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A comparative study of the utility of new media technologies and power distance in doctor-patient communication in the Philippines and the United States

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Abstract

This study's purpose was to examine the role of power distance in physicians' desired impression by patients, as well as doctors' attitudes toward utilizing new media technologies. Qualitative interviews were conducted in the United States and the Philippines - which have divergent power distance scores. Results revealed three major themes. First, power distance was manifested in how each country's doctors wanted to be perceived by patients. The second theme was that doctors perceived today's patients to be more informed than in the past; however, Philippine doctors viewed this as a challenge while U.S. doctors viewed it as an opportunity to initiate conversation. The third theme identified differences in litigation concerns, which influenced attitudes toward using new media technologies in their practice.

Keywords: *power distance; new media technologies; in-depth interview; Philippines; United States; physicians*

Introduction

As the world moves into the digital age, a new phenomenon is taking place affecting many aspects of culture, health, and communication. One example is the traditional doctor-patient relationship, where doctors are perceived as the experts who diagnose passive patients through a process of information diffusion. Research demonstrates how new technologies hold great potential in dramatically influencing the relationship between patients and physicians (Kreuter, Chheda & Bull, 2000; Neuhauser & Kreps,

2010; Weisbrod, 1991). With the perpetual availability and ease of use that new media technologies provide, expectations of this relationship have transformed passive patients into empowered, participating and active members of the healthcare process (Couchman et al., 2001; Roter & Hall, 2006). Patients are using new media to research individual symptoms, discuss treatment options with online communities, and gain immediate access to second opinions and/or alternative physicians, thus providing patients more power in the physician-patient relationship. It is unclear, however, how receptive physicians are to this change in power dynamics.

When studying power preferences, it is important to consider culture. According to Hofstede (1980), power distance is the degree to which a culture believes and accepts unequal power in institutions and organizations. Since culture is defined as learned customs, beliefs, values, knowledge, artifacts and symbols that are constantly communicated among a set of people who share a common way of life (Akindele & Trennepohl, 2008), this signifies a society's entire learned way of living. This includes, not only more abstract taxonomies such as Hofstede's concept of power distance, but also bureaucratic and system-bound aspects that may affect one's values, customs, knowledge, and artifacts. The traditional doctor-patient relationship has often been viewed as skewed in power terms in favor of medical practitioners. With the potential of new technologies to rebalance the power distribution in a doctor-patient relationship, how might doctors feel, and how might this affect the way they communicate with patients? It is important to begin the exploration of this question by considering the desired impression that physicians wish patients to have of them. For instance, in high power distance cultures, doctors may put a premium on being considered authority figures on medical issues, compared to low power distance cultures. Similarly, doctors from high power distance societies may value having patients view them as leaders on patient health issues, instead of seeing their relationship as being even and cooperative. The way doctors prefer to be viewed may therefore have implications as to whether they will embrace new technologies and the rebalance of power in their relationships with patients.

This study, therefore, begins by examining whether power distance is manifested in physicians' desired impression by patients. In addition, it examines physician attitudes, as well as considers societal and bureaucratic institutions mentioned by physicians, that may affect their attitudes toward the use of new media technologies in their practice. Two sets of data were collected from the United States and the Philippines. This study will first discuss literature surrounding new technologies and then will review the concept of power distance, followed by the methodology of the study. Finally we present the results and conclusions.

New media technologies and doctor-patient relationships

While power structures in traditional healthcare organizations posit physicians as experts that diagnose and treat patients in a top-down process, new media technologies are influencing this relationship. New media is defined as social communication and interactive technologies, such as the Internet, laptops, videos, websites, iPhones and tablets (Jenkins, 2006). The interactive features of new media have been found to shift power to audiences in many industries, including advertising (Turow, 2007), politics (Shirky, 2011), and public health (Brown & Walsh-Childers 2002). The United States National Cancer Institute (2001) explains that digital distribution of health information shifts power to the patients and enhances opportunities for increased awareness of health issues. This phenomenon has been extensively examined as both a tool of mass media, as well as an interpersonal process.

There are many structural elements of mass media features that allow for such a dynamic change. Today's Internet users have unlimited opportunities to engage and interact with content through various features of the Web 2.0 environment, (O'Reilly, 2007; Caceres Zapatero et al., 2013). Web 2.0 advances the amount of interactivity and participation users have with media content, including features such as social networking, interaction orientation, customization and user generated possibilities (Wirtz et al., 2011). This increased interactivity often results in more educated, empowered, and motivated audiences (Buenting, 2006; Dijck, 2009; Boulos & Wheeler, 2007). Users are able to customize their own content while encouraging direct communication and enabling greater control over media choice (Chan-Olmsted & Ha, 2003; Lin & Cho, 2010; McMillan et al., 2008). While these structural tools of mass media are important to study, it is also important to explore how the interactive features of mass media influence the interpersonal communication between physicians and patients.

Recent public health research has extensively examined the influence of client participation on healthcare decisions. Increased participation has demonstrated benefits for patients and physicians alike. Results point towards a strong desire by patients for an increase in healthcare participation (Cegala, 2010). Patients who are able to participate in the healthcare process through a more active role are also shown to engage in more regular communication and visitations with their physicians, leading towards stronger long-term health outcomes (Haean et al., 2008; Say et al., 2006; Collins et al., 2002; Vaughan, 2011). Additionally, higher levels of client participation are associated with more positive perceptions of the quality of service

they receive from physicians (Gallan, Jarvis, Brown & Bitner, 2013). Overall, literature in this area has found mostly positive advancements through this increase in personal patient health management. Client participation is now a critical component in the development of health care campaigns and processes (Longtin et al., 2010).

Today, health-related websites have proven themselves as a new resource for users interested in taking a more active role in their personal healthcare (McMillan & Macias, 2008), with over 80% of Internet users in the United States currently seeking health information online (Pew Internet and American Life Project, 2011). Users have more opportunities on these websites than simply gaining awareness of information. There are many interactive features that allow users to share, connect and engage various healthcare communities. Interactivity influences attitudes that shape social norms, prompt action, demonstrate healthy life skills, reinforce knowledge, illustrate benefits of behavior change, advocate a position on health issues, increase support for health services, refute myths, and strengthen organizational relationships (The National Cancer Institute, 2001). These features have helped transform passive patients into more empowered and active participants in the healthcare process (Couchman et al., 2001; Roter & Hall, 2006).

Literature shows that new media technologies advance patient empowerment and user satisfactions (Hong, 2006; Warner & Procaccino, 2007), access to information, the type of personalized health information patients receive, and the amount of communication patients are able to have with physicians (Brough et al., 2009; Deaton, 2004). Current health communication literature continues to suggest that physicians and patients should increase the amount of interactivity through new media communication (Anderson et al., 2003). However, Ha and James (1998) argue that interactivity features are only as good as the extent to which communicators are willing to facilitate each other's communication needs. It remains unclear how receptive physicians are to the change in power dynamics that may result when patients use new interactive technologies. Much of the research tends to focus on the outcomes and satisfaction of patients. Through this project, insights will be gained into how physicians feel regarding the changing power dynamics that new media technologies provide.

Power distance

Research demonstrates the role that culture plays in individual relationships between power, technology, and place, especially when it comes to healthcare systems (Poland et al., 2005). In order for the most effective utilization of new media technologies, the predominant national culture in which the organization is embedded must be

considered. Often, contemporary health care organizations introduce new clinical technologies with little regard to cultural expectations (Paunkoviċ et al., 2010). The result can be detrimental to the many possible benefits of new media technologies. It is important to consider how the culture of power may influence a physician's willingness to incorporate new media technologies into their everyday practice.

Culture is an imperative element of the human experience and influences what is seen, what is remembered, and how information is processed (Oyserman, 2006). According to Hofstede's (1980) dimensions of culture, power distance is the extent to which less powerful members of organizations and institutions accept and expect that power is distributed unequally. These normative cultural inequalities become imbedded into the fabric of every day life when family structures, forms of government, architecture, religion, and other institutions are created under the collective mental programming of these cultural ideologies (Hofstede, 1980). The dichotomies associated with power distance include, but are not limited to, superior accessibility/inaccessibility, hierarchical privilege/equal rights, tangible hierarchy/hierarchy for convenience, and dependence/interdependence.

Superior accessibility/inaccessibility deals with closeness or distance dimensions of immediacy (Herrera et al., 2011). High-contact cultures prefer close distances and touch, while low-contact cultures prefer less distance and touch. In a low power distance culture, hierarchical privilege and inequality are minimized, and the expectation is that those in power should attempt to look less powerful than they really are. In a high power distance culture, there is an order of inequality where everybody has a rightful place, and high and low hierarchical privileges are protected by this order (Hofstede, 1980). Tangible hierarchy speaks to power as a basic fact of society, where its legitimacy is irrelevant. In a society of hierarchy for convenience, latent harmony exists between the powerful and the powerless, as there is a potential for the redistribution of power. The measure of dependence/interdependence deals with how individualistic or collectivist a society is. In a highly individualistic society, the expectation is that one should be self-reliant and display initiative while looking after themselves and immediate families (Oh & Yoon, 2012). More collectivistic societies act in the interests of the group and not themselves. Here, personal relationships prevail over task and company, and in-groups are often hostile towards out-groups. Most cultures' identities and behaviors exist somewhere between the polarity of these extremes (Hofstede, 1980).

While many dimensions have been added to Hofstede's original taxonomies over the decades (Hofstede & Bond, 1988; Hofstede, Hofstede & Minkov, 2010), this study is based on the overall general premise that power distance explains the extent to which the less powerful members of institutions accept and expect that power is distributed

unequally (Hofstede, 2011). This is a critical area of research when it comes to the relationship between patients and physicians. Public health research points to positive outcomes when patients feel empowered and autonomous about their healthcare decisions (Emanuel & Emanuel, 1992).

It should be noted that there are multiple criticisms of Holfstede's power distance research and the extent to which it should be used to explain individual human actions (McSweeney, 2002; Gerhart & Fang, 2005; Brewer & Venaik, 2010). However, recent health-related research continues to utilize the model to examine the influence of power distance in health communication between physicians and patients (Gao, Burke, Somkin, & Pasick, 2009; Meeuwesen, van den Brink-Muinen & Hofstede, 2009; Ryan & Sysko, 2007; Altshuler, Sussman & Kachur, 2003). This study serves as an extension of this literature.

Research suggests that collectivist cultures, like many in South East Asia, tend to adhere to norms of high power distance. Individualistic cultures, such as the United States and many European nations, tend to be low power distance (Hofstede, 2001; Merkin, 2006; Dysart-Gale, 2006). For collectivist cultures, individuals in positions of power are given the utmost respect, allowing for hierarchical displacement to become tangible in reality, so that differences in status are inherent and not human constructs. One manifestation of power distance, therefore, is in the medical field, in the sense that cultures may accept or reject doctor superiority over patients, depending on the predispositions of the culture. For example, in a traditional doctor-patient relationship, the doctor has greater access to medical information, is presumed to hold expert medical knowledge, and has the role of dispensing medical information, diagnoses, and prescriptions. This relationship is generally unequal in status and power, but the rise of social media has led to a new phenomenon where patients search the web for medical information and self-diagnose, challenging the traditional model of medical care. This may have implications on how doctors relate to patients. Having awareness of the influence of power distance on a certain culture becomes a crucial concept in understanding communication between doctors and patients (Dysart-Gale, 2006).

This study focuses on two countries with divergent power distance scores, according to Hofstede's research. Hofstede, Hofstede, and Minkov (2010) report that the U.S. scores (-)92 and the Philippines scores 162 on the power distance dimension. The Philippines' large positive score shows that the culture has high power distance, while the U.S.'s low negative score reflects that it is low power distance. Another reason why these countries were chosen for comparison is the fact that both countries have high levels of English literacy. The study focused on doctors in urban areas in both countries, because there are higher levels of social media penetration.

It is important to also examine physicians' desired impression by patient. This information provides insights on the specific manifestations of power distance in their relationships. Physicians' attitudes towards the equalizing nature of new technologies could be heavily influenced by their expectations of power distance between them and their patients. Based on the discussion of the utility of new media technologies in doctor-patient communication and power distance, this study advanced the following research questions:

RQ1: How do doctors desire to be perceived, in general, by their patients?

RQ2: Are there differences that would have to be taken into account in U.S. and Philippine doctors' attitudes toward using new media technologies in their practice? What kind of differences can be pinpointed?

Methodology

Sample

A total of forty in-depth interviews were conducted from 2012-2013. Twenty were conducted in the United States and twenty in the Philippines. Interviews were conducted in English. In the Philippines, participants were recruited using snowball sampling. All respondents practiced in the urban city of Manila. One of the researchers was born and grew up in the Philippines, and returns periodically to visit and conduct research. Thus, her background and experience closely influences the perspectives of this study.

In the United States, interviews were conducted among practitioners in Pennsylvania, Maryland, West Virginia, and Delaware. Participants were recruited using personal contacts, followed by cold-calling and e-mailing of doctors using business information on Internet directories. Subsequent interviews were conducted based on recommendations from these practitioners.

Thus, while the study uncovers some quantitative and qualitative trends between physicians from the two countries, it is not meant to generalize across any population. The study is exploratory in the sense that it sought to uncover comparative similarities and differences between doctors in two countries that showed polarity on the power distance scale. However, open-ended questioning allowed for the exploration of other cultural and societal differences that might affect doctors' use of new media technologies, such as legal institutions and the nature of health care institutions.

Prior to the start of interviews, physicians were told that they would be asked questions about their professional new media use. If respondents asked for clarification on the construct of new media, the definition given earlier in the literature section (i.e., social communication and interactive technologies) was provided. One of the limitations encountered in the U.S. interviews was that several of the participants were recruited through their social media accounts and may hold a natural bias towards utilizing new media technologies, compared to physicians without accounts.

The researchers used a semi-structured protocol to assure uniformity of questions, but also allow for in-depth probing, as needed. Semi-structured interviewing is guided by a set of questions, but the researcher is free to deviate in order to "understand the complex behavior of members of society without imposing any a priori categorization that may limit the field of inquiry (Fontana & Frey: 366)." The Interview Protocol (See Appendix A) was pretested on two physicians prior to data collection. Interviews were recorded, conducted in English, and lasted from 10-30 minutes (with an average of about 20 minutes). Ten female and ten male doctors were interviewed in the Philippines. They represented various specializations and had careers that spanned between 1-26 years. Eight female and twelve male doctors were interviewed in the United States, and represented various specializations. Their careers spanned between 1-34 years. All physicians were asked how the healthcare industry has changed over the past 10 years. Respondents were provided IRB protocol stating that they could opt out of any questions that they did not feel comfortable answering. Most physicians who have not been practicing over 10 years still hypothesized based on their interactions and training as medical students.

Data analysis

Qualitative interviews were analyzed following social science guidelines for qualitative data analysis. Interviewers took detailed notes while interviewing. Data was analyzed following Seidman's (2006) guidelines. Specifically, the process of identifying key themes from the interviews was done by reducing the text of interviews to what was most interesting for the research. "Most important is that reducing the data be done inductively rather than deductively ... the researcher must come to the transcripts with an open attitude, seeking what emerges as important and of interest from the text" (Seidman, 2006:117). Huberman and Miles (1994) call this "analytic induction," where an iterative process examines the set of cases and makes inferences that are then refined or modified as more data is considered.

It is important to note that the results represent the most salient and pertinent sentiments to the research, not necessarily the findings with the greatest frequency. For example, all physicians talked a great length regarding the many benefits that new media technologies might provide patients. However, these findings are already

apparent in current health literature. Instead, in the final analysis, researchers focused on sentiments relating to perceptions, relationships, power, and social/institutional components.

Transcribed interview data was then repeatedly read and analyzed by individual researchers, in order to identify relevant narratives that existed. For RQ1, a variable was created that coded responses on a question that asked doctors to give five words that described how they wanted to be perceived by patients. Results of RQ 1 were based on responses that were recoded relative to their thematic content. It was useful to provide the frequency in this question because it showed the prevalence of how U.S. vs. Filipino doctors wanted to be perceived by patients. Researchers had discussions on the open codes and agreed to collapse them into five categories for this variable, namely: *behavior toward patients, perception of work ethic, knowledge base/intellect, effectiveness*, and "*image" as medical provider*. The last category included a small number of responses that did not fit the first four, such as "physician," "pleasant-looking," "acupuncturist," and "holistic."

To answer RQ2, researchers had several discussions on themes that emanated from the rest of the interview questions. RQ 2 is a qualitative question, and so the authors were not as concerned with the frequency of themes, so much as they were interested in the salience of sentiments. Therefore, actual comments from doctors are presented verbatim, in order to support findings. Frequencies of responses are also included in the discussions of some of the themes.

Overall, this inductive process of coding meanings from interview transcripts resulted in three emergent themes that were useful in shedding light on the research questions of the study.

Results and Discussion

The first theme uncovered from the interviews involved doctors' preferences in desired impression by patients(RQ1). While this study is qualitative in nature, doctor responses were collated into a table that showed the categories of responses in desired impressions, mainly to reveal differences between the two groups of participants. As mentioned in the sample section, the study makes no attempt to generalize beyond the sample of doctors interviewed.

Both countries had the highest number of doctors' responses (about half) under the category of *behavior toward patients*, with the top answers being "caring," "friendly," "approachable," and "good listener." However, Pearson chi-square testing showed

significant differences between U.S. and Philippines doctors in the category of "effectiveness." *(See Table 1)*. Chi-square adjusted residuals show that American doctors were significantly more likely to prioritize *effectiveness* (residual=2.4), compared to Filipino doctors. Words under the category of *effectiveness* include: "solved problem, won't stop until job is done, healing, good at what he does, and effective." Adjusted Chi-square residuals also show Filipino doctors' preference for *good work ethic* to approach significance (residual=1.7).

Both Philippine and U.S. doctors placed *good work ethic* second; however, almost twice the percentage of Philippine doctors rated this important (27%) versus American doctors (15%). *Good work ethic* included items related to responsibility and professionalism, such as "responsible," "hardworking," "dedicated," and "honest." The third priority was *knowledge base/intellect* for Philippine doctors (17%). Typical *knowledge base/intellect* responses included "knowledgeable," "intelligent," "logical," and "competent."

Table 1: *Doctors' preference on how patients perceive them*

	U.S.	**Philippines**	**χ^2**
Patient perception	n=54 (%)	n=96 (%)	**χ^2=9.31, df=4, p<.05**
Behavior toward patients	29 (54%)	47 (49%)	
Good work ethic	8 (15%)	26 (27%)	
Knowledge base/intellect	6 (11%)	16 (17%)	
Effectiveness	6 (11%)	2 (2%)	

Image as medical provider	5 (9%)	5 (5%)	

Compared to American doctors, Filipino doctors exhibited more preference toward "knowledge base/intellect" and "good work ethic," which support the notion of higher power distance. These results can be understood using power distance concepts of hierarchical privilege/equal rights, and dependence/interdependence. The nature of the social health care system in the Philippines also helps explain the importance given by Philippine doctors to this item. The premium Philippine doctors place on *good work ethic* is a function of the hierarchical three-tier nature (public insurance/private insurance/private pocket) of the health care industry in the Philippines. This nature results not only in highly unequal power between doctors and patients, but also in unequal access to health care and hierarchical privilege for the rich. For example, there is no law requiring employers to provide health insurance to employees. Only about 20% of the population has private health insurance, and about 34% of the population is served by government health insurance (Manila Times, 2012). The rest either pay (the rich) or rely on emergency services provided by government-run facilities (the indigent). The three levels represent 1) those who are financially well off, who pay out-of-pocket for their care, 2) those with private health insurance who are tied to Health Maintenance Organizations, where doctors are often overloaded with patients, and 3) the indigent, or those who rely on government-provided care, usually from practitioners who get a fixed monthly salary, regardless of number of patients they treat (Rosell-Ubial, 2008).

This three-tier structure is further reinforced by the polychronic (Hofstede, 1980) nature of Philippine culture, one characteristic of which is that there is little emphasis placed on being on time. It is rare for doctors to have scheduled appointments. Often, secretaries post a sign-in sheet early in the morning and patients are seen by the doctor when office hours start. Therefore, another level of hierarchical privilege exists in terms of doctors' privilege over patients in time management. Patients can often expect to wait hours to see a doctor, who may be late for reasons as varied as unpredictable traffic, other commitments, or a patient that took longer than others. Furthermore, a physician who does not have appointments can choose to see private paying patients first, before those with government insurance are seen, or those who are paid a fixed monthly salary may choose to drag out appointments and see only a few patients each day. Azfar and Gurgur (2008) also explain how physicians accept bribes and kickbacks. This is one of the leading factors influencing health outcomes in the Philippines, as they could lead to a perception of laziness and unprofessionalism on the part of doctors who provide service under the latter two private and public health insurance systems. Power distance is manifested here because the relationship

between the doctor and patient is unequal, leading to doctors having control over patient time and whom they see. This explains the cultural importance that physicians place on being viewed as having a good work ethic.

Philippine doctors also want patients to perceive that they hold superior *knowledge base/intellect* vs. patients. Issues of dependency related to power distance can come into play. Based on interviews, doctors state that they have greater access to quality medical information than patients. This accessibility accords them higher status, in terms of medical knowledge, leading to expectations that patients should be dependent on them for dispensing information, diagnosis, and treatment. In effect, they expect patients to have confidence in them as medical practitioners, reflecting high levels of power distance between the doctor and the patient. Thus, when patients bring in information they got from the Internet, doctors perceive this as a challenge to their authority.

Most patients know about their diseases,.. (but) it is difficult because they might preempt whatever it is the doctor wants them to do. It's ok for them to know, but they should leave it to the doctor to have the definite say in medical things because we went to med school and of course we know more about what's happening.

Interestingly, there is little concern among Philippine doctors that their image is ineffective; further testament to an attitudinal norm that reflects high power distance, as it venerates doctors as experts who are effective in solving the problem. In contrast, American doctors desired patients to see them as effective, reflecting a more equal level of interdependence between doctor and patient. Because the U.S. health system is heavily insurance-based, doctors are under pressure to abide by rules such as sticking to appointments, which are commonly first-come first-serve within each practice. The monochronic nature of American culture (Hofstede, 1980) and the limited amount of time allotted each patient, emphasize timeliness. Patients are generally seen close to their appointment time (Galanti, 2008). American patients, therefore, have greater power in terms of time management as far as *when* they see doctors. However, this regimented process, also limits the length of time doctors spend with patients, which might explain why doctors desire patients to see them as effective.

I get up at five. I'm in the office by six. For two hours before, which gives me three hours of paperwork a day, which should be more than sufficient. But I know having to put in 20 min appointments and it takes me 20 to do their paperwork. It takes me a good 4-5 hours each day to do a good job on their charts. If I can just click click click and go, which a lot of physicians have done, the charts are not as detailed or as well done as before. My fulltime partners have decided to do patients every 15 minutes and

they will see 35 patients in a day. A doctor seeing five patients an hour, in and out, in and out, in and out, and each patient walks out with a prescription and that's it.

The second theme that arose from the interviews was that both Philippine and American doctors perceived today's patients to be more informed than those of years past; however, Philippine doctors viewed this as a challenge, while U.S. doctors viewed it as an opportunity to initiate conversation.

Virtually every participant in the study reported that their patients come into appointments more knowledgeable about their ailments, prescriptions, and alternative healthcare options. However, American and Philippine doctors reacted to this phenomenon very differently. American doctors tended to embrace their patients' newly founded level of knowledge as a way to initiate communication during in-person visitations.

It's given the patient an opportunity to ask more questions, get more involved in their care. Before I'd imagine a physician would prescribe a drug and that would be it. Now a patient is going to go home, research that drug, have questions about that drug and say you told me to take this, but I found information about this other drug and I think that would be better. Patients are more educated and involved in their care. Office visits are more streamlined because they come with questions and we can go right down the list while they're in the office.

American doctors explained how informed patients are now asking questions based on the information that they receive on the Internet. This communicative initiation allows the doctor an opportunity to then provide feedback and guide the patient towards a correct set of information. American doctors valued this initiation because it prompted conversation. Even though many spoke of how patients were likely to be misinformed, this process acted as a means for patients to freely communicate their inquiries and take part in their personal healthcare process.

Filipino doctors, however, did not embrace this phenomenon. As stated earlier, they saw this type of patient behavior as a challenge to their authority. Doctors expected patients to have confidence in them as physicians, reflecting a hierarchical relationship where physicians had more knowledge and power over patients. While it may be argued that patients' use of new media technologies to get their own information can bring about the potential to equalize the relationship and give them the opportunity to question doctors, this was not welcomed by physicians. Although doctors reported patients to be highly informed, 17 out of 20 interviewees perceived that the amount of misinformation found on the Internet created more problems than solutions. One Filipino doctor used the term "*weaponry*" to describe this information, in the sense that it can battle with the doctor's knowledge base.

The knowledge that's in the website, in books, in magazine articles are not really what the patient should know about and sometimes it's also difficult to somehow undo or erase some of the knowledge that is self-researched by the patient.

Others reported that misinformation tended to be used for wrong self-diagnoses and treatment.

Take for example, child psoriasis. There is no cure, only management. But some patients go on the Internet and try out things like feeding clay to their child.

One interesting finding is that although American doctors tended to embrace self-informed patients, none of them recommended using the Internet as a primary source of information, with the exception of medical journals. In contrast, Filipino doctors generally perceived informed patients as a challenge, but reported that they would recommend American websites, such as WebMD and Medscape. The general perception among Filipino practitioners was that if the website was from the United States, it was more acceptable and reputable than other options. This is another reflection of power distance – this time between countries. Twelve out of twenty Filipino doctors interviewed clearly perceived information from American websites to be superior to local sources.

The third theme from the research identified differences in concerns about litigation between U.S. versus Philippine doctors, which then influenced their attitudes toward the use of new media technologies in their practice. This represents another important aspect of how differences in the two countries' legal institutions may affect doctors' attitudes toward new media technologies. Societal norms on litigation influenced physicians' willingness or unwillingness to utilize new media technologies to communicate with patients.

One dichotomy of power distance includes hierarchical privilege and equal rights (Hofstede, 1980). The ability to file suit if the physician does something wrong, influences the power relationship between doctor and patient. Rather than serving as an "all-knowing" prescriptive entity, American doctors must consistently deal with a client base that has the ability to hold them accountable for any missteps. U.S. doctors seemed unwilling to utilize new technologies to bridge this power gap any further, in fear of opening themselves up for further litigation.

Lawsuits are rare in the Philippines, especially in the healthcare industry. Filipino doctors have little concern for being sued, as it rarely ever happens. As an example of this, take the case of one of the respondents, whose practice involved LASIK eye surgery. In their practice, the procedure is recorded, and DVDs are provided to

patients for their viewing pleasure. This practice might be considered unusual in the United States considering the litigious nature of American culture.

Sison and Palma-Angeles (1997) describe Filipinos as a non-confrontational and non-litigious society. Additionally, Mello et. al. (2006) explain that lawyers in the Philippines scarcely represent public-interest healthcare cases. This naturally creates a culture of high power distance. Physicians are presumed to hold expert medical knowledge, and are able to dispense medical information, diagnose, and prescribe treatment to a passive patient, without question or ramification for missteps. If something were to go wrong, there is little that a patient can do in response.

Through in-depth interview discussions with Filipino doctors, it became clear that the interactivity features of new media technologies were the first times that Filipino doctors experienced challenges from patients:

Before, doctors are the source of information but now doctors are afraid to reveal information because the minute you say something they will say 10 things to contradict that. And they sometimes have printouts ready. Unlike before when (doctors) say it, it becomes gospel truth. Now that is not the case anymore. Now doctors are forced to act like they are under the patient, not the authority.

Doctors also expressed dissatisfaction with their patients having the ability to utilize online communities to discuss and rate their physicians:

We have had patients post on their FB account that that their child was admitted on the hospital. For me, if it's just the emotional , how the parents feel about their child, that's fine. But sometimes they also post negative reactions to doctors' management or hospital policies, which are unfair for doctors like us because we can't respond to it.

New technologies have changed the relationship between physicians and patients in the Philippines. These changes have brought many challenges that most Filipino respondents were still trying to figure out. Some feared that unsatisfied patients would utilize new media to find a new physician. However, concerns of litigation still did not emerge:

"Right now a patient will not rely on the physician 100% in terms of the diagnosis. Some may probably even doubt the physician's diagnosis because a lot of them will go to the clinic with a lot of information, so trust between patient and physician may be affected. Before the patients trust the doctor 100%. That's one. Because of that doubt, there is a tendency for them to go doctor shopping until they are satisfied using the Internet as a standard. Doctors will have to be prepared."

It is widely understood that the United States is a highly litigious culture. Large numbers of malpractice lawsuits have resulted in many healthcare costs, both financially and in practice. Research demonstrates that litigation is responsible for over $30 billion dollars in American healthcare costs (Searcey & Goldstein, 2009). U.S. physicians practice in fear of getting sued, resulting in the leading factor for risk of error in hospitals (Bagnara et al., 2010). Many physicians have begun focusing their practice on "bite-size" specialties, resulting in health professionals "who know more and more about less and less" (p. 6). This practice leads to even more prescriptive medicine without taking into account whole body medicine. While none of the Filipino doctors mentioned litigation as a concern, the issue of possible litigation was apparent in 12 of the 20 U.S. physician interviews:

Many other countries embrace the technologies because it benefits them and the patients. Medical liabilities in other countries, it's very different. Doctors here get sued for the silliest things. That's a huge difference culturally. Privacy is of utmost importance, especially because of litigation. In other countries there is no such thing as HIPPA (The Health Insurance Portability and Accountability Act), not saying that's a good or bad thing, but in the U.S. everyone is conscious of it.

Other U.S. physicians were hopeful that by strengthening the relationship with patients, they would be less likely to get sued for malpractice:

The better relationship the physician has with the patients, the less likely the physician will be sued by their patients. For right now, it's the way the health system is set up.

A majority of U.S. respondents expressed high levels of uncertainty regarding the legality of communicating with patients through new media technologies. Specifically, physicians who graduated from medical school more than ten years ago seemed unsure about how to most effectively utilize new media technologies and maintain patient privacy:

Anybody can sue anybody for anything. You have to be as careful as possible. Most of the concern revolves around security and privacy. Privacy being the biggest concern because of physicians fearing that if they start having dialogue with patients, or somehow there's a perception that they are having a discussion with a patient, that is a violation. If a patient wishes to disclose something on a public forum, or have lab data or health information online, could someone somehow hack into that and get it?

Overall, these interviews present a clear shift in the ability of Philippine patients to mitigate power distance in their relationship with physicians. While U.S. patients have always had the ability to file malpractice suits for physician wrongdoing, Philippine patients are beginning to use new communication technologies as an immediate space

for ratings and recommendations. Nonetheless, this was not welcomed by Philippine doctors. Neither physicians in the U.S. or Philippines expressed a strong willingness to utilize these new media technologies to communicate with patients, despite their understanding of the advantages towards doing so. U.S. physicians believed that the current healthcare system does not allow them to engage audiences on such a personal level without fear of litigation. Filipino physicians, while not as concerned about litigation, were beginning to see shifts in patient attitudes toward challenging their authority.

Conclusion

This study sought to explore the differences between U.S. and Philippine physicians' desired impression by patients, as well as to uncover their attitudes toward the use of new media technologies in their practice. Using the framework of power distance, the study uncovered differences between the two groups. The exploratory nature of the study allowed for semi-structured interviewing that uncovered, not only themes related to the abstract cultural dimension of power distance, but also bureaucratic and system-bound aspects of society (such as the organization of health care systems and legal institutions) that affected doctors' dispositions toward new media technologies. Throughout both sets of interviews, repetitive narratives emerged, pointing towards clear protagonists and antagonists in the physicians' daily professional activities. U.S. doctors spoke of insurance companies, paperwork and HIPPA privacy regulations as consistently preventing them from effectively treating the number of patients in the manner that they would prefer. This construct emerged six times during interview discussions with U.S. doctors. Filipino doctors told a different narrative that questioned the potential of technologies for rating their work, and questioned patient misinformation as preventing them from effectively treating and interacting with their patients.

While health literature predominantly posits new media technologies as a positive advancement, this study reveals the complications that cultural norms, such as power distance, create. For example, differences in doctors' attitudes towards the use of new technologies are heavily influenced by issues of power distance. In high power distance countries like the Philippines, doctors may resist new technologies because they pose challenges to their authority. In the United States, doctors expressed a greater willingness to utilize new technologies as a means to begin communication with patients hoping to forge an interpersonal bond between the two parties. However, there is resistance towards technological communication due to fear of litigation. It is, therefore, important to realize how cultural differences may affect perceptions of new technologies more negatively than the literature suggests. Although technologies have

a potential to aid in communication between doctors and patients, cultural differences influence the manner by which the specific technology can be used.

It is also important to note that these interviews are only representative of the areas in which they were conducted. While researchers originally investigated the United States and Philippines, due to their polarity on Hofstede, Hofstede, and Minkov (2010) power dimension index, it quickly became clear that findings were tightly bound with the nature of the healthcare systems, as well as with cultural norms and practices. It would be far-reaching to assume that the themes that emerged with American physicians are representative of all low-power distance cultures, and themes that emerged with Philippine physicians are representative of all high-power distance cultures. It is probable that even physicians practicing in more rural areas of each of these same countries would provide vastly different responses to the questions. Similarly, future interviews could involve physicians who represent different dimensions such as private versus public sector doctors, physicians who work with ethnic minority clients, physicians who work with predominantly richer versus lower income clients, etc. Future studies should more broadly investigate these constructs through holistic measures to better understand this relationship.

Overall, power distance was evident in the themes uncovered for both sets of physicians. Specifically, in the Philippines, results underscored the hierarchical privilege doctors had over their patients, physician expectations of patient respect, physician accessibility to and right to dispense medical information, expectations of patient dependence on doctors, and physician discomfort with patients using new technologies for feedback on doctors. The social hierarchy of the medical system and its effects on physician corruption and perceived laziness also led to doctors wanting patients to view them as having a good work ethic. American doctors showed lower levels of power distance in that they were more welcoming of patients' use of new media technologies as jump-off points for communication, and were more concerned about being viewed as effective rather than having a good work ethic or knowledge base. However, they were quite concerned about the litigation consequences that could arise from use of these technologies in their practice. This reflects a lower level of power distance because patients have recourse to seek redress when they feel something has gone wrong in their treatment. In contrast, Philippine doctors were not concerned that patients might sue them, another manifestation of high power distance in the doctor-patient relationship in that country. Instead, they were concerned that new technologies were affording patients the power to provide feedback and comments about them online. It seems, therefore, that new technologies were providing Filipino patients an avenue to begin equalizing the relationship, but doctors were resisting this change.

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Appendix A

Interview protocol

1. "Can you give me 5 words that you would like patients to describe you as?"
2. Is there a difference between today's patient compared to 10 years ago? How knowledgeable do you feel patients are?
3. Have new media technologies influenced the amount of information a patient has when they visit your practice?

4. How have new media technologies changed your everyday practices as a physician?
5. How open are you to incorporating these technologies in your practice?
6. What opportunities do new technologies provide for patient communication? Would you be willing to use new media technologies as a regular means of communication with patients? What about hard-to reach patients?
7. What challenges do new media technologies provide for patient communication?
8. What new media technologies are patients using to improve personal healthcare management? How do you feel about this trend?
9. Do you feel that the dispensing of medical knowledge should be in the hands of medical practitioners, or are you supportive of patients using these media to self-diagnose or treat themselves?
10. Do you have standard recommendations for websites patients can go to?
11. How do you perceive the nature of the dynamic between you and your patients to evolve with new media technologies?
12. Do patients use social media to seek social, emotional counseling or support (from regular people) for their illness?

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