PATIENT PORTAL ADVERTISEMENTS:
A DISCOURSE ANALYSIS

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ABSTRACT

Information and communication technologies that connect patients to their healthcare providers are becoming increasingly widespread. One of these technologies is the patient portal, whereby patients can access health information and complete tasks such as messaging physicians, booking appointments, accessing educational materials, and requesting medication prescriptions. In the present study, we analyse advertisements produced by the National Health IT Board to identify the hopes and expectations that have been used to 'sell' patient portals to patients and doctors in New Zealand. Two conflicting sub-discourses were detected. In the first, healthcare is constructed in terms of physical and emotional connection, presenting patients as vulnerable and dependent, and doctors as experts. In the second, healthcare is constructed as a commercial product, provided by doctors to consumers, in which efficiency is paramount. Our analysis shows that patient portals could reconfigure traditional relationships between health professionals and their patients, altering the conventions of closeness, and at the same time, shifting some responsibilities and stresses of clinical administration onto patients.

Keywords: Patient portals; New Zealand; medical sociology; discourse analysis; Dryzek

INTRODUCTION

In his seminal text, Marshal McLuhan (1994) referred to media as the 'extension of our own bodies and senses' (p.15). Such a notion is exemplified in the current information society, where an increasing number of technologies and mobile 'apps' digitally capture, monitor, and share health information, allowing users to consume healthcare on the move, irrespective of time and space. One of these technologies is the patient portal: an online platform which can

give patients access to their medical records and, depending on the setup, allow patients to exchange electronic messages with physicians, book appointments, access educational materials, pay bills, and request repeat medication prescriptions (North *et al.* 2013). Patient portals have been promoted to primary care practices in New Zealand (Ministry of Health 2013) and government incentives have encouraged the implementation of similar technologies in the United States, Canada, Australia, and Denmark (Adler-Milstein *et al.* 2014). In March 2017, over 445 practices offered a patient portal and 336,576 patients were registered with a patient portal service in New Zealand (Ministry of Health 2017).

A speculated benefit of patient portals for healthcare practices is that costs from labour processes will be cut (North *et al.* 2013), because, in a similar vein to internet banking or self-scan checkouts, work is delegated to the technology and, although less publicised, the customer. Manufacturers have recommended that practices 'stress patient convenience and access to avoid any inference that the portal is a self-service tool designed to reduce health system workload' (Oldenburg 2013, 242). This statement indicates that part of the motivation of patient portals is to reconstruct human work in a way akin to Fuch's (2015) theorisation of digital labour, in which users' unpaid labour is veiled by free access to a digital platform. The workload is externalised to an online medium, and patients are tasked with specialised processes in order to increase productivity and efficiency.

Another rationale of patient portals is to empower patients to 'take a more active role in the management of their health and wellbeing' (Medtech 2017, para. 1). This statement may signal a cultural shift from the more paternalistic delivered healthcare of the past (Cayton 2006). Nikolas Rose (2007) discussed how the power once held by doctors has been constrained by the apparatus of bioethics, evidence-based medicine, and patients' demands for autonomy. At the same time, with consideration to the cost-savings associated with the re-delegation of tasks, we wonder whether this claim is a way of disguising resource rationing, while shifting the burden of care onto civic responsibility. Similar concerns have been made by analysts concerning the use of empowerment and self-management discourses in healthcare (Bury 2008; Kendall *et al.* 2011).

It is important to recognise that a patient portal may allow patients to be involved in managing elements of their healthcare and result in added conveniences for some people, but its social effect is far-reaching. Hans Gumbrecht (2004) maintained that materialities can become 'present', impacting human

senses, emotions, and bodies. Hence, agency resides in 'a joint mediation between the built-in properties of objects and the intentions and purpose of human subjects' (Fairhurst and Putnam 2004, 18). For example, an electronic medical record might be implemented so that information can be accessed more efficiently, but it also impacts behaviours and social processes by standardising aspects of professional practice, curtailing professional autonomy, and redistributing clinical work within and across professional boundaries (Petrakaki, Klecun, and Cornford 2016). Furthermore, the act of viewing and updating these records and the physical presence of an electronic device changes the interaction between patients and healthcare providers (McGinn *et al.* 2011). Today, information and communication technologies have blurred the lines between an array of once stable distinctions: between work and play, production and consumption, coercion and choice, and publicity and privacy (Nealon and Girous 2012).

In the present article, we analyse five advertisements to identify the hopes and expectations that have been used to 'sell' patient portals in New Zealand. As stated by Nelly Oudshoorn (2011), technologies' expectations, 'not only define the relevant actors, they also allocate specific roles to them as well as to the (future) technology. How people and things should act' (p. 35). Furthermore, as Borup *et al.* (2006) stated, 'Novel technologies do not substantially pre-exist themselves except only in terms of the imaginings, expectations and visions that have shaped their potential' (p. 285). Significantly, while studies have examined the impact of patient portals on matters such as organisational efficiency (Goldzweig *et al.* 2013), medication safety (Heyworth *et al.* 2014; Wright *et al.* 2015), and patient perceptions (Haun *et al.* 2014; Woods *et al.* 2013), no known studies have investigated how patient portals are presented in promotional material.

Our analysis was influenced by Dryzek's (2013) typology, which involved examining the basis of the discourses operant in the texts: the entities constructed or recognised, the assumptions made about the relationships between and among the stakeholders in the adoption of patient portals, the motivation of the agents of the discourses, and the rhetorical devices deployed in the attempt to create the portals as a social reality. The advertisements in focus were produced by the National Health IT Board; a board established by the Ministry of Health to provide strategic leadership on healthcare IT in New Zealand, which has since been replaced by the Digital Advisory Board (Brown 2016). The advertisements were circulated and are now in the public domain, appearing in newspapers, magazines, healthcare practices, and online, as part of a campaign in 2015 costing $900,000 (Coleman 2015), and unlike previous

campaigns, included the general public in its target audiences. It is for these two reasons that the texts seemed to us to be significant: if the portals required an extensive and expensive advertising campaign in order to achieve wide social acceptance, it seemed that the premises on which the promotion was based was worthy of examination.

METHODS

The advertisements were retrieved from the National Health IT Board website. Clearly, three of the advertisements target doctors (Figures 1–3), and the other two target patients (Figures 4–5), as they address the target audience directly with phrases like 'your practice', and the images in the doctor-targeted advertisements are set in healthcare clinics, while those in the patient-targeted advertisements appear to be set in patients' homes.

The analysis was influenced by Dryzek's (2013) typology of four inter-relating elements. The first element is the entities recognised and constructed in the language associated with a phenomenon. The second element is assumptions about natural relationships between and among the entities that are construct-

Figure 1

Figure 2

Figure 3

Figure 4

Figure 5

ed within the discourse. Such assumptions are present in all discourses, and this might include entities being placed in competition with one another, or in a hierarchy based on gender, race, wealth, and expertise. The third element is the agents of the discourse and their motives. The fourth and final element in the typology is the metaphors and any other rhetorical devices that are employed to build effect in the discourse. We did not follow his method of discourse analysis in a strictly linear way, but instead, we used his four principles to guide an examination of the images and written text in the advertisements.

RESULTS

Theme One: Caring and concern

The advertisements all, one way or another, show examples of care in action: doctors regarding their patients with focused concern; a mother cuddling her child. Thus, we contend that *caring and concern* is one of the entities constructed in the promotional discourses of patient portals, and is heavily present in all the advertisements and brochures. This is expressed through the images that depict intimacy and closeness between the characters, most notably perhaps, in the obvious visual metaphors in the patient-centred advertisements showing medical professionals emerging from technological devices. Here, the suggestion is that medical support is always close at hand whenever it is needed. Additionally, some of the images are redolent with standard tropes associated with caring: as we have already said, among the images in the patient-targeted advertisements, there is a mother holding her sleeping child (Figure 4), and the implication is that a patient portal means that medical expertise and care is close at hand to alleviate parental worry. The image in Figure 5 showing two adults sitting arm to arm with their coffee on a table in front of them suggests that receiving medical care can be as informal, comfortable and chatty as two friends having coffee. In scholarship dealing with medicine as a social institution, it is not uncommon to find that a distinction is drawn between two 'faces': between, technology and humanness, between cure and care, and between the science and the art of medicine (Putnam *et al.* 1985). It is clear that the latter of these distinctions is present in this discourse. The care constructed in these images is consistent with Milton Mayeroff's (1971) concept, consisting of caring ingredients such as patience, humility, hope, trust, courage.

As well as showing an idealised closeness between practitioners and patients, these images construct simultaneous but somewhat conflicting views of patients. On the one hand, they are shown in charge, having access to the con-

venient technology, depicting a consumer model of care, where patients are in control as decision-makers (Emanuel and Emanuel 1992), but also as vulnerable and dependent on their doctors for help, reassurance and support, closer to a more paternalistic care model (Emanuel and Emanuel 1992). Vulnerability is signalled in the advertisements by featuring children and elderly people, and by showing body language of concentrated attention on the practitioner (Figure 2), in which an older man is bent towards the doctor, clearly listening attentively, and Figure 4, in which a child is shown cuddled curled up on her mother, seeking comfort. At the same time, the patient portals encourage vulnerable patients to hope for good outcomes, because their body language suggests optimism, as though the affordances of the patient portals offers a certain peace of mind. It is fair to say, however, that these patients do not appear acutely unwell, so perhaps the ultimate message is 'care and concern *everyday*': the portals would have no appropriate place in acute or emergency situations.

The intimacy and closeness between the characters shows a recognition of the social and psychological components of healthcare, which contrasts with a biomedical viewpoint (Nettleton 2006). Healthcare is here constructed as more than just the delivery of medicine or the mending of physical ailments: it is also a tool of reassurance, where the act of medical care is delivered through compassion and the simulation of physical touch. This is significant because the technology itself is the opposite; the patient portal creates not just a physical space, but also one that is social and cultural, as the technology creates a new dimension to proxemic space within the health setting. The images of doctors rising ghost-like from digital devices personalise the patient portal (Figures 4 and 5), suggesting that by logging in you are accessing a familiar person, 'your GP' [General Practitioner], who is close by, in your living room whenever necessary.

The new technology, therefore, promotes its distant service in terms of the most established form of medical practice, the face-to-face contact, and in this respect, maintains the convention that doctors control the encounter and are central to the patients' well-being. Thus, the healthcare professionals are constructed as the binary opposites of the patients: they are experts, and their expertise is represented by their confident body language and reinforced by various symbols of the medical profession, including a nurse's uniform (Figure 2), scrubs (Figure 3), a lab coat (Figure 1), and a stethoscope around a doctor's neck (Figures 4 and 5). It is not a coincidence that these symbols have been included, because they not only identify the roles of the different 'characters', but they also represent and perpetuate the power of the medical profession

(Goffman 1968), as expertise is the surest way that doctors can exert power over patients in the context of healthcare delivery, even if they do it unconsciously or with the best of intentions. As these representations depict western practitioners working within a traditional biomedical environment, this is framed as being superior to other cultural practices, such as acupuncture or Ayuverdic medicine, which are not present and are thus rendered as invisible or irrelevant to medical practice.

The entities recognised and constructed in the advertisements can be deciphered from the written text as well as the images, which feature verbal messages superimposed directly on images that are bound to be familiar to the target audiences. Fairclough (1992) speaks of forms of synthetic politeness created by the use of personal pronouns in otherwise impersonal contexts, and we contend that here they are used to build synthetic caring. This familiarity, together with the use of the second person pronouns, relates to, and draws in the viewer who is addressed as 'you'. The written messages are woven into the structure of the pictorial fantasy. For example, Figure 2 shows the image of a doctor smiling at two patients. The image is accompanied by the words, 'Because the highlight of your team's day is seldom admin', which suggests two things: first, that the interaction with patients, and perhaps that helping others in need, is the real highlight of the medical profession, and second, that a caring leader of a team would do whatever it takes to reduce the 'admin' load by providing staff with a patient portal. This presents healthcare practitioners as the kind of carers which, as Fitzgerald (2004) has described, maintain 'a deeper and more complex motivation towards work than the simple desire for financial remuneration' (p. 335). Taken together, the image and the written message evoke the notion that medicine is more than just a job, and that delivering care is a higher calling that serves the greater good.

The doctor-targeted advertisements contain four sentences claiming that a patient portal should be implemented because it will give, '… more time to spend with the patients you really need to see'. The last five words of this tagline are particularly telling, because they highlight the value placed on face-to-face interaction, and it positions patients as being in need of the doctor's aid, although it simultaneously suggests that some patients are not ones the doctor 'really needs to see': that they are, at the worst, time wasters, and at the best, distractions from the important work, placing increased value on emergency and acute care, which is unexpected, given that the advertisements target doctors working in primary care. As with the other Figures, the use of the second-person pronoun 'you' appeals directly to the target audience and builds identification with the product. Part of the identification under construction

here occurs because of the separation of 'you' from 'they' – the patients – who are referred to in the third person. This lexical separation suggests that the makers of the patient portals have an intimate and sympathetic understanding of the problems of physicians' work, and want to help solve this problem, the burdensome and time-consuming patient who does not 'really' need to be seen. This advertisement stands in marked contrast to the personal identification established with 'your team' in Figure 2. The doctors and the doctors' team are personalised, while the patients are not, another signal that the relationship between patients and healthcare providers is unequal.

The nature of relationships varies in the advertisements. In the patient-targeted advertisements (Figures 4 and 5), intimacy and closeness is depicted between patients and their loved ones outside of the medical establishment, demon-strating a separation and a relationship shift that is constructed by the patient portal, in which the doctor is repositioned from the carer to the expert, and the patients' loved ones become the providers of support and care. For example, the patients are depicted outside of the medical facility. Conversely, most of the images in the doctor-targeted advertisements (Figures 1–3) show a close-ness between patients and healthcare practitioners, and state, 'Enhance your relationship with your patients'. Thus, the doctors are constructed for the two different audiences as both experts providing medical knowledge and patients' carers and sources of support, and both constructions occur through the me-dium and mediation of the patient portal: the doctor-targeted advertisements (Figures 1–3) claim that a portal will give doctors more time with their patients, while the patient-targeted advertisements (Figures 4 and 5) claim that it will allow patients' healthcare to be managed in the home, with the care and love of family.

One of the entities constructed in the discourse of care and concern is *techno-logical safety*, and this entity is developed and substantiated in two ways. Oddly, the first method of bringing technological safety into being is to de-emphasise technology altogether and to emphasise people instead: people interacting with others – family, doctors, patients. Thus, through the safety and convenience of this new technology, the discourse of patient portals constructs enhanced in-terpersonal relationships, possibly a tactical move to circumvent uncertainties and doubts about the online safety of personal health information, as studies have shown that patients worry about the privacy of information in patient portals (Fischer *et al.* 2014). The entity of technological safety, therefore, runs parallel with assumptions about the medical safety of the portals: the discourse of care and concern cannot function as a representation of social reality unless it is predicated on a sense that patients are in virtual hands that are as safe as

human hands. Despite the reassurances offered about the safety and convenience of patient portals, the texts directed at patients do not contain images of people using technology. One reason for this might be that not all the target audience are digital natives and some people might either not have access to the technology, or might have been frustrated by online programs in the past, as usability issues have been shown as a barrier to the successful uptake of healthcare technologies among patients (Fischer *et al.* 2014).

There are two instances where the use of a pun exemplifies the caring and concern discourse. Broadly, both puns refer to the patient portal as enhancing relationships while simultaneously decreasing the physical proximity between patients and doctors. The first pun occurs in the word 'closer', in the tagline 'Your GP has never been closer' which is in the advertisements targeted at patients (Figures 4 and 5), and the second occurs in Figure 1, in the word 'connected', as in the phrase, 'Stay more connected with your patients'. The puns may have been unintentional, but considering the benefits that patient portals are meant to offer both sides of the doctor-patient relationship, it is unlikely that the straightforward denotative meaning of either words was intended. Reading the taglines in the context against the purpose of the advertisements, it becomes clear that the portals are desirable for patients because they make medical care accessible from a distance, which in real terms, is the opposite of 'closer', although the idea is reinforced by the images that depict doctors emerging from electronic devices. Conversely, the advertisements directed towards doctors place value on the way the portals can improve the psychological connection between doctors and patients, as it shows a doctor caring for a frail man.

These two taglines are significant for various reasons. Firstly, both are part of the largest, most dominant written text, and they are placed in such a way to catch the reader's attention. Therefore, it is likely that much thought was put into the meanings and connotations associated with the phrases. Furthermore, the way that the two puns bring the viewers' interpretation to the different meanings show the conflicted nature of the caring and concern discourse: on the one hand, the care it expresses is occupied with eliminating all but 'the patients you really need to see' from the doctors' day, but on the other, it brings the doctors 'closer' to the patients than ever before. The two goals are contradictory and incompatible: it is hard not to feel cynical about the intentions of both the discourse and technology, and to view them as anything other than a product driven by commercial imperatives. The taglines also demonstrate the different technological functions of the portals, redefine concepts of closeness and care in the patient-doctor relationship, and notably, that this concept is

not a negotiated one, but rather, is technologically determined. Choice exists, at least for the time being, for patients to accept or reject the use of portals, but if they do accept them, then this is a new model of 'closeness' to which they must acquiesce. In the case of the doctor-targeted advertisements, the focus of the discourse of 'care and concern' rather concentrates on the way the portals can assist and preserve the traditional patient-provider relationship where the doctors are the holder of the power.

Theme Two: Business of healthcare

Although the discourse of the business of healthcare is less overt than the caring and concern discourse, it is present, and deeply embedded within the advertisements. The discourse of caring and concern dominates the images in the advertisements, but the business of healthcare discourse becomes evident when the verbal component of the advertisements is examined. For instance, Figures 1–3 use terms such as 'workflow' and 'administrative burden', and we contend that these are noticeable examples of medical practice being colonised by the discourses of business and managerialism. On the surface, the business of healthcare discourse seems even less explicit in the advertisements that are directed at patients, but such images as those in Figures 4 and 5, of a doctor ghosting out of a digital device, accompanied by written suggestions that patients can manage more of their healthcare for themselves, are subtle examples of this discourse in practice. Much has been written elsewhere of the colonisation of private life by the service of capital (Beverungen, Böhm, and Land 2015; Lazzarato 1996), and the same principle is in operation here: this time, patients are given or pay for the privilege of 'managing' their own health.

The business terms quoted above construct doctors not only as experts, but also as capitalists with a market mentality, and, therefore, concerned with efficiency, profit margins and revenue generation. It is doctors-as-business-people, rather than as healers, that the doctor-targeted advertisements address directly. For example, Figures 1 and 2 state, 'A patient portal can reduce your general practice team's administrative burden and improve workflow, giving you more time to spend with the patients you really need to see'. In this sentence, the doctor's employees and colleagues, the 'team', are presented as being inefficient or at least not as efficient as they would be if a patient portal were implemented, improving 'workflow' and streamlining the manner in which the medical practice is run. The language resembles that associated with a factory production line and operations management. Furthermore, the use of the word 'burden' suggests that healthcare practitioners are overworked because of an excessive amount of administration, which hinders their time with patients. The

words 'patients you really need to see' imply that delivering care and concern is still a priority in the medical profession, but taken within a business context, this indicates that caring must also return a profit. These representations are consistent with new managerialism, referring to the displacement of a private sector management style into the healthcare sector in the 1980s (Nettleton 2006). Notions of what constitutes 'good' staff includes cost-effective management and efficiency, in addition to providing adequate care (Ryan, Patterson and Carryer 2003).

The idea of reducing administrative burden and improving workflow is surely appealing. However, here the discourse is long on claims and short on detail: these business 'buzz words' are, on one level, impossible to oppose, because what sensible person would not want healthcare to be more efficient? However, as we have already pointed out, the claim is predicated on the idea that present systems need improvement, and that medical practice is readily conceived of as a throughput. Business thinking, as an entity constructed in the discourse, is demonstrated in other ways. The verbal message in Figure 3 states: 'because the 30 hour day is unlikely to eventuate', supporting the suggestion to practitioners that they are overworked from administration, which can be lessened by streamlining services with a patient portal. Aligning with the idea that patient portals commodify healthcare, the advertisements directed at patients show them as consumers who have agency and the resources to make free and informed decisions about the portal services available to them. The depiction of doctors emerging from electronic devices close to patients suggests that a strong, positive relationship exists between patients and technology. The assumption that patients can and will use patient portals presumes a continual need for information technology capability, while failing to recognise that many individuals, particularly elderly and higher risk groups, do not use information technology (Crothers *et al.* 2016), and struggle to effectively engage with patient portals (Czaja *et al.* 2015).

The discourses of business embedded in the advertisements construct an entity of patients as motivated and informed consumers buying health. The advertisements (Figures 4 and 5) state, 'A patient portal is a fast, safe and convenient way for you to manage more of your own health care'. Thus, the patient portals present an idealised view of patients, as pro-active purchasers of health. In constructing the claim that portals put patients in control of their healthcare, the advertisements make a series of assertions about what that means. According to the advertisements (Figures 4 and 5), control means to 'Book appointments with your GP, request a repeat prescription, check lab results, see your health information and communicate more easily with your practice'. Thus, in

this realm, control means to overcome the barriers of time and location. This also constructs healthcare as a series of measurable and purchasable services delivered by healthcare practitioners in spite of the images that depict caring and concern. Furthermore, the management of healthcare is undertaken by the individual, not the community, as demonstrated by the first-person pronoun 'you', and so holistic perspectives of health that emphasise family wellbeing are discounted, such as the Māori four-sided health construct (Durie 1985). Additionally, the idea that healthcare needs to be managed objectifies it as something that is external to the person that can and should be managed online with the assistance of products, available through portal technology. This appears to be part of a broader trend, as several analysts have similarly discussed how patients are being expected to take more responsibility for managing their healthcare in New Zealand (Barnett 2000; Fitzgerald 2004), including in asthma management (Trnka and McLaughlan 2012) and breast screening (Brunton 2004). Although this might seem economically desirable, as Rose (2013) explained, responsibility is a 'double edged sword' (p.349); patients have more information and decision-making, but they are also obliged to take on this role and to accept some of the consequences of their decisions.

The doctor-targeted advertisements do not construct the patient portals as an important intervention in the delivery of healthcare, but rather as a tool to reduce administrative burden, and increase time for face-to-face care. They state: 'A portal can reduce your general practice team's administrative burden and improve workflow, giving you more time to spend with the patients you really need to see'. Furthermore, none of these advertisements depict patients using portals, which is a noticeable absence, given that one of the most important functions of all portals is the ability to give patients access to their health records and to contact their healthcare practices electronically. Taken as a whole, then, the patient-doctor relationship constructed in the business of healthcare discourse is one in which doctors are the providers of a business service and the patients are the discerning consumers of this service. Each of these agents is constructed as possessing personal motivations: the consumers as wanting control of their healthcare, and the doctors as wanting to streamline their services and maximise efficiency and profit. The two sets of advertisements show curiously little awareness of the other audience: the doctor-targeted advertisements are one-dimensional in their focus, showing little acknowledgement of the needs of patients, and, although the patient-targeted advertisements recognise the doctors as providers of healthcare, they, equally, pay no concern to the efficiency of medical practices. We cannot state with certainty why the advertisements were produced in this way. It may be an oversight, or, more likely, an attempt at targeting the audience's envisaged interests and desires,

but such a finding is unexpected, given that the patient portal is designed specifically for both sets of users. Nevertheless, like the discourse of caring and concern, the business of healthcare presents patient portals as capable of delivering both of these goals.

SUMMARY AND DISCUSSION

We analysed six advertisements for patient portals in New Zealand, influenced by Dryzek's (2013) discourse analysis. Within the overarching discourses of medical technology in general, and patient portals in particular, two sub-discourses were detected. In the first, the caring and concern discourse, healthcare is constructed in terms of physical and emotional connection, presenting patients as vulnerable and dependent, and doctors as experts. In the second, the business of healthcare discourse, healthcare is constructed as a commercial product, provided by doctors to consumers, in which efficiency is paramount. Although both discourses stress the benefits of patient portals and appear to be motivated by strong, socially-oriented altruism, they are essentially promotional, and primarily serve the companies selling patient portals in the medical marketplace and the neoliberal influences on health policy which is driven by a political economy of efficiency, individual responsibility, and competition for scarce resources. In giving the impression of serving two quite different audiences, the discourses of the patient portal seem somewhat contradictory, but the unifying element in each is the concept of care, albeit a form of care plotted along two quite different axes. In the doctor-targeted advertisements, our analysis showed that profit and the delivery of care go hand-in-hand. This finding is significant in that, within the context of patient portals, care is removed from being straightforwardly a natural human reaction that characterises the relationships in the medical profession, and is, instead, conflated with profit and success in business, rather than success in simply helping people get through illness.

The producers of the advertisements, the National Health IT Board, are invisible in the discourses, but have a strong impact on the implementation of patient portals. The National Health IT Board represents the Ministry of Health, and seeks to effect behavioural changes to gain efficiencies in the health sector. Correspondingly, both sets of advertisements depict a commodified version of healthcare that reflects the growing financial pressures in the healthcare sector and the introduction of new managerialism, in which a private sector management style is used in the healthcare sector (Nettleton 2006). As Allanah Ryan, Lesley Patterson, and Jenny Carryer (2003) explained, new managerialism exacerbated the theoretical split between caring and curing into

another dichotomy: of caring versus cost effectiveness. This dichotomy has been demonstrated by other analysts (Fitzgerald 2004) and our own analysis. For instance, while care and concern was depicted in the advertisements as a priority in the medical profession, within the business context observed, caring must also return a profit.

This in turn alters conceptualisation of closeness. In the doctors' advertisements (Figures 1–3), closeness is depicted between patients and healthcare practitioners, which constructs a relationship of a paternalistic nature (Emanuel and Emanuel 1992), where doctors provide physical care and support for patients. Simultaneously, the discourse of the business of healthcare constructs healthcare as a business in which doctors are sellers of a service, and closeness is commodified as a part of the product, aligning with a consumer model of care (Emanuel and Emanuel 1992). In the patients' advertisements (Figures 4 and 5), closeness occurs not in a clinic, but within the home, and not with doctors, but with family. Communication with healthcare professionals occurs at a distance via the patient portal.

The shift towards a consumer model in healthcare care has been documented by several analysts (Emanuel and Emanuel 1992; Figert 2011; Sobo and Loustaunau 2010). In this model, the doctors impart information and treatment options to their patients, and the patients are in control as the ultimate decision-makers (Emanuel and Emanuel 1992). As we showed in our analysis, this model can be seen in the adoption of business terms in healthcare, with patients becoming consumers and doctors becoming providers. Consumerism from this perspective supports the free market to function, which allows consumers to have information to enable them to make informed choices. This could rearrange power dynamics in healthcare as it focuses on the consumers' rights and the providers' obligations. However, if the patient becomes a consumer then the doctor is a supplier of a commodity, and this could see the replacement of professional ethics with marketplace or business ethics (Rowe and Moodley 2013).

This shift has not been overtly framed in the advertisements in terms of neoliberal ideology, but what appears to be functioning in the discourse is a naturalised acceptance that what technology makes possible should, *ipso facto*, become part of the institution of healthcare. Jeffrey Nealon and Susan Girous (2012) argued that rather than giving in to a kind of technological determinism, in which forms of digital participation are uncritically celebrated, we need to question how digital participation will be framed and configured, maintained and contained, and for whose benefit. A conclusion from our analysis that can

be drawn is that the patient portal technology serves a wider social purpose than simply making life more convenient for doctors and patients. The technological determinism (Marx and Smith 1994) of the portals is altering the conventions of closeness, in the senses of both physical proximity and emotional connection, and at the same time shifting some of the responsibilities and stresses of clinical administration onto patients.

The presumption of new closeness – the doctor is always *in* (the device) – makes no mention of any new stresses that might adhere to the new technology, nor to the fact that the work of organisations has been shifted to patients-as-consumers, in much the same way as has happened with online banking, self-scan checkouts, and travel bookings, and a whole raft of other areas of social life. In actuality, other digital technologies have not encouraged interaction consistent with the caring and concern discourse, but rather the treatment of individuals online with dispatch, like the way we treat objects (Turkle 2011). The notion that patients should manage their health is widespread in modern healthcare (Cayton 2006) and while it may give patients more information and decision-making, at the same time, they are subjected to the expectation that they can and will be responsible for their health (Rose 2013). Thus, health is moralised to a heightened value and is presented as a result of individual choices (Conrad 1987; Crawford 1980) involving notions of self-responsibility and autonomy, which may conflict with the values of patients from high-context cultures (Hall 1976) who receive low-context medical care. It could be argued that an increased emphasis on patient self-management puts more attention on preventative measures and chronic conditions, in a system which has traditionally focused on acute care. However, it has the inherent consequence of increasing medicine's scope into fundamental life processes (Crawford 1980), as patients, 'are obliged to manage almost all aspects of their lives in the name of health – diet, lifestyle, monitoring of risks by regular check-ups, perhaps now taking genetic tests and so forth' (Rose 2013, 349).

We can see in the advertisements that closeness is being changed, and we wonder whether the changes will undermine the trust that patients need to place in their healthcare professionals, or whether it will lead to a different kind of trust from the past. By 'a different kind of trust', we mean that trust might come to be based on the technological virtuosity of the portal itself, rather than on the interpersonal and medical skills of doctors. The discourse of the business of healthcare raises the issue of whether efficiency equates to effectiveness in the context of healthcare. The doctor-targeted advertisements claim that the patient portal lessens the administrative burden practices carry, giving doctors

more time to spend with their patients, and thus increasing the effectiveness of a consultation. However, the inevitable equations in a business model are that less administration equals fewer staff or more consultations. Reduced costs and increased income are pertinent matters in relation to patient portals, as clinics must cover implementation costs and on-going operating fees. It seems unlikely, therefore, that patient portals will enable doctors to spend more time with their patients.

A weakness of our analysis is the risk that the discourses we have identified exist only in the advertisements we have studied and analysed. However, the implications of our findings signal the need for further research that monitors the outcomes of novel technologies such as patient portals. Our discussion of the discourses has highlighted some scepticism about the consequences of patient portals, but we would argue that what we have found is neither completely positive nor completely negative, but instead reflects a change that is defined by and expressed in new language. What our analysis has also shown is that the use of terms like 'health' reinforce changing social obligations on the healthy, what it means to deliver care and healthcare, and who is included within the reach of the healthcare establishment.

NOTES

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