advisor, Becky Vartabedian, PhD, who has offered constant support, encouragement, and commitment throughout my thesis-writing journey. She has worked diligently with me to ensure that my thesis adequately portrays my passions of the medical system alongside my interests in philosophy. She has also provided me with invaluable knowledge and skills. In addition, I would like to acknowledge my reader, Amanda Hine, PhD, who has provided me with insightful feedback and strengthened the arguments within my thesis. I would also like to thank my family and friends for their endless support and encouragement to follow my dreams and go above and beyond in all that I do. Finally, I would like to thank the Regis University Honors Program, Dr. Kleier, Dr. Narcisi, and Dr. Howe. This program has challenged me and has deepened my thinking and understanding of the world and I am honored to have been a part of this phenomenal program that has raised me to higher standards and expectations for my future successes as a lifelong learner.

INTRODUCTION

You are a number. In actuality you belong to many numbers: the second child, bank account number or a phone number. This may come as a shock to some people, but in terms of managing a growing world of over 7.5 billion people, a system of digits is necessary to store and administer information. There are employee badge numbers, social security numbers, bank routing numbers, numbers, numbers, and more numbers. The list is endless, but they all have one thing in common: they are specific to you and your personal information; they follow you throughout your entire lifetime, and these numbers contribute to the composition of who you are as a person. With the extreme use of numbers it is certain that they will never cease as long as the population continues to grow and the advances in technology increase. However, these numbers and databases of information are not all bad. They allow for much of the world's research, such as censuses that are conducted in countries to determine the average gross income or racial demographic of a town in order to implement change or continue the same patterns in order to benefit the greater good of society. The scary part is that most people do not know this personal information is being accessed. This is because of the ease of access and universality of technology that is prominent across the globe.

Technology has, arguably, led to a new way of social interaction, where there is a disconnection between two people simply because they are not sure how to interact with one another. The introduction of Twitter, Facebook, and other social media has ultimately

lead to a world that is separate from social reality, and physically separated by a pixelated screen. In this day and age, any answer can be found by doing a quick Google search. Actually, the phrase "Google" it is so commonly used by society that it is found in the Merriam Webster dictionary and is defined to be "the use of the Google search engine to obtain information about (someone or something) on the World Wide Web" ("Google"). With all this information at one's fingertips, there is no limit to what people around the world may know. Yet, the information is out there and slowly beginning to replace certain personable skills such as eye contact and legible handwriting (Shachak, A. and Reis, S., 2009).

The replacement of personable skills impacts those in society, since technology acts as a bridge between two different worlds in order to make one's life easier, comprehendible, and faster. For example, an online bank account is more efficient, secure, and convenient to use than going it the bank every couple of days to withdraw or deposit money. In this case, technology is not limiting, but boundless and allows for more possibilities to make one's life better. In many situations, technology does make our lives better and it bridges reality with tech to create an organized system. Though this system is improving human life, there are instances where the use of technology can be restrictive and inefficient and the old way of paper and pencil recording is often taken for granted.

The technology within the medical system, specifically where millions of people's information is linked to an electronic medical record (EMR), is taken for granted. This record acts as a resource for physicians to access that hold information from

medical history to patient concerns and collaborative elements from other physicians. While the record itself is uploaded to a cloud of information, all that is stored inside is information that is critical to one's health and identity. The assigning of these numbers is less humanistic, like a social security number or school ID number; the medical record is assigned chronologically. For example, when Bob Smith is born, he is assigned the record 12468; if you are born next in the computer system, you are assigned record 12469. People rarely know information in their record because of how it is used as the main way for physicians to communicate their observations between other physicians.

While the information in these records is essential to understanding the history of a patient in relation to their health, predispositions to certain disease, and current conditions, it is information that many assume to be private – or at least private between the physician and patient. The reality is this information is accessible by anyone with the proper credentials to view this information, such as Health Insurance Portability and Accountability Act (HIPAA) certification or department clearance. In an ideal world this information remains in the correct hands, but how does this awareness of the possibility of universal access effect the trust of patients and integrity of the physicians and clinicians observing such information? While physicians, care providers, and researchers are bound to the contract of protecting patient privacy and safety there is always the possibility of information being shared to unwanted sources. An example of this is seen in research. In all cases, clinical research requires Institutional Review Board (IRB) consideration and permission when dealing with secured patient information, typically in a hospital database. Most of the time the research of specific patients in a study are linked

to a number, which is then used as an identifier within the study. While this protects the patient's privacy, it also diminishes them to a number rather than a human being with a name. This act of dehumanizing, while not intentional, should not go unnoticed. Later chapters will explore the connection between technology and security that lie in the medical system and the patient-physician relationship.

I argue that a better understanding of how to utilize and find a justification for the use of electronic medical records in necessary, it should be more than a way to communicate within the system. With the hopes of furthering my education and testing my ethics in medical school and as a physician, it is crucial to analyze and deduce what my personal beliefs are both in what I expect from a physician as I interpret what I would expect from myself. To turn this point around, my claim for this thesis is not to come to any conclusion of the adequacy or inadequacy of EMRs or a solution to better EMRs, but rather the justification behind using them in a clinical setting. Obviously, EMRs are essential in research and understanding the details of a patient's history and conditions from a physician's point of view, but the well-being and relation with the patient is also an important component in medical care. Therefore if one can justify the use of EMRs simply to gather information, that is private between the physician and patient, and then be fully engaged and interactive in the clinical setting, this can lead to better treatment and overall better medical care.

In order to understand the justification and use of electronic medical records to become a more efficient physician, it is imperative to look at all aspects of the argument.

To begin, we will look at the established positions and assumptions about humans and how they should be treated and viewed with and without the EMRs. This will lead to the analysis of the critical theory of human beings as well as the ethical components of EMRs in medical practice. The theory of human beings of interest in phenomenology, where each person's differences lead to a greater understanding of intrapersonal and interpersonal views. The intrapersonal component is crucial to understanding the expectations people have of their physicians, as they are the ones healthcare serves, and whose opinion is the most valued. When looking at interpersonal relations, we see that the theory of human being theory develops into the idea of phenomenology and how one's experiences contribute to their beliefs of how they are oriented in the world. We will take a look at how certain philosophers and ethics researchers view this phenomenon in relation to medicine and it's effects on society. In order to come to a relative answer to the proposed question, it is required to look at the fundamental practice of EMRs during patient interaction and the ethical analysis behind this.

From a medical standpoint, the EMRs are extremely prevalent and used by many physicians and healthcare providers around the world due to their ease and quick relation to a patient that distinguishes them from hundreds of others. However, there is the issue of disconnection when a person is seen as a number or electronic chart rather than a person. For example, if a patient comes in for a routine clinical visit, the physician may be engrossed with the information on the computer screen rather than addressing the patient's current concerns. This is not only an American problem, but also one seen internationally that impacts how a patient sees and interacts with their healthcare provider

(Ball, M.J. and Lillis, J., 2001; Booth, N. Robinson, P. and Kohannejad, J., 2004). Therefore, the concern is not whether or not EMRs are wrong or right to have in medicine and a clinical setting, but whether they are adequately justified or unjustified in practice.

Furthermore, when taken into a clinical setting, there is evidence that the use of EMRs have both positive and negative effects on the patient-physician relationship as it is an effective tool to gather and record medical information (Ball, M.J. and Lillis, J., 2001; Shachak, A. and Reis, S., 2009), but it takes away from the affinity and emotional connection between a patient and physician in the clinical setting. In order to address this issue, it is important to look at the dependence on the practice and use of EMRs and how they require the physician to think about humans, perhaps even in a different way than what is expected.

Previously proposed expectations from the patient that were studied are related to the ability for the physician to have a clear understanding of the patient's conditions while maintaining a comfortable amount of communication. Shachak and Reis studied the patient-doctor communication with the presence of EMRs where they found that there are both positive and negative influences when EMRs were used in a clinical setting (Shachak, A. and Reis, S., 2009). The positive impact was seen in how well the physician was aware of the patient's current conditions because the information was accessible and present on the computer in front of them during the visit. However, this lead to the negative effect of having a weak connection with the patient because they were more concerned with the computer tasks and focused less on eye-contact with their patient.

These effects, both positive and negative may be simple and not an issue at the time, but in the long run these physicians are not aware of the greater implications they have on each patient as well as their own personal skills.

When there is a disconnection in the patient-physician relationship, there is not only a lack of communication, but there is the possibility that the care and monitoring of one's health will not be adequate. Along with the lack of communication amongst patients and physicians, there is the possibility of teams of doctors not working well and sharing ideas and thoughts of shared patients. There is much debate over this question primarily because every physician is a person and all human beings are different. Based on these differences, one may say that the EMR is beneficial to providing the best care possible, whereas another may believe that the EMR in a clinical setting is distracting and removes the physician from the interaction with a patient. Therefore the question of whether or not medical records in a clinical setting, and to go further, technology in a clinic are adequate must be addressed. If EMRs are an adequate way for one to provide care, then the patient-physician relationship begins to become less personal and there is often dissociation between the physician and the patient. The dissociation can be seen in a lack of trust and identity in both the patient and physician, when these are compromised, the ability to treat an ill person or be the caregiver becomes difficult. Chapter 1 will discuss the trust in relationships in greater detail.

The advancements in technology introduce the ability to store and access patient medical records through using EMRs in the clinical setting. While it may not hold much significance to or impact the physician, there are instances where there was an observed

disconnection between the patient and physician when a computer was present upon the clinical visit. In order to best improve the patient's healthcare, one would argue that it is necessary for a physician to be fully engaged with the patient; after all, they are creating a relationship that is built on trust. To do this, there needs to be a justification for the use of EMRs in the clinic and how they do or do not disrupt the connection that is so crucial in medicine. If this justification goes undefined, there is the possibility that there will be a case of malpractice where information was missed, misinterpreted, or ignored, which is the fault of the physician. Thus, the use of electronic medical records must be justified as an adequate resource in the clinical setting when improving the patient-physician relationship.

CHAPTER 1
Established Positions

In this chapter, I discuss how the concept of phenomenology, a philosophical approach to the interpretation of a person through their lived experiences, exposes the misuse of electronic medical records (EMRs) and their effects on the patient-physician relationship. Thus, the relationship between the physician and patient will be discussed to show the limits and expectations within a clinical setting. I am most interested in how trust is the most essential part of the patient-physician relationship, and how this can be lost due to the advances and use of technology. This is especially true in the clinical setting, which we will take a closer look at in this section.

Thoughts on Existence

In the case of the electronic medical records, one must begin with analyzing the condition of the patient. In this clinical context, analysis is not the same as diagnosis. One would argue that analysis is the determination of the physical qualities, in a person, based on what they consist of beyond the flesh and skeleton. I find myself asking questions such as: do humans have souls? How are other people different from me if we are all the same species? Do other people see and think as I do? All these questions soon become perplexing and daunting, especially as we try to find our niches in the world. There are

many methods to cracking these cases and answering such questions, but the most relative approach is by beginning at an individual level. One suggestion is through a method known as introspection or reflection of mental and emotional processes (Russon, J., 2014). By starting at the roots of what makes us human, there is the possibility that we can begin to understand why we are human and how we fit into this world. I agree with Ann Berlak as she claimed "introspection as ordinarily understood is more often an imaginative *construction* than a retrieval process" (Berlak, A., 2008). Based on our histories, experiences, and goals, our minds and emotions are influenced and once we come to this realization, we can have a better understanding as to where these processes were derived.

Turning inward on these processes allows one to see that the world is dependent on uniqueness and an understanding of what lies deep within. When one comes to this realization, it can be referred to as introspection. Introspection, at an individual scale, allows one to turn inward to determine what kind of person they want to be. Of course, there is a lot that makes up a person, and some desired characteristics may not be attained through this process, which is why there is jealousy, lust and greed. I would argue this is a quality of imperfection is what makes us all human beings. Furthermore, this idea can be related to a searching for more, understanding where we come from, and desiring to be something greater than what we already are is constantly working in and shaping our lives. This is a sense of identity that is shaped by our personal experiences as well as the perceptions that come from the external world. An example of this is the question: what do you want to be when you grow up? There is typically an expected transformation of

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thought from when someone is five years old and wants to be a princess, to becoming an accountant when entering college. This transformation is characteristic of humans because it is the realization that one's role that is expected in society is dependent on how they associate themselves in the world (Russon, J., 2014). Over the course of the twelve or so years between the first career question and the one prior to entering college, a lot changes in a person. The fantasies and dreams of simplicity begin to fade as time continues and we are faced with reality, a world of conformity and dependence on one another's successes. This conformity, arguably, leads to a more secure world and a world of understanding (Russon, J., 2014; Fishman, J., 2007). However, one cannot reach this conclusion if they are first not willing to construct their histories and processes that brought them to this moment in their life. This is the approach of phenomenology defines our identity to be where our experiences and goals in life are analyzed to give us a better picture of the life we are living in relation to the world around us.

Furthermore, if each individual comes to the same ultimate realization that our lives have more meaning and are destined for greatness through one another's contributions to society, there is the possibility of realizing that all humans carry the same potential. With this truth in line, we can narrow the focus in on the contributions of larger systems that impact humanity. Before leading to specifics, it is worthwhile to see the contributions of a community – made up of individuals – and the impact a community has on the experiences, decisions, and position of an individual in the world. While a community is composed of individual people, they are composed of something on an even more fundamental level of what it means to exist in this world: desire to be part of

the community and world. Every human has this relationship with the world and searches for exactly what that relationship is: meaning and purpose. There is the metaphysical and Cartesian ideology that must exist to enable one to have passions and desires (Leder, 1992). One could argue that a person could live in this world without such passions, but my counter argument would be that the world we live in does not cater to these dispassionate types of people, rather it makes their lives more difficult and complicated because they are forced to create their own path in solitude. Therefore, to exist one must have a sense of meaning that is rooted in their desire to be a passionate entity in this world.

Secondly, in a world where we exist, we must also be able to interact with other existing beings (Nelson, M., 2016). Through these interactions it shows that we are more than just matter in space, but actually have the ability to connect with other beings that exist as we do. These encounters with others – who also have goals – solidify the fact that there is a sense of community to what humans strive for. This is seen in any type of setting, for example an entrepreneur starting a business, where one person is dedicated to the development of a company, and others who are interested and have different strengths contribute to the growth and success. Inversely, there is also the possibility that our differences set us apart, which allow for warfare and distinction between societies as commonly seen in the ideology of Natural Law discussed by John Locke. In this case, Locke argues that survival is of the utmost importance and humans will do anything to survive and thrive (Locke, J. and Macpherson, C.B., 1980). While this is a valid argument, I hold the belief that humans are past this point as existing beings. What I

mean is that, as existing beings, we have more desire and connection with one another to survive in this world synergistically. This is due to a human's ability to rationalize within the world and determine goals and meaning within themselves. Although war and differences are prominent, this is simply a point of not realizing this connectedness with one another. Acceptance of differences between beings is the most difficult and limiting part of change in a large system, which is why introspection at a personal and communal level is essential.

Lastly, through these positive interactions we must be able to find confidence, support, and trust that lead us to fulfill something beyond ourselves. This trust can be lead to the greatest success of any human being and is necessary for fulfilling one's purpose in life due to the support of others in the community, especially in the clinical setting. Though it may be far-reaching, it is not impossible. We create the world we live in because of our interactions and experiences we have with one another and we must be able to relate to others in order to live. Is this not what it means to exist in the world? Thus the definitions of existing aid our understanding of relationships – built from trust – that are essential for our ultimate well-being. This is because trust leaves us to be vulnerable and exposed in the world, but it also allows for a support system and better understanding that our uniqueness and identity is what makes us human.

Further implications of our existence extend into larger systems that require certain degrees of trust, communication, and understanding. One example is seen in the clinical setting and the expectations of this system that are made by the patient and the physician. The question at hand is how patients view themselves as existing within the

clinic. Are they simply another patient on the agenda that will be hustled through paperwork and a brief physician encounter, or are they autonomous beings that will be listened to? I argue, that humans, in this large medical system, are often not seen as beings, but rather objects *being used* for treatment and study. One French philosopher, Maurice Merleau-Ponty, wrestles with this idea of distinguishing between the body-as-object and claims that we exist as a "lived body" that has perception, motility, experiences, and desires (Merleau-Ponty, 1962). The "lived body," he characterizes, is what makes us human and different from objects or machines. If patients are treated as humans, with external and internal feelings derived from a "lived body," rather than being subjected to what is written in the chart, there is the possibility that the care of medicine and attention to detail in the clinic will flourish. Though later chapters will discuss the "lived body" in greater detail, the phenomenological approach will necessarily observe the relationship between patients and physicians in a large medical system.

Another position to be observed is how technology impacts the way we see ourselves as existing. One approach people use to view their existence is through a technological lens. This is done through the use of digital portrayals or avatars that one may have on an online source such as a social media site. There have been a few findings on how this is seen as a way people characterize their existence because it is how they view themselves. Leigh Johnson writes that there is a virtual or digital self that is thought to be real, but it is not true. The reason this virtual or digital self is not true is because it is often not the, as she calls it, "Flesh-and-Bone-You," but rather something called the

"Digital-Self" (Johnson, L., 2013). There is a distinction between the two and they ultimately have two different definitions. On one hand, the "Flesh-and-Bone-You" is physical, where one's existence is distinctly clear and perceivable. This physical body is capable of interacting with the world and other humans in a more realistic way, Johnson claims, and is thus a more representative way of being in the world (Johnson, L., 2013). On the other hand, there is the "Digital-Self" that is the illusory image and rather an extension of one's self. The difference here is that the "Digital-Self" is something that cannot exist in the physical world, but perhaps it is the truer version of oneself as they perceive themselves. Thus, the "Digital-Self" becomes dependent on the physical and experienced qualities felt by the "Flesh-and-Bone-You." In one instance, an avatar or digital identity creates a façade of the actual life and experiences of a person. Ultimately, qualities of the "lived body" with physical experiences are blurred when incorporated and transferred to a profile of a digitized self.

One application of the "Digital-Self" versus the "Flesh-and-Bone-You" is seen in social media. Social media acts as a platform that shares information specific to only one aspect of a person's identity, what they want the public to know. In other words, the information shared on Facebook or Instagram, while relevant to one's life, does not tell the whole story and is edited down and represented by characters, images, and daily posts rather than physical qualities.

When linked to the question of the medical records, we can see how both of these points of view relate to the overarching relationship patients wish to have with their physicians: to be seen physically and understood technologically. A patient seeks a

physician's help and requires examination as a physical being, as the "Flesh-and-Bone-You," but also interpretation and record as the "Digital Self," the form that is permanent and characterizes who we are. This is very much a late 20th- early 21st-century phenomenon, but one that is evident in medicine because, I would argue, there is a disconnection between the patient and physician. Furthermore, this approach proposed by Johnson, is a concrete example for how these patients want to be viewed as real, existing, human beings from their healthcare providers. In an ideal situation, these patients would be able to have a connection with their physician where they are able to identify in anyway they want on paper (the Digital-Self) and then interact as the Flesh-and-Bone-Self where they are seen as a real person. This relates to the ideology of the Cartesian corpse that focuses on the inanimate and dead body rather than the living.

According to Drew Leder, a physician with a doctorate in philosophy, the practices and diagnoses of medicine are based on the physical and inanimate corpse. This instills the belief that medicine is somewhat dehumanized and physicians are trained with this type of mindset to treat the symptom rather than the patient. Treating the symptom before the patient will be elaborated on later as the patient-physician relationship is discussed in greater detail below. The uses of technology are then different for the physician, where the goal is to try and connect the patient coming from the outside of the hospital system, or "other", to a system of medicine that is beyond their comprehension. For example, a patient may come in with a sharp abdominal pain, but seeks the help and advice of a physician who has an inside perspective and understanding of more advanced medical terminology and treatments. Technology is simply a way for this information to

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be conceptualized for the patient with a general understanding of the pain/discomfort/unease they are experiencing, whether in electronic records, information from the physician, or Internet resources.

Development of Relationships

Relationships can be created in many different ways and for various reasons. However in order to maintain a relationship, it requires trust. This is not a strenuous requirement for a relationship because it can be easily upheld on both sides; the only difficult part is gaining and keeping one's trust in the process. For a physician and a patient, this relationship is not extreme where they are either "best buddies" or "mortal enemies," but rather a way to relate to and understand one another as human beings. Therefore, this type of connection is more relaxed but it still requires engagement on both sides.

For a physician, the stereotype others see is for them to be relatable, approachable, and intelligent. This belief of the physician also includes being welcoming, humble, and caring, but are all of these qualities always upheld in the clinic? One would argue that physicians are too thinly stretched and more stressed in their professions, and adversely are unable to care for their patient completely. While it may not be evident in every physician, the stress of medicine soon begins to grow and impact how one treats his or her patients. Some may be more inclined to completing their chart work and rapid firing through all the patients on the schedule for the day. But something in this routine is lost in the physician's day that is essential to building trust, and that is patience. While my perspective comes from the outside of the system and is the viewpoint of a patient

and a student, it is important to consider that those looking in are not fully aware of medicine as a practice and the duties of a physician to keep the system running. After all, a physician is not typically seen as a comrade, colleague, or coworker by a patient, rather, they are seen as a role model and someone who wants to care for their needs. The role model and patient relationship then creates a power dynamic between the physician and patient prior to the clinical encounter because of the differences in how physicians are seen by patients and other physicians. One situation is a role model position, whereas the other is a friendship. When the power dynamic idea is tested or stretched too far, this may leave the patient questioning if the physician they have is worthy of their trust and sharing their most personal information with. On the other hand, there is also trust required of the patient. The patient trusts that all the information they are given by their physician is adequate and in the best interest of their personal care. Either way, trust is required between the patient and physician in order to have the most efficient relationships. This trust allows for the vulnerabilities of the patient's identity to be received and healed through no judgment and acceptance of their differences.

In any relationship, the ability to communicate is always of utmost importance. After all, this is how we as human beings interact and share our thoughts, perceptions, dreams, and experiences. Without the ability to communicate, a part of who we are as human beings is, arguably, lost. The common misconception is that a conversation is based on the language and speech that we use to convey ideas, however there are many components to what make a conversation. Body language, eye contact, facial expression, tone, receptivity, physical touch, are to name a few components that contribute to

communicating with other beings. This study of the patient-physician relationship is interested in how these components not only allow the patient to feel comfortable, but also for the physician to be able to gain the trust of their patients. The word commonly used to describe the dialogue between the patient and physician is rapport, which translates to the satisfaction of the patient based on the physician being able to answer socio-emotional questions regarding their health (Ball, M.J. and Lillis, J., 2001; DiMatteo, M.R., 1979; Sullivan F. and Wyatt, J.C., 2005; Sullivan, F. and Wyatt, J.C., 2005). One could think of this as a connection, relationship, or understanding between the two beings.

In this connection, it is crucial for the patient to be seen as an integral part of the treatment and clinical encounter. We will dive deeper into this concept in following chapters, but this integration and inclusivity seen in medicine is related to hermeneutics: the practice or study of interpretation (Leder, D., 2016). This scenario calls attention to the position of the patient, physician, instrumentation, and medical system as a whole, collective group. One example of how this type of organization is displayed is as that is model based on a descriptive and prescriptive relationship. The descriptive is the direct encounter with the patient and physician in a clinical setting, which is then transitioned to the prescriptive piece where there is analysis, collaboration, and diagnosis. While this model is fairly straightforward and is the ultimate goal of medicine, there are holes that lead to ambiguous results, and unclear patient EMRs. This is due to the inability for a patient's story to be effectively expressed by the secondary source: the physician to the EMR. Thus, while the patient may be truthful in their storytelling and simply seeking

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answers from the physician, the information conveyed holds the highest priority. Dr. Daniel Wozniczka, an internal medicine resident at Northwestern University, said that the most important part of medicine is caring for your patient. He claims there are many ways to do this, but the most important is to see them as a person in need of help (Wozniczka, D., 2017). In this sense, humanity is restored and the idea that we are all humans searching for compassion and trust, healing and relationships are evident. There is not necessarily a solution, but rather a change of mentality to one that approaches medicine from a more holistic and embodying practice. The only way trust can be formed is if the information shared through conversation is correctly and accurately received and transmitted.

Adequacy of Clinical Records

To find this balance, especially as a practicing physician, another position regarding the adequacy of electronic medical records must be considered. There are many opinions on this matter, but the two most distinct, yet opposing, ideas are that EMRs have a positive as well as a negative influence on the patient-physician relationship. I discussed this issue briefly in the Introduction, but a deeper analysis of the issue is now possible. The terms positive and negative relate to the ability for the physician to perform their job. After all, it is not the patient's job to go into a clinic and tell the doctor what their diagnosis is, that is the doctor's job! Therefore, the positive term refers to the ability of the physicians studied to be able to multitask by: asking critical questions about the patient's life and concerns, while inputting the information given by the patient into the EMR. While the physicians that do this are seen as the most innovative and efficient

members of the clinic, the only thing being accomplished is more contribution to the EMR and less direct attention to the patient. The negative term then sheds light on the fact that not all physicians are perfect, while these physicians were able to input information into the EMR, they were unable to maintain an adequate conversation and relationship with the patient. This was observed through minimal eye contact and body language when responding to the patient's concerns or questions. While it may be important to have the EMR up to date and fully functioning, this does not mean that it is most efficient during the actual visit. Are the EMRs adequate? This position needs to be analyzed in more detail, but from the point of view of Shachak and Reis, it is inevitable that the presence of an EMR will have positive and negative influences from the physician that disturb the visit with patient.

The question of adequacy is not how technology is influencing these changes, but rather how the physicians and medical systems need to adapt to these changes to make them better. The use of clinical EMRs provides efficiency and timesaving advances for the physician, but there are disconnects when it comes to the actual information being relayed and stored. For example, a patient may come into clinic to describe their condition and seek advice from their physician, saying, "I was out shopping when my vision suddenly went very strange. It became fuzzy and blurred in my right eye; the image got all mixed up and then briefly moved to blurring on the left side. There was an impression of double vision. I had something similar about a year ago, but that was slight weakness on my right side and the visual disturbance was not the same" (Marshall, R.J. and Bleakley, A., 2013). Though the physician attends to this patient encounter and the

situation is a conversation between the two people, there is the possibility that the story being told is translated into completely different language when placed in the medical record. An example of a brief, truncated translation would be: 'sudden onset of blurred, ?double vision. h/o previous TIA-like attack' (where h/o is 'history of', and TIA is transient ischemic attack – a sort of minor stroke)" (Marshall, R.J. and Bleakley, A., 2013). In this example, the approach for diagnosing becomes mechanistic. There are also several possible points of error in this entry. For one, there was no specification of which eye was being affected first and the history of the illness was not chronic or acute, but random. If another physician (or the same physician) were to see this patient again, there is the chance that they would be unaware as to the original details and actual experiences of the patient at the time. The history and patient information would then be recollected in order to give the physician a better understanding of the record, which leads to more time being spent scanning the record. This is an example of passive healthcare, which is more focused on diagnosing a patient rather than treating, which will be discussed in further detail. Therefore, the issue at hand is not the technology and EMR as a tool, but how the tool is used that leaves room for human error, misinterpretation, and possibly misdiagnosis/mistreatment.

The adequacy of electronic medical records is then slightly limited, as it does not capture every aspect of the person's experiences or intentions when going to the clinic. Rather, the record serves as a way to jot down notes and cover issues at a glance instead of with thorough detail. One would argue that with the use of passive healthcare, the holistic and active approach to medicine is then lost, and the treatments for patients also

lose their potency. If everyone who came in with blurry vision, like the patient above, it would be highly unlikely that they all would have TIA. There is value in the story told by the patient, and a medical record must be able to accurately and holistically portray this story.

In terms of research, the use of EMRs follows a protocol that allows for specific information to be retrieved and analyzed from appropriate patient forms. However, there is often ambiguity and generalization of the subject's (or "other's") chart when sifting through information to go into a research database. Furthermore these, messily written records, with important experiential information missing, are often part of long-term studies, where many "others" may not be aware of the use of these records. While there is the de-identification of such records, as well as a glass ceiling that protects specific information from general access, there is still the possibility that this information could be shared and may contribute to future studies of medicine. One example is that of the HeLa cells, where the cervical cancer cells of Henrietta Lacks have contributed to thousands of medical discoveries and act as the longest lived human cell line ("Henrietta Lack Biography," 2018). There are many controversies with HeLa cells, mostly in part that they have been used for over 60 years without Henrietta's knowledge or consent to use the samples from her body. This is considered private information and it was openly exploited in the name of medicine. This situation of shared information holds a lot of ground in medicine, and is heavily protected, but that is not to say the same type of

situation can occur with a medical record. Consent of these stories and experiences that hold meaning are significant, even if it is in the name of science.

One must then turn their attention to the care of the whole patient. At the end of the day, the research and clinical encounters are narrowed down to the overall care and hospitality a physician and healthcare staff can provide a patient. The collective story is an identity, but as Edmund Pellegrino says, "There is a shift in the moral center of the clinical encounter from the physician to the patient" (Thomasma, D.C. and Pellegrino, E.D., 1994). This is the idea that a patient, who is apart from the medical field and seen as the "other," should not be reduced based on their medical records or status within the system. This system will be discussed in detail in the next chapter, but it is crucial to see the patient as a pawn within the EMR system. When a record is seen as a sole source for information or a way to relay a message from one treating physician to the other, there is also a loss of humanity because the patient is characterized by the brief notes in the record rather than the story that sits at the core of their identity. As discussed previously, the eye contact that establishes rapport in a clinical setting can lead to missed information or insensitivity to the dialogue. Disjointed entry into a chart can lead to unclear diagnoses, treatments, and general patient history, thus making it difficult for physicians and patients alike to understand what the problem really is. While medical records serve as a way to store valuable information, they are ultimately seen as a tool that is being in-adequately used.

Through discovery of the human being's existence as an individual, commune, and system proves to be relevant when related to the greater picture of medicine. Not in

the way that humans are simply pawns in the world, but that our experiences and relationships that we develop are integral to who we are and how we treat one another. This phenomenological idea is one that does not stop at the self, but extends to a world that is dependent on communication, connection, and trust; disturbances in the balance of the world thus lead to a disjointed and messy relationship. After careful examination of the EMRs and how they are used as inadequate tools for patient information entry, it is evident that the problem at hand is not one concerned with technology, but rather how technology integrates into the world, experiences, and relationships we have.

CHAPTER 2
Status of the Patient-Physician Relationship

Phenomenology, as a philosophical method, has several approaches, but all of them are concerned with determining a first-person perception of the world and the experiences that shape and influence a human being within their life in order to answer the question of what it means to exist. This is seen in Maurice Merleau-Ponty's argument where he is primarily concerned with the idea of body-consciousness and how the world and our position in the world are subjective and a segment of a greater system. In other words, our bodies are part of the world and "inhabit," or are positioned in the world, in a specific way at any given "space and time" (Merleau-Ponty, M., 1962). Merleau-Ponty theorizes that human beings all have individual experiences and their bodies are meandering down different paths depending on how one perceives and interacts with the world. "Inhabit," according to Merleau-Ponty is a fluid and mobile position in the world where only pieces of our being are able to be perceived at a time once they come to our direct attention. It is as though one's body acts as a semi-permeable vessel that is exposed to different stimuli and depending on how this stimulus is perceived, it assesses and adapts. This is the body-consciousness or awareness of the physical body within the experiential world that is positioned and inhabiting space at any given time.

While the body-consciousness and awareness of the physical body is the main focus of Merleau-Ponty's phenomenological method, there are instances where the body of a person is seen as an object rather than the mobile vessel of a person experiencing the world. This is when the awareness of the person's body is no longer seen as a unified, but objected to be separate. The insight of Merleau-Ponty's body-consciousness reveals that while the physical body inhabits space and time, there is a lack of awareness concerning all bodies as subjective and individual bodies within the medical system. The bodies in the medical system, specifically in the clinical setting, see a patient as separate from a body and more of an object that is being observed, diagnosed, and treated with the use of medicine. This chapter will look into how the medical field has been organized to see the patient as an object rather than a human being; how there is a strain on the level of trust between a patient and a physician; how the medical system is seen as an impeding force between this level of trust; and how phenomenology can act as a rehabilitative factor on the human body being seen as such and not an object.

The Self and the Story

The first question we can ask ourselves is, is there a distinction between treating a patient on paper as opposed to in person, the physical body? This answer should be obvious: yes, a patient on paper will never hold the whole, true story; rather the paper version of a person is just a glimpse into their life. A paper version in this instance offers only a physical description of a person (Ash, J.S., Berg, M. and Coiera, E., 2004; Campbell, E.M., Sittig, D.F., Ash, J.S., Guappone, K.P. and Dykstra, R.H., 2006; Hambrick, S., 2018; Sanjusky, W.V., 1998). For example, the patient's family, personal,

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and medical histories are all accessible in notes and coded phrases used in electronic medical records. However, I would argue, these histories only offer an external view of the patient. Physicians are only able to barely scratch at the surface of what makes a human being whole and more than code and notes in a record. These patients are seen as a history, a note, and ultimately an object that is weighed down and judged by an external viewpoint. It is then essential to observe the physical person more thoroughly while using the paper or electronic version as a reference point to base a discussion from. Not only does this make the patient feel as though they are more than a number, but also that you, as the physician, are aware of their condition and are prepared to hear the details behind their life.

One would claim that the electronic medical record offers a better sense of time management for the physicians to see more patients in the day, but I would argue that this does not hold true. Ultimately, the electronic medical records are faster and offer the possibility of having information accessible at the tip of one's fingers. However, when asked, on average, how many hours of charting a physician does in a day, the answer is likely to be extensive. One medical resident, Dr. Daniel Wozniczka, recalls for "every one hour of patient interaction, two hours of charting is required" (Wozniczka, D., 2017). This is because electronic medical records require thorough information to be in each entry such as the patient history, description of the reason for the visit, and the treatments recommended by the physician. How does this time and focus away from the patient ultimately remove their physicality? With charting requiring hours of entry, one would expect that there would be a limited lapse in information, but this is still the primary

concern when actual, physical care for the patient is compromised and limited compared to time spent away from the patient.

Removal of physicality is something that relates very closely to objectification of having a unique body. This removal acts as a way to view the body and the mind as a unit that is controlled and only the physical dead body is valued. This is closely related to Descartes methodology on the Cartesian corpse, where he believes our medical practices stem from. By displacing the dualism of the mind and body, one can also treat the two components individually, but disproportionally. Leder views this disproportion within the medical system where he claims that medicine is based on the methodology of treating the patient's physical body and eternal souls independently, or rather as a "body-machine" instead of "lived body" (Leder, D., 1992). He refers to this methodology of treating the body as a machine as the Cartesian corpse, which analyzes and diagnoses based on dead bodies and the information that can be gathered from these inanimate bodies.

While the bodies are separate from the mind, because they are no longer functional, does this also mean that our corpses are subject to objectification? What about the bodies we currently live in? Leder claims that medicine has shifted to a position to treat all bodies qua Cartesian corpses; objects that can be studied and pieced apart that are independent of soul, opinion, or life. He sees that "the living body can be treated as essentially no different from a machine," and while our bodies may function similar to a machine, the part that Descartes missed is that we are also living bodies (Leder, D., 1992). The two, ultimately can be see as both separate and coherent, but unless they are

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combined, there is a loss of self and awareness of the whole human being. Separation, then, leads to imbalances of one's experiences, thoughts, and position in the world.

Thus with the separation evidenced in our daily lives, it can also be modeled in medicine, where there are obvious imbalances seen between and used describe relationships with ourselves as patients, physicians, and human beings. This can be further understood when looking at examples of how the "material you" (MY) or physical person is dependent on the "digital you" (DY) (Johnson, L., 2006). In Johnson's argument, the paper or electronic version (DY) and physical person shows that both are crucial components, but one is more necessary and true than the other, depending on the person. A patient, in this definition, are both MY and DY, but from the perspective of the physician they are objectified and diminished in their medical records in a clinical experience. This is because there is a gap in the information of the MY being shared in the DY or electronic record and thus the care of the patient's MY characteristics are not completely addressed. Physical touch and encounter with a physician are necessary to create this part of the clinical experience. One way to put this into perspective is to look at a modern scenario. Imagine that you have a good friend and have trusted them with many secrets about your life, of which you would like to remain private. You discuss one of these secrets with your friend when out to coffee. This is a wholehearted gesture and you are spilling you life out, but you find that your friend is engrossed and distracted by their cellphone. Every once and a while they are receptive to what you say, but there is no telling whether or not they hear and respect all of what you are saying.

The same scenario can be applied to the clinical setting where the rapport of a

visit is distracting and disconnected. This can be attributed to the fact that physicians are overloaded and occupied with other thoughts that are associated with the electronically recorded DY of the patient, and not focused on the MY. After all, one does not really know what is going on behind that screen. At the time of your visit, the only thing you are sure of is that the screen is acting as some kind of distraction and barrier between you and your physician. All of the information may not be fully received and transcribed in the way that you intend it and the materialistic body may be underrepresented or misrepresented when transferred to the electronic version. An example of this is seen in the actual information that is inputted into the EMR, which is truncated and abbreviated so that significant context may be missing. In a patient report, one could find that the physician observed 'sudden onset of blurred, ?double vision. h/o previous TIA-like attack' where h/o is 'history of', and TIA is transient ischemic attack – a sort of minor stroke" (Marshall, R.J. and Bleakley, A., 2013). At a first glance, this report is reasonable, seemingly credible, and gets to the point, however the message being transcribed is missed. The patient describes that the blurred vision happened a year ago, but was not due to a stroke, but unknown causes (Marshall, R.J. and Bleakley, A., 2013). Because this detail was missed in the report, it is likely that this patient's condition will go misdiagnosed and mistreated for a TIA rather than other, possibly more severe conditions such as optic nerve damage or degeneration of the retina. This example goes to show that a person and their stories are more subjective than objective and cannot be generalized and systematized.

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One argument to support this point is that the information provided by the patient acts as clues that lead to a diagnosis. Medicine, in this regard, is seen as a profitable industry that brings in sick people and yields *healthier* people. Part of the issue is how the medical industry is organized, as a top-down system where there are specific regulations that are enforced to "focus on either the structure or the processes that produce the outcomes" (Mukamel, D., Haeder, S. and Weimer, D*.,* 2014). This includes, first and foremost, the adequate and proper training of physicians. The American Society of Training and Development stated, "health care is the industry that spends the least on training, both per employee and as a percentage of payroll" (Berger, S., 2000; Miettola, J., Mantyselka, R. and Vaskilampi, T.; Shachak, A. and Reis, S., 2009). However, with over 92,000 residents in North America, the cutbacks on training are not worth the benefits they sacrifice in the long run (*AAMC*, 2017). Basic training, such as the medical knowledge required of a physician are necessary for the development of a doctor, but the ability to listen and communicate are also essential skills that are often glanced over in medical school. If a person cannot communicate with another and see them as a holistic patient with an MY as well as DY identity, they will not be able to understand how to best understand, trust, and treat them.

To avoid objectification of patients and gain trust within the relationship, the two remaining positions of Leder and Merleau-Ponty can be combined to point out flaws between the physician and patient. While both are human beings with their own phenomenological identity of being, as suggested by Merleau-Ponty and Leder, they must also be able to have a strong relation or belief in one another. To understand the issue of

trust in a relationship, there must be a clarification as to whether or not it is seen as one or two-sided. One could argue that the physician is simply a receiver of information and does not need to reciprocate in the relationship besides giving advice and medical attention. However, this defeats the purpose and intention of most doctors, as it is understood to be a profession of communicating with and improving the well-being of other people. On the other hand, the patient may be seen as absent from the relationship in that they are simply using the physician as a means to be healthy. Again, this idea is not represented in the basic understanding of what a relationship entails: reciprocity.

Reciprocity is a form of equality that levels the playing field between the artificial, socialized factors of reality the world places on a person or group, and the free nature of one choosing how they belong in the world. This is to say that reality and how we perceive the world is dependent on certain norms and expectations that are placed on us by society as well as freedoms that we have within ourselves. When compared to the medical field, one can see that it holds its own realities with a top-down effect where certain standards for workers and the functioning of medical practices are regulated. However, there are also personal choices that allow the medical system to be more free and not held to standards. One example is the medical system seen in France where every person has health care and this allows their patients, as well as the physicians, to have more choice (Shapiro, J., 2008). In France, there is a two-way relationship that is dependent on the mutual decision-making of patients and physicians. Ultimately, this eliminates objectification of either person because they are given more choice to be free in their differences than simply existing as an "other" or someone different.

While the complete elimination of objectification through the use of medical records may not be the final solution or even possible at this time, there is still the question of if we can alleviate the problem. In other words, is it possible to use the method of phenomenology as a rehabilitative way to make the human body to not be seen as an object? This is a difficult task and not easy to conceptualize, however, I would argue that Leder, in accordance with Merleau-Ponty, has the strongest claim in support of this rehabilitation. They both see that our existence is habitual, but also a relationship of seeking our own wholeness. Merleau-Ponty phrases this to be the *eros*, Leder, on the other hand, says the "intending" body (Merleau-Ponty, M., 1962; Leder, D., 1992). Both are associated with finding a greater passion or purpose in our life that will ultimately fulfill it. This is not to say that everyone should aspire to be billionaires or big time lawyers because these distract from another important piece of the method: meaning. Without meaning, how we understand the world comes to exist and how we decide to interact and exist in the world become obsolete. This is a necessary point of realization and one that may phenomenology specialists thrive for, but come short of often because of how difficult a task it really is.

The realization that we are something more and have the ability to be something more is what drives our existence and contemplation of how we associate ourselves in the world. To be out of balance in our bodies, then leads to phenomenological imbalance of how we perceive and act in our world. In the medical field, for example, these imbalances lead to differences and limitations of power that effect the patient-physician relationship, as seen previously. On the other hand, a patient may be diminished and seen as an object

or nonliving corpse to be studied, poked at, and pumped with treatments. One way to go about resolving these differences and struggles in the patient-physician relationship is to strengthen the components that drive the medical system: personal interest alongside passion. When the best interest of the patient is taken into consideration, such as being heard properly and adequately nourished back to health, it makes the physician's job of wanting to help these people easier. This is not a drastic change, but rather a way to utilize a method that can help one understand how to interact with others in the world that we are living in.

Hermeneutics of Medical Records

When outlining the patient-physician relationship, it first begins with the patient seeking help from the physician. This starts the cycle of a clinical visit, which I will describe in the terms of hermeneutics. Typically, hermeneutic methods are involved with the interpretation of written words, such as in the Bible or other texts open for interpretation. However, I will use this method in a more philosophical approach that interprets what it means to be human and how one's actions can be interpreted differently. With this respect, hermeneutics is a way to interpret humanity and come to the root of certain phenomena. Hermeneutics in medicine can be used to observe a clinical encounter by looking at four major components: the patient, the story, the physician, and the instrumentation, each of which contributes to the overall diagnosis and treatment of a person who is ill (Foucault, M., 1973; Hunter, K.M., 1991; Leder, D., 2016; Svenaeus, F., 2001). I will go into each of these components and how this relates to the use of technology within the clinical setting that can be seen as limiting and misused.

The patient acts as a vessel of an identity that is engrained in experiences, thoughts, desires, and so on that allows them to be unique individuals who are also part of the greater society of the world. When a patient falls ill, the identity can be seen as damaged or in distress and in need of healing. Many can relate to this phenomenon when we do not feel like ourselves when we are sick, or think that our bodies are ailing. This is where the patient reaches out to a physician and bridges their personal experiences to the treating physician through a story or description of why they believe they are ill. This story not only provides evidence of the patient's awareness, but also clues to which the physician can piece together a picture of the distressed body. The distressed body and story leaves the physician with a narrative that leads to more interrogation of the physician. After the general history is taken, and the story is heard, the physician can then focus on the physical body; through touch and physical examination, the body as a whole living thing can be examined. Philosopher Maurice Merleau-Ponty, would allude to the point that physical examination leads to the most interpretive process in the whole method. He claims, "The knowledge resides right in the body" (Merleau-Ponty, M., 1962). Thus, physical examination is not something that comes first, but rather after hearing the story and perspectives of the patient.

Only from here can one move to a diagnosis. This is where the method of the medical system, in my opinion, becomes ambiguous. In the diagnosis process, there is a lot of analysis and data retrieval that occurs, primarily with the use of technology. Technology and other devices "make available to us quickly and easily information that would otherwise be burdensome, or perhaps impossible, to access" (Leder, D., 2016).

With information literally accessible at the touch of a button, or through an analytical test – x-rays, blood tests, MRIs – there is also the possibility of not including all possible information, or glancing over other clues. In the EMRs today, there are many different methods that can be used to structure patient information so that it can be easily inputted and observed at later times. Some methods include, using "touch-screen, speech recognition, handwriting recognition" to input information into "empirically refined templates" or "pick lists" (Weber, J., 2003). This in turn leads to minimal delays and the input of information to be more relaxed and specific. However, the specifics of pick lists may be too simple for a patient. Take the patient previously introduced with a TIA; perhaps the pick list does not have an option for the specific condition or injury sustained by the patient. Are these pick lists and refined templates just acting as filler for information that should be expanded on more? This then turns to the question of the adequacy of EMRs being used as diagnostic tools. While EMRs serve to incorporate information quickly into the system with little work required by the physician, the information transcribed may not be concise or as relevant as it should be.

Technology as a Tool

Adequacy, in the medical field, directly correlates to efficiency, precision, and accuracy. Without these components, there is a good chance that the medical system will be reconstructed to fulfill these needs (Svanaeus, F., 2001). This is due to the fact that medicine and medical practices do not have room for error when dealing with patients and their medical histories, health, and quality of life. With the case of EMRs, there are many instances where they have proven to be efficient and time-saving for physicians

and have actually improved the medical system and they have offered many options for storing medical information (Blumenthal, D. and Glasser, J.P., 2007; Hersh, W.R., 2002). Several decades ago (and even today), paper copies of medical information were kept on file, but the fact of the matter was there was not enough space to store all of the physical files and documents of hundreds of thousands patients at one clinic. To save space and time, clinicians and other healthcare providers use technology.

I would like to focus on the word *used*. In the case of technology and *using* space, one can see how, in medicine, these devices are more than just a hunk of metal, but a tool that play an important role in the functioning of the medical system. I would argue that the use of technology is beneficial to the healthcare system, but there is a lack of training and deeper understanding, which makes the instrumentation and devices more of a problem down the long run. In a way, I am scrutinizing the human error found in medicine, but this error comes from the inability to adapt and learn new methods (The Institute of Medicine, 2000). In part, most of what is taught in medical school glances over the humanistic qualities of physicians that make them relatable. For example, the American Society of Training and Development, who are responsible for teaching companies and employees how to improve revenue and satisfaction in the business setting, found that the average expenditures to train each employees in "leading-edge firms was $1,966" whereas the healthcare system spent "$345 per employee" (Berger, S., 2000; Chaudhry, B., Wang, J., Wu, S., Maglione, M., Mojica, W., Roth E., Morton, S.C. and Shekell, P.G., 2006). In a field where training should be expected and a top priority, the healthcare system is lacking. When trying to function hermeneutically, as seen

above, it is the role of the physician to be able to convey information effectively, which is primarily done by being trained properly on how to adequately listen and transcribe information. The transition to electronic medical records was beneficial, as it saved money, storage space, and accessibility, but with this technology, there was minimal training on how information should be stored and shared, which delayed the technological impact of EMRs.

It is worthwhile to look into EMRs and see how they function as a tool and what physicians can learn from them. Firstly, EMRs are a very efficient way for information to be stored, transmitted, and accessed. As discussed previously, the medical record offers insight to the patient's life, as understood by the physician, which can be easily typed into an online document *forever*. The permanently stored item provides reliability, accessibility, and reassurance for some patients, knowing that their information is up in the cloud. However, there is always the risk of pushing "delete" and having all information erased, changed, or lost. Secondly, the records used by physicians do not need to be replicated with each visit, but are rather updated. This is one of the most beneficial parts of an EMR because of how the patient has minimal work required of them when going to the clinic. Rather than filling out another four page medical history, there are instances where they can sign into a tablet and check boxes if any information has changed. For one, there is minimal work, which means the patient has the ability to have more time with the physician. On the other hand, there is again the possibility of

human error where the patient may incorrectly input their updated information, but this is what the physician is for.

As a visualization of this system, thus far, I would like you to think of a trip you would regularly take for an annual health physical appointment. The first thing asked at the front desk is what is your birthdate? Just like that, the secretary can access your file and send it off for you to update. In this update process the patient has the ability to change limited aspects of their lives. Perhaps, since the last year, eating habits have changed, mental state, or even more physical questions and concerns arise such as "this weird new mole" that they would like to ask their doctor. This information, once completed, is then directly uploaded to the physician's chart from which they can base the physical examination off of. In a physical, it is a gathering of more history. What I mean by this is that the medical record is already complete, but more information is being added to it to make it more holistic and suitable to you. At the time of the annual physical, all the information necessary is explained by the patient and received by the physician to make its way into the cloud of information. The beauty of the physical is that the next year, the same process occurs and the information is somewhat similar or unchanged.

Now, take this idea to an emergency room setting where the physician and emergency department are meeting you for the first time. Perhaps, a medical history is difficult to take because you are unconscious, but they are able to link your file to one you previously had at that hospital. However, at first glance, information of your history can be lost. Maybe you are currently receiving cardiovascular treatments and cannot be

given blood thinners, but the emergency staff administers them anyway because you are developing a clot. The situation can play out to be terrible. This misread, misinterpreted or missed information can then lead to severe repercussions. The issue at hand is then that the format and information in a record are not easily replicable and there is a lack of consistency and sharing capacity of these charts that make it difficult to pass between information. One would argue that there is inadequate technological training and ability to have a universal medical file that is leading to discrepancies and errors in the medical field. The EMR tool cannot be adequate if the information belonging to a person is not all included.

While there is no easy solution to the inadequacy of using EMRs as a tool in the medical field, in the next chapter we will look at possible changes to improve the way medical information is stored, shared, and created. Used as a quick way for information to be accessed by all physicians and caregivers on a given patient. My main goal is to bring awareness to the general population that the medical system encourages the use of electronic medical records in the clinic because they are easily accessible and updated by other physicians. The main issue is that there is a lack of communication across all ranges of medical practice (clinical, emergency, specialty) where every part of a patient's identity and story should be accessible universally.

Dehumanization of People to Patients

While the information in EMRs is essential to understanding the history and identity of a patient through their experiences and perceptions of their bodies at a given visit to the clinic, it is information that many assume to be private between the physician

and patient. The reality is this information is accessible by anyone with the proper credentials to view this information. As discussed in the introduction, HIPAA certification or department clearance allows for any kind of information from a medical record to be received. In an ideal world this information remains in the correct hands, but the level of trust to allow this access can be affected. The question of trust in physicians who have private information is a reoccurring theme because essentially one's life is tied to these records. With one swift movement or a typing mistake, all information can be lost of altered. While physicians, care providers, and researchers are bound to the contract of protecting patient privacy and safety there is always the possibility of information being shared to unwanted sources. One way to prevent this accidental spread of knowledge is to use a numbered system While this protects the patient's privacy, it also diminishes them to an object that is numerically bound rather than a human being with a name. This dehumanizing act is not intentional, but it is something that should not go unnoticed.

To be able to conceptualize the dehumanization of EMRs, as I see them, it is easier to see that these records act as a mask that is covering a person. The same analogy can then be extended to say that the mask is objectifying the person to a set of conditions; whatever information is written in the chart automatically becomes part of this person's identity. In this instance, I refer to the person as a "material object," rather than an existing being because of how their known, personal identity is stripped from them. From a medical standpoint, the idea that patients are observed, analyzed, and treated becomes mechanistic and routine, which often leads to monotony in the field. For example, one

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rarely hears stories about a generic day in the office as evidenced in the dialogue between a physician and their spouse where when asked about their day, it seems to be dull and unexciting. However, when something out-of-the-ordinary occurs, the medical practice is seen as riveting and intriguing. The "material objects" are just that, simple, routine, and dull until something unique about them stands out. This is not to say that all patients are seen through the scrutiny of an interesting object or a bland object, but rather that this distinction is intrinsically created within the physician. I would argue that a passion to *re*-humanize these "material objects" to lived bodies is required, as suggested by Merleau-Ponty (Merleau-Ponty, M., 1962). The only question is how?

There is no concrete solution, but one possible start would be to have universal medical records. This is a far-reaching idea but it is one that extends to embody the whole person. Rather than being seen as an object with different components – where some may be bland and others exciting – every piece of information regarding the person's identity would be accessible. An example or model of this would be to have a medical number that stays with a person for life, much like a social security number, but on the global scale. This way, if an American is traveling in China and becomes ill, they are able to go to the hospital, provide their universal number, and have all of their information accessible. The universality of this method is similar to that of medical bracelets, the one's I am thinking of are for brittle type I diabetics. On the bracelet, there is information about a person's condition and a code that can be inputted into a system that retrieves medical history, such as medications, past episodes, and primary care providers. If each

person had access to such resources, the risk of misdiagnosing or missing something crucial in a patient chart could possibly be avoided.

Through analysis of the connections that EMRs allow between the stories of a patient and what is actually recorded in their record by the physician shows that there is much room for improvement. This improvement is not necessarily in the technology that is driving the EMRs, but rather how we as human beings interact with one another and identify through a more critical lens. This is to say that EMRs are a tool that can be used to make the life of a physician easier, but there are specific ways of utilizing the tool that allow it to be an adequate resource. Furthermore the idea that we, as human beings, should not be seen as "material objects" extends to the idea that EMRs should be a complete analysis and description of the identity the patient associates with. Whether this is through a universal system, or one focused on the acute attention to details of a patient's story, there is still room for improvement within the utilization and methodology of EMRs.

CHAPTER 3

Reconstruction of Established Positions and the Patient-Physician Relationship

I realize that many of the points I have made throughout this thesis are controversial or are multifaceted and require more contemplation and discussion, especially when relating the philosophical interpretations alongside the bioethical dilemmas seen in medical practice. In order to do this, it is only right to become a reductionist like the famed philosopher René Descartes. With this, I will begin with returning to original positions and reconstructing my views based on the wide spectrum of *all* human being's identity and how this drives desire to understand one's position and meaning in the world. Furthermore, I will look into the discrepancies of the patient-physician relationship in regards to control and assimilating roles. Lastly, the error found in the medical system is important to analyze in order to understand how we view the previous points of identity and control. I argue that issues with basic communication skills when information is being transferred from the primary source to a secondary source (the EMR) are a result of the differences in assumed power between the patient and physician.

Individuals of Humanity

Through careful examination, one can make the assumption that there is an interconnected relationship between humanity, identity and desire. However, this

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relationship is not the same for every single human being. This stems from the idea that every human's experiences are individual and specific to their life, which are developed from childhood (Russon, J., 2014; Marratto, S., 2012; Merleau-Ponty, M., 1962). If a child is abused, there is a likelihood that in their adult life will continue to be tentative in situations where emotions trigger a protective response. But the experiences of individuals should be considered on a case by case basis. The identity I have made for myself is significantly different than a person across the world for a variety of reasons. This is the beauty of humanity. That any human being can be a physical human – the species of *homo sapiens* – but they are ultimately unique and individual in this humanity. From this idea of humanity within the physical human, stems the idea of identity.

While identity is a mix of experiences and desires, there is a distinction that these are internal (personal) as well as external (communal). Like any type of relationship, identity serves with a give-and-take principle. The experiences one develops internally reflect how they are interacting with and exposed to the external world. In this context, does an identity posit relationship between individuals? Another way to explain this would be to say that the identities we affirm for ourselves – gay, straight, woman, man, activist, pacifist, etc. – are influenced by the world around us *and* our own understanding of ourselves. To then claim that everyone has an identity and therefore a relationship, to some degree, with the world around them is therefore true. Evidently, there is the possibility of misinterpretation or a false representation of these identities. For example, the Digital-Self is one that is constantly changing in a dynamic equilibrium as it is trying to fulfill the physical characteristics of the "Flesh-and-Bone-You." It changes with our

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social media profile pictures, comments, and posts that are in response to something outside of ourselves, but felt internally and physically as seen in previous chapters. This feeling that is internal is what keeps the equilibrium dynamic and allows one's identity to shift and wane.

The dynamic equilibrium can also be seen in what we desire. It was brought to my attention that not every single person has the desire to live on this planet, as evidenced by suicide attempts or self-mutilation. Thus, while a person may identify as lonely or depressed, their desire to exist is absent. Desire, in this connotation is something that is driven by our identity, but it does not necessarily need to be present in every person's life. For example, a woman may identify as a feminist, but she may not have the desire to be an activist, whereas a man who also identifies as a feminist may have the internal drive to fulfill his identity to something more. This search for more is not necessarily a deciding factor, but rather a deeper drive to fulfill one's identity. It is not bad that one does not have desire, rather it is just a lack to fulfill and act on identity.

In medicine, there is an individual identity that is assumed by physicians, patients, and healthcare providers alike and each develops on an independent level based on their desire to fulfill such identities (Bleakley, A., Blight, J. and Browne, J., 2011). I see this as a way for the medical system to exceed expectations of critical care as well as adequate treatment, but there are different levels to how this is attained. In Westernized medicine, the focus is surrounded around the treatment of the physical body through analysis, instrumentation, and observation. This is essentially a different way that medicine can be identified and it posits the distinction that different disciplines of the system of medicine

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can be subcategorized to create a spectrum and model of identity. To come to this conclusion means that identity is the soul of how a human being identifies with humanity and the external and internal interactions they have with one another. This identity is then further divide based on the desire each individual possesses.

Position and Power

Through the identity, one can begin to create relationships with similar beings, as seen in the creation of a relationship built on trust. This trust is then dependent that the desires, interests, and interactions of the other or external person relate to the same internal feelings of the self. Trust is necessary to understand how we situate ourselves in the world and is based on the dependency of other people who share similar interests and goals as ourselves (Charon, R., 2001). However, there is the possibility that there are differences in interests and goals that still allow for trusting relationships. The clearest example of this is the relationship between the physician and the patient. There are obvious differences between these two subjects: one is a medically trained professional who has probably spent a most of their life dedicated to medicine, whereas the patient can be anyone from a small, innocent child to an astrophysicist with multiple PhDs (to name a few examples). The issue at hand is not that the relationship does not have trust, but that there is a struggle of where the control and power in the relationship should lie.

In general, patients claimed that they felt as though the physician deserved more respect for their intuition and advice in a clinical setting than the respect a friend giving advice would need (Hersh, W.R., 2002). In a way, the control and power dynamic between the physician and patient in the relationship appears assimilated as part of the

medical culture. The role of the physician in the clinic then becomes one as a role model above the patient rather than someone working for and with the patient. I come to find that the control one has is not based on education, engagement in extracurricular activities, or overall likeability, but rather the physical position a person is in. Take a clinical setting for example. The patient sits on an examination table, maybe even vulnerable in a medical gown, while the physician (dressed professionally), sits at a table or stands in front of the patient. This physical placement automatically situates power to the "bigger man," or in this case the physician who has freedom to move and dress as they like. The patient is immobile and exposed. Prey, if you will, for the physician to interrogate and diagnose. This is not always the case in a clinical setting, but more often than not there is a clear power difference between the patient and physician.

This raises the question if this power difference effects the communication skills and receptivity of the physician. It is not likely that a doctor would agree to not having efficient communication skills because this harms their identity that the name "physician" brings with it. The study of communication skills is therefore a difficult one, but it is no less important than the physical control assumed by the clinical encounter. I believe that the communication of a physician should be the most proficient of any profession for two reasons: building trust and credibility within a relationship and effectively treating patients. The latter is the ultimate desire for the medical system; people who are ill will be treated and not have to come back for more treatment. However, when this is not the desire of the physician, there is a disconnect between the identity of the physician with more control than the identity of the patient or "object" as seen in Chapter 2. When

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treatment is the primary concern, the communication between the patient, physician, and other healthcare providers must be solid. There is no wavering in ideas or beliefs. This taps into the bioethical concerns of communication, which focus on the care and well-being of all aspects of medicine, but with the patient at the center. To identify as a physician implies that one will have the desire to care for and treat others through effective communication.

The most effective way to communicate is directly (primary contact), but when being recorded and transcribed to outside resources (ie. other physicians and caregivers) the secondary contact of EMRs are adequate. However, if a physician cannot effectively communicate with the primary source, there is evidence that they will not be able to convey the patient desires and thoughts effectively in the secondary source (Leder, D., 2016). The solutions to this problem are endless: have more required communication training, make a universal language on EMRs, have smaller collaborative medical teams, etc., but the most effective is improving the identity of the physician. The goal and desire should be to help, treat, and *listen* to the patient's desires and identity.

The philosophical interpretations alongside the bioethical dilemmas seen in medical practice presented in previous chapters are ambiguous and controversial. However, I have come to the conclusion that all human being's identity is driven through desire and this instills that humans are rooted in humanity. The identity of physician thus implies that there is automatic control and power in the medical system. While this is a divisional thought, there is evidence that within each system, each individual will identify and act independently.   While I do not have any answers to the situation of

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communication in the medical field, I find that there is most of an inadequacy of how the

patient is received by the physician based on their differences in identity and control.

CONCLUSION

The analysis in this thesis has allowed me to elaborate on the topic of what it means to live as a human with other people through an established identity that is molded by one's experiences and perceptions of the world around them. Furthermore, this identity is not only shaped by how we view ourselves, but also how we experience the world around us through our interactions with other humans. Thus one's identity is determined by external and internal experiences, but also how the phenomenological idea of a "lived body" is something that is beyond a "material body" (Merleau-Ponty, M., 1962; Leder, D., 2016). Not only does this realization of the body allow one to associate themselves in the world, but it also leaves space for relationships to be built. These relationships are atypical as they are based on several different factors to ultimately develop a connection based on trust and compassion. I believe that the only way a relationship can then be efficient and fruitful is if both parts of the relationship (the other/outsider and the self) are willing to find similarities as well as differences that fulfill their desires and identity within the world.

In a medical practice or clinical encounter, I see the identity as one that is focused on the position, control and power of each person in the relationship. For the physician, they should be, focused on the whole care of the patient and ultimately their well-being above all else. The error is only found when the communication between the physician and patient is not adequate. This is typically found within secondary communication in the

medical system between the physicians to outside sources through EMRs. It is important to analyze the adequacy of communication in order to understand how we view the previous issues of identity and control. It is my main argument that issues with basic communication skills, when transferring information from the primary source to a secondary source (the EMR), are a result of the differences in assumed power between the patient and physician. The critical analysis of why this happens and what can be done to amend this is of utmost importance.

However, the adequacy and use of EMRs goes beyond good medical practice and the hermeneutics of a large system such as healthcare. Beneath all of the trust, practices, and communication of medicine, there is the underlying fact that the phenomenology of a person – the concern of a first-person perception of the world and the experiences that shape and influence that person within their life in order to answer the question of what it means to exist and have meaning – is of upmost importance to realize, especially in a clinical setting. As students and young adults aspire to fulfill their dreams of becoming a physician, the philosophical implications discussed previously validate good practice and make great physicians. Beyond the technology, instrumentation, and money in the healthcare system, all humans have a purpose and story that should be observed and respected. This is the primary job of a physician.

Though the listening and understanding of a person's story does not provide a clear answer as to whether or not EMRs are the sole contributor to a lapse in patient-physician rapport, one can see that medicine extends beyond the clinic. Rather medicine is not necessarily a practice rooted in what can be tested, measured, and observed, but

rather is an art form that can be shaped, interpreted, and admired. From the words of Hippocrates, "wherever the art of Medicine is loved, there is also a love of Humanity." The advances in technology, such as EMRs, allow one to transcribe the stories of each individual patient, but the ultimate goal of treating them as a person rather than a medical record should be valued first, then the medicine will follow.

In conclusion, the electronic medical records are in no way at fault, they serve as a tool that makes the job of the physician easier, information is more protected and consolidated, and there is a greater ability to share information in a collaboration. The only error is found in the way information is processed and thus inputted or transmitted into the medical records incorrectly or incompletely. While I cannot come to any solid solutions, it would be worthwhile to look into a more universal electronic medical record system. This was briefly proposed, but there are logistical issues, such as patient accessibility and the creation a somewhat monopolized industry. However, in the eyes of treatment, coherence, and maintaining one's identity, a change in how medical records are created is necessary to maintain the love for humanity.

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