

“I TRY TO CONNECT WITH THEM ON SOMETHING”: A QUALITATIVE STUDY
OF PATIENT-CENTERED CARE FROM THE DOCTOR’S PERSPECTIVE

A Thesis

Presented to

The Faculty of the Department
of the Jack J. Valenti School of Communication
University of Houston

In Partial Fulfillment

Of the Requirements for the Degree of
Master of Arts

By

Emmanuelle L. Descours

May, 2015

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ABSTRACT

In today's world, successful health care and patient satisfaction is not only dependent on the medical treatment patient's receive, but also the relationship and communication that takes place between the patient and physician. Patient's value when physicians are communicative, caring, and treat the patient as an equal. Patient-Centered Care (PCC) addresses this by helping ensure both the physician's and patient's needs are met. PCC creates effective communication and results in better overall health outcomes for patients. Therefore, this study examined the communicative behaviors and practices that physicians use to implement PCC, specifically seeking to understand (a) the communicative strategies that participants implement when communicating with their patients and (b) the barriers preventing these strategies from taking place. The study used in-person, semi-structured interviews to elicit personal experiences from participants. Based on responses from nine physicians, participants utilized proxemics, connection, transparency, empathy, and patient involvement when fostering relationships with their patients. All participants expressed similar barriers that prevent the use of these communicative strategies, describing both systematic barriers and patient-related barriers. The implications of this study could provide the basis needed for a more widespread approach to PCC by reducing the barriers that physician's experience when communicating with their patient.

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CHAPTER I

INTRODUCTION

“I’m Emma. I’m 11 years old and I was on a road trip with my dad. We were in a car wreck.” I repeated this statement several times to myself when I woke up in the Intensive Care Unit three weeks later. I was confused, I was terrified, and I couldn’t speak because of the breathing tube in my throat. As I lay there watching people move around me, completely healthy and going on with their everyday lives, I tried to comprehend what had happened to me.

My body suffered multiple injuries. My right arm had snapped completely in half, the right femur was broken, my pelvis shattered, my lower left leg was broken along with the Achilles tendon snapping, and I had a laceration on my liver, which resulted in internal bleeding. I lost enough blood to leave my doctors wondering how I had survived. The worst injury would be the one to completely change my life, both mentally and physically. My right ankle had been completely crushed, with a large portion of it ripped out, resulting in the loss of 16 millimeters of bone.

By the time I was 16, I had 31 surgeries, stayed in six different hospitals, and taught myself how to walk again. Through the efforts of two extraordinary doctors, my leg was saved rather than amputated. I had dozens of doctors, nurses, technicians, physical therapists, and other professional caregivers who worked with me, but I realized there was something that separated the great from the good: It wasn’t their professional expertise, but rather how they interacted with me. The relationship I developed with one doctor in particular, Dr. K, had the largest impact on not only my physical healing but also on my mental healing and emotional well being.

Dr. K, a reconstructive plastic surgeon, performed the 16-hour muscle flap operation that helped restore the muscle, tissue, and blood vessels in my right leg. Just as importantly, he was someone with whom I could speak comfortably, both about my health and my everyday life. This relationship, in particular, helped me cope with the aftermath of the wreck, understand my injuries, and motivated me to get back to the life I had before. When patients are going through trauma, they often have the need to make sense of what is happening through story. To do so, they need someone to listen to them. My relationship with Dr. K – which continues today – showed me how important it is to have a relationship with my doctor.

The interaction between a healthcare provider and her or his patient can have a significant influence on the ways patients react to their diagnosis, manage emotions, and negotiate treatment. Patients often feel that their interpersonal interaction with healthcare providers is the most important therapeutic aspect of their experiences with healthcare (Manning-Walsh, Asmus, Chambers, Reed, & Wylie, 2004). Through relational communication, patients and providers are able to share information, provide resources, determine diagnoses, and develop treatment plans (Beach & Inui, 2006).

I have been fortunate enough to experience patient-centered care and its benefits firsthand. Patient-centered care (PCC) occurs through processes and outcomes in the patient-provider encounter and assists patients in taking on a more active role in medical interactions. This can be accomplished only when physicians view their patients as equal participants in their healthcare (Roter & Hall, 2011). PCC builds the foundation for a stronger patient-provider relationship that is based on mutual trust, respect, and commitment (Epstein & Street, 2007). This model of care not only recognizes the

importance of patient involvement during medical decision making but also includes the need for acknowledging the patient's ideas and expectations, tailoring information for the patient, being aware of the patient's reactions, and discussing decisions (Duggan & Thompson, 2011).

PCC requires action from both patients and physicians. For physicians, Epstein and Street (2007) define PCC as: a) eliciting, understanding, and validating the patient's viewpoint; b) understanding the patient within his or her own psychological and social context; c) reaching a shared understanding of the patient's problem and its treatment; and d) helping a patient share power by offering him or her meaningful involvement in choices relating to his or her care. PCC for the patient is defined as involvement in the consultation and decision-making process by asking questions, stating preferences, expressing concerns, conveying understandings, and sharing opinions (Street & Millay, 2001). When the patient and physician work together, they can identify common ground, resolve differences in opinions, and negotiate and come to an agreement on treatment plans (Epstein & Street, 2007). When both the patient and provider act accordingly, shared understandings and humanized healing can occur (Engel, Zarconi, Pethel, & Missimi, 2008).

Still, although I – and a growing number of researchers, healthcare practitioners, and patients – recognize the impact that PCC has on mental, physical, and emotional healing, inherent barriers within the medical system continue to challenge this type of care. Thus, this study aims to explore the communicative behaviors and practices that physicians purposefully employ to foster meaningful healthcare relationships with their patients. Given the centrality of PCC in healthcare, I next provide a summary of current

literature regarding PCC, the history of the biomedical and biopsychosocial models, and the existing barriers between patients and healthcare providers. After this discussion, I detail the methods used to conduct this study, including the interview guide, participant demographics, and resulting themes. Then, using a narrative framework, I provide the results of the study using participant quotes. Finally, I conclude with a discussion of the results, limitations of the study, and directions for future research.

CHAPTER II

LITERATURE REVIEW

Biomedical vs. Biopsychosocial Models of Healthcare

Throughout history, the biomedical model has been the dominant standard for healthcare delivery and communication (Manning-Walsh et al., 2004). The biomedical approach evolved between the late 1700s and early 1900s and utilized “doctor-centered” communication, in which objective signs of disease are the focal point for all patient problems and the doctors alone take responsibility for making all decisions (Swenson, Zettler, & Bernard, 2006). The biomedical model disconnects the mind and body, representing the disease as a deviation from normal biological variables, resulting in the patient having no self and the lived experience of the patient being devalued (Engel et al., 2008). Patient care that is guided by the biomedical model means identifying the patient’s symptoms and only looking at the biological abnormalities when diagnosing and treating the disease (Fortin, Dwamena, Frankel, & Smith, 2012).

In the late 1970s, George Engel (1977) argued the need for a new approach that would consider the interactions of the biological, psychological, and social dimensions of disease. Engel encouraged physicians to consider not only the biological evidence of the patient’s symptoms, but to also look at information regarding the patient’s emotional and social effects of illness (Engel et al., 2008). In the mid-1980s, the structure of healthcare organizations shifted from focusing solely on illness and healing to an emphasis on the business and economics of healthcare. Due to this shift, the notion of caring and importance of relationships decreased and resulted in the need for healthcare in which relationships between and with practitioners, patients, and their families are valued

(Manning-Walsh et al., 2004). This stems in large part from Engel's (1977) biopsychosocial model, in which the objective disease and subjective experience of illness are not seen as being independent parts of the mind or body, but instead influences on one another both psychologically and physiologically (Frankel & Quill, 2005). This approach to medicine consists of physicians appreciating the patients' perspectives, responding to the patients' needs, and including the patient and their family when determining treatment plans (Williams, Frankel, Campbell, & Deci, 2000).

Engel's (1977) biopsychosocial model focuses on the subjective explanations of the patient's health and illness, rather than the objective focus that the biomedical model uses. The main point that separates the biomedical and the biopsychosocial model is the different uses of the terms *disease* and *illness* (Fortin et al., 2012). The biomedical use of the term 'disease' emphasizes the objective and biological aspects of treatment that the model follows, while the biopsychosocial model utilizes the term 'illness,' focusing on the idea that health experiences are subjective, resulting in patients with the same symptoms or disease having different experiences.

The biopsychosocial model led to the patient-centered interview, which incorporates a variety of factors when determining diagnosis, such as social factors, psychological factors, and behavioral factors (Fortin et al., 2012). This method for clinical encounters focuses on the relationship between both participants and embraces six components (Stewart et al., 2003): a) pursuing the experience of both the illness and the disease; b) recognizing the person as a whole; c) cooperatively collaborating on treatment and management; d) discussing disease prevention and health promotion; e) exploring common ground; and f) recognizing clinical setting barriers. These components

were based on the advocacy for each person to be understood and treated as individual human beings with unique experiences (Engel, 1977).

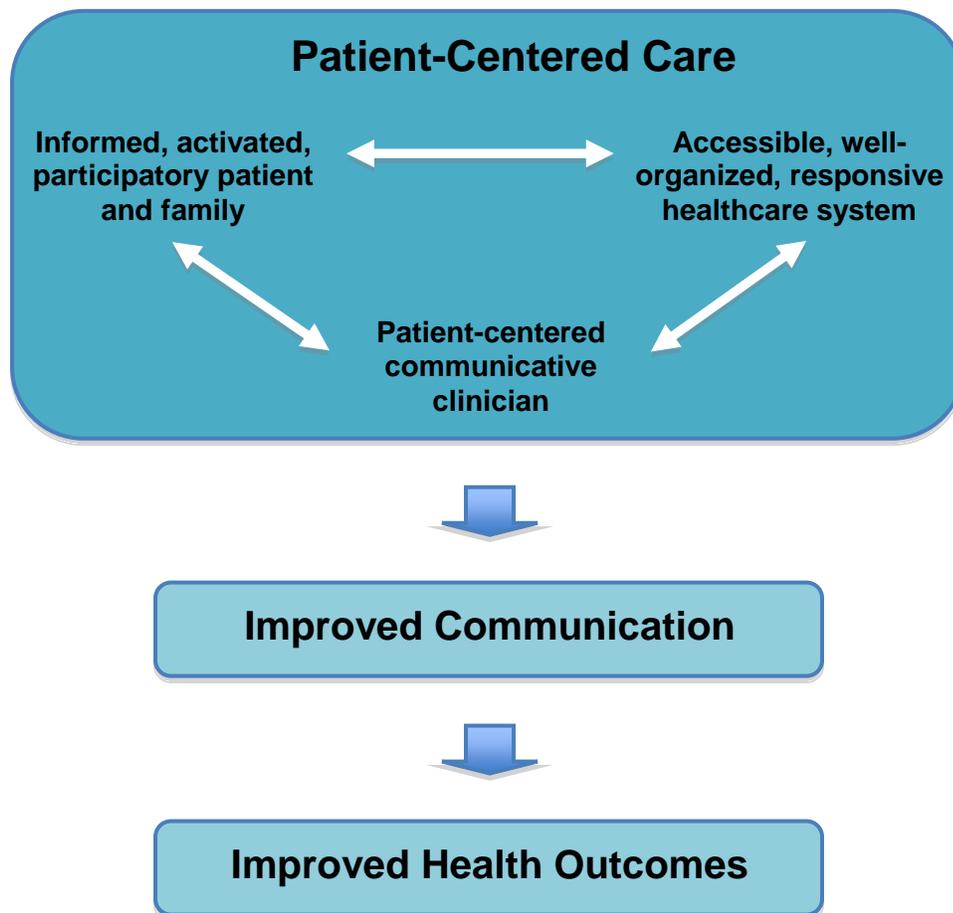
Due to the biopsychosocial model, the need for a patient-centered care (PCC) approach grew, with research stating each patient has to be understood as a unique human being (Beach & Inui, 2006). Patient-centered communication identifies and acknowledges patients' views and emotions towards their illness and uses this to establish common ground regarding their illness, treatment plans, and the roles of the patient and physician (Swenson et al., 2006). To achieve optimal communication between the practitioner and patient, there are particular communicative skills that the doctor should exercise when interacting with the patient, such as practicing compassion and mindful listening, expressing empathy towards the patient, and engaging in narrative medicine. These skills offer a variety of benefits to both the patient and the doctor (Engel et al., 2008).

Patient-Centered Care Framework

Patient-centered care (PCC) acknowledges the importance of patient involvement in medical decision-making (Duggan & Thompson, 2011). In this method, the physician aims to understand the patient as well as the disease while addressing both the patient's and the physician's agendas (Saha, Beach, & Cooper, 2008). As Figure 1 demonstrates, PCC requires active participation from the patient, a receptive healthcare system, and a communicative clinician. These elements work in tandem to improve communication in provider-patient interactions, which in turn lead to improved health outcomes (Epstein & Street, 2007). Research shows that when physicians use a patient-centered approach in their communication, patients report higher satisfaction, have increased adherence to

prescriptions, keep up with behavior change, and have overall improved health outcomes (Williams et al., 2000). Thus, this thesis specifically examines the patient-centered communicative clinician in the framework.

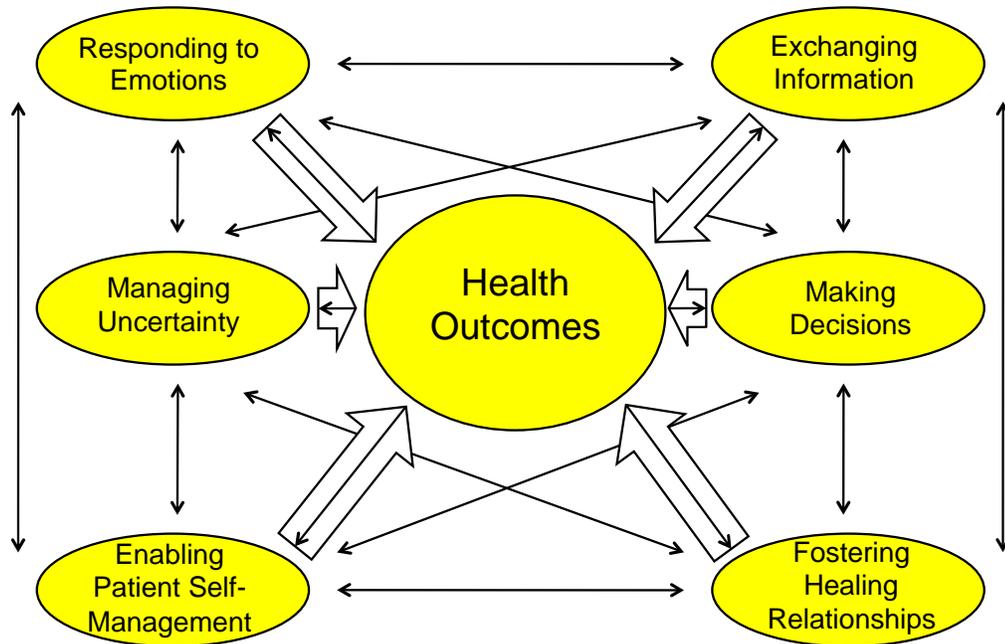
Figure 1: Patient-Centered Care Framework



Epstein and Street (2007) identified six essential functions that characterize patient-centered communicative clinicians: a) fostering relationships between patients and providers; b) exchanging information; c) responding to emotions; d) managing uncertainty; e) making decisions; and f) enabling patient self-management. As Figure 2 illustrates, all six functions serve as important tools for achieving PCC and work together

by overlapping and interacting to create effective communication that results in positive health outcomes (Epstein & Street, 2007).

Figure 2: Six Essential Functions for PCC



Fostering Relationships Between Patients and Providers

In order for the relationship between a patient and provider to grow, there needs to be a sense of trust and rapport, along with mutually agreed upon roles of each participant (Epstein & Street, 2007). Ozawa and Sripad (2013) explain that “quality of interaction, degree of disclosure, amount of autonomy in decision-making, continuity of care and level of engagement in behavioral change are all influenced by trusting patient-provider relationships” (p.10). These relationships not only provide emotional benefits for the patient, but also help patients improve their self-efficacy by fostering an

environment that empowers the patient to participate in decision-making (Golin, Thorpe, & DiMatteo, 2008). With the amount of information that patients now have access to, the need to bring the patient in as an active partner in healthcare is vital (Manning-Walsh et al., 2004).

The patient-provider relationship is also strengthened when it is characterized by a sense of rapport. When providers are able to actively engage the patient and families, stronger relationships are able to develop (Epstein & Street, 2007). Creating these relationships reinforce the importance of the interactions among the participants as being therapeutic and healing (Tresolini & The Pew-Fetzer Task Force, 1994). By striving to understand the patient's world outside of the healthcare context, a positive rapport can begin to build as the patient begins to feel as an equal with the provider (Manning-Walsh et al., 2014). Although the patient and provider each have expectations regarding the roles that each person should play, the relationship will have a higher chance of being successful if "the clinician and patient cooperate and coordinate their communication to establish mutually agreed upon norms for their relationship" (Epstein & Street, 2007, p. 19).

Exchanging Information

By ensuring the patient understands the information regarding their health, providers are able to develop relationships, promote shared decision-making, and ease patient concerns (Epstein & Street, 2007). When providers are more informative, patients have shown less emotional distress, an improved resolution of symptoms, and fewer limitations in the patient-provider relationship (Golin et al., 2008). The information that

patients receive will increase overall satisfaction and provide the ability cope (Arraras et al, 2004).

Responding to Emotions

Conversations between patients and providers often center around sensitive topics and can lead to emotions such fear, sadness, depression, and anxiety. Due to the impact that emotions can have on a patient's well-being and quality of life, it is extremely important that providers recognize and respond to patients' emotional state (Epstein & Street, 2007). Golin and colleagues (2008) explain that physician responsiveness to patients' emotional states reduce levels of patient distress and improve symptom resolution, and patients that are encouraged to talk about their concerns have improved physical and social functioning, health status, and blood pressure.

Managing Uncertainty

Emotional distress, loss of sense of control, and a diminished quality of life can all result when a patient experiences uncertainty (Epstein & Street, 2007). Patients may experience uncertainty when aspects of the illness, treatment, or recovery are perceived as strange, uncertain, or complicated (Mishel et al., 2005). By using patient-centered communication, providers are able to help reduce and also manage uncertainty by framing the information by what is known and not known by the physician (Epstein & Street, 2007).

Making Decisions

In order to make a high-quality decision, providers must take into account the patient's needs, values, and preferences (Epstein & Street, 2007). This can be difficult since patient preferences vary when it comes to decision-making (Janz, et al., 2004)

According to one model, decision-making can be either paternalistic (e.g. provider makes all decisions), shared (e.g. mutual decision-making between the patient and provider) or informed (e.g. decision is made by patient based on information from a variety of sources). All three types of decision making go through three stages: information exchange, deliberation, and final decision (Charles, Gafni, & Whelan, 1999). To help facilitate decision making, providers should check understanding, actively listen to the patient, set the agenda, promote patient involvement, consider patients' preferences, and convey a sense of empathy and warmth (Epstein & Street, 2007).

Enabling Patient Self-Management

Patients feel enabled when they have the perceived ability to self-manage aspects of their health, such as discovering information regarding their illness, managing treatment effects, and reaching out for the appropriate care when needed (Bodenheimer, Lorig, Holman, & Grumbach, 2002). Providers can do things for the patient to help with this such as removing barriers to self-management and helping the patient be more independent.

Barriers to PCC

The term 'barrier' has many meanings, but for this topic I define barrier as something that is blocking effective communication between people (Quill, 1989). Barriers can result when two people join together to work towards a common goal (Quill). Barriers can interfere with the trust, curiosity, and respect in relationships, resulting in the impairment of data gathering, establishing a therapeutic relationship, and establishing treatment plans (Quill). Practitioners who practice patient-centered care have the knowledge, attitudes, and skills to overcome barriers to communication (Saha et al.,

2008). This literature review explains the institutional & organizational, language & cultural, and technological barriers.

Institutional and Organizational Barriers

Well-functioning teams within health care organizations are a result of proper clinician-clinician relationships (Safran, Miller, & Beckman, 2006). High-functioning organizational culture results in facilitative leadership, shared goals and expectations among clinicians, staff and administrators, mutual respect, shared knowledge, and efficient conflict management (Safran et al., 2006). Although lack of insurance coverage and other economic issues are most known as organizational barriers, the way in which medical care is delivered is equally influential (Scott, 1987). In one survey, forty-two percent of physicians reported not having enough time with their patients (Bodenheimer, 2008). With an insufficient amount of time to interact with patients, providing information and engaging in shared decision-making becomes challenging (Bodenheimer).

Relationships between physicians and patients are becoming increasingly difficult due to a number of organizational barriers. Cost constraints within healthcare organizations have resulted in a reduced amount of time when meeting with patients (Scott, 1987). Organizations have implemented a fast-paced process, which prevents physician-patient relationships from developing (Scott). With an increase of specializations in medicine, patients experience a higher amount of professionals becoming involved in their healthcare (Scott). The more professionals involved in a single patient's healthcare, the risk for confusion about who is responsible for what becomes higher (Scott).

Collaboration among organizational members can help with issues such as staff shortage, work-related stress, and burn-out (Gaboury, Lapierre, Boon, & Moher, 2011). Collaboration leads to meaningful relationships, which help to achieve shared understanding of patient's experience (Beach & Inui, 2006). Gaboury and colleagues (2011) found that interprofessional collaboration impacts the extent in which practitioners trust, cooperate, and exchange knowledge with colleagues.

Practitioners often experience stress as a result of organizational processes and in return are more susceptible to burnout (Scott, 1987). Burnout occurs when the physician feels a sense of depersonalization, experiences emotional exhaustion, and has a reduced sense of accomplishment (Ratanawongsa et al., 2008). When practitioners experience burnout, they tend to distance themselves from patients, develop cynic attitudes, and dehumanize patients (Scott, 1987).

Language & Culture

As many as 27% of patients in United States hospitals require an interpreter (Zabar et al., 2006). In order to have successful health care, practitioners must learn effective and efficient use of interpreters, elicit health belief models, and be culturally aware of biases and barriers (Zabar et al.). Effective rapport and information gathering is hindered by language barriers and can have a negative impact on the patient-provider relationship (Zabar et al.).

Acknowledging patients as members of ethnic or cultural groups, rather than individuals with their own set of experiences or perspectives, might result in inappropriate assumptions about their beliefs and behavior (Saha et al., 2008). It is important to recognize that both the patient and the provider bring their own cultural

perspectives to the medical encounter. All factors need to be considered when discussing cultural barriers. The champions of cultural competence movement took into consideration a set of wide-ranging issues when creating a training program to build cultural competence: a) the impact on health and healthcare experience from race and class; b) historical experiences that may contribute to distrust among particular minority populations in patient-provider relationships; (c) the significance of social factors, support systems, and literacy; and (d) one's own racial attitudes and stereotypes (Saha et al.).

Technology

Technology plays a large role in healthcare, ranging from online health information and social media, to electronic medical records and note taking. Electronic Health, also commonly referred to as 'e-health,' is the use of emerging technology, especially over the Internet, to improve healthcare (Eng, 2001). PCC is based on effective communication and trust, and a technology system that may be untrustworthy can become a barrier between the patient and provider, which can result in a decrease of trust (Weiner & Biondich, 2006).

Technology is a beneficial tool for both patients and physicians. Physicians can use the Internet to search for medical literature and find full-text medical journal content, and patients can seek health information or access support groups online (Mandl, Katz, & Kohane, 1998). The benefits also come with barriers, including a lack in context, a technology gap, and the potential to for physicians to overlook information (Klein, 2007; Katz & Moyer, 2004).

Electronic Communication

Electronic communication provides better access to providers that healthcare consumers have increasingly demanded over recent years (Klein, 2007). These new communication tools are seen as much more efficient than face-to-face visits and telephone conversations and patients will actively seek out these options (Katz & Moyer, 2004). Online communication can provide an alternative to face-to-face visits, but due to a rising digital gap there is a large group of the population who do not use e-mail on a regular basis and will be unfamiliar with this concept (Katz & Moyer).

Online communication can have an impact on the relationships with patients, with a lack of context and the challenge of confirming the patient's understanding of content (Klein, 2007). Because of technology-based communication, patients will often have concerns that are not discussed fully and expectations are not met (Weiner & Biondich, 2006). Another negative impact that can result from online communication is the use of e-mail to provide abnormal test results or bad news (Mandl et al., 1998). Electronic communication has the chance to depersonalize relationships, which in return creates a barrier between patients and providers (Whitten & Love, 2005).

Electronic Medical Records

Electronic medical records (EMR) require physicians to spend more time entering in data but then do not provide a means for automating manipulation or interpretation of the same data (Weiner & Biondich, 2006). Due to the amount of effort needed to input data information into these systems, physicians spend less time with patients and instead spend their time as data-entry clerks, which in return are more likely to experience malpractice claims (Weiner & Biondich). While EMRs are beneficial when managing and transferring information, inputting and retrieving data, accessing medical records,

and managing pharmacy data, there are few practitioners who use them to help in building relationships during patient visits (Ventres & Frankel, 2010).

Electronic health records cannot provide empathy, develop relationships, or offer personal qualities that physicians are able to provide to patients (Ventres & Frankel, 2010). Since humans are naturally inclined to use a narrative framework due to our evolution as social beings, physicians can detect the difference between electronic and hand-written medical records (McEvoy, 2014). When using EMRs, physicians are prompted to use cut-and-paste or auto-populate entries – an aspect that is beneficial for financial aspects but has the potential for the problem of information loss (McEvoy). Physicians have reported that documents facilitated through electronic health records often fail to fully communicate the necessary narrative needed for diagnosis (McEvoy).

The use of EMRs has resulted in an increase of copying and pasting notes from previous medical charts and copying and pasting medical history (Hartzband & Groopman, 2008). Copying and pasting notes has potentially detrimental results for the patient and can also be considered a form of medical plagiarism (Hartzband & Groopman). When a patient's medical history is copied and pasted, there is a chance for overlooking important new patient data (Hartzband & Groopman).

Online Health Information Seeking

Over the past decade, active health information seeking has become a popular method for obtaining medical information (Galarce, Ramanadham, & Viswanath, 2011). Patients have become more active in decisions, self-monitoring, and have an increased self-efficacy, leading to a shift from physician-centered care to a shared-decision making paradigm. The Internet now provides an easy way for patients to conduct their own

research on health and in return, the information they find will largely impact their lifestyle choices, how they engage in decision making, understanding treatment plans, and coping with disease (Galarce et al., 2011). Patients now have access to other sources besides their doctor that they can rely on if they feel dissatisfied with the information given by their physician or if they want more information on the subject (Fallowfield, Lipkin, & Hall, 1998).

Although online health information seeking provides an alternative source for patients and may provide them with a feeling of empowerment and mutuality, the patient must have a high level of self-efficacy when it comes to the Internet in order to identify appropriate information (Sundar, Rice, Kim, & Sciamanna, 2011; Hong, 2006).

Obtaining incorrect information can harm health outcomes and interfere with the physician-patient relationship (Sundar et al., 2011). The highest predictor of an inadequate patient-provider relationship is the physician's feeling that the patient is challenging their authority when they come in with information (Murray et al., 2003; Sundar et al., 2011). When patients bring information with them, a number of physicians feel that visits are less time efficient if the patient wanted the physician to consider information they felt was unsuitable (Sundar et al., 2011).

Given this review, my study aims to answer the following questions:

RQ1: What do physicians perceive as barriers to patient-centered care?

RQ2: What communicative strategies do physicians use to enhance patient-centered care?

CHAPTER III

METHODS

To best answer the research questions, I conducted in-depth, face-to-face interviews with 9 physicians in Houston, Texas. Participants were invited to participate in the interview with the knowledge that, while they will not directly benefit from participation, they may gain a better understanding of how patient-centered care can improve communication between patients and providers. All aspects of data collection and analysis were first approved by UH's Committee for Protection of Human Subjects.

Participants

Using convenience sampling based on personal connections and participant referrals, I recruited 10 practitioners to participate in individual, in-depth, face-to-face interviews. Of those 10, 9 consented to interviews, and 1 declined, citing lack of time. The following table highlights participant demographics, including (a) gender, (b) nationality, (c) number of years in practice, (d) medical specialty, and (e) the typical patient relationship they have with their patients. As shown, my sample – while small – is balanced in terms of participant gender, and is rich in diversity regarding participant race and the nature of the participants' medical practice and experience.

Table 1: Participants

Name	Gender	Nationality	Years in Practice	Specialty	Typical Patient Relationship
Dr. A	Female	Indian American	11	Internal Medicine - Infectious Disease	Long-term
Dr. B	Male	European American	43	Internal Medicine – Adult Cardiology	Long-term
Dr. F	Female	European American	5	Internal Medicine – Adult Cardiology	Long-term
Dr. H	Male	Lebanese American	45	Internal Medicine – Adult Cardiology	Long-term

Dr. J	Female	Pakistani American	8	Internal Medicine	Primary doctor
Dr. L	Male	Chinese American	10	Internal Medicine - Adult Congenital Cardiology	Long-term
Dr. M	Female	African American	13	Internal Medicine	Primary doctor
Dr. O	Female	African American	8	Integrative Health	Short-term
Dr. P	Female	Pakistani American	6	Family Medicine	Primary doctor

Data Collection

Because this work is largely narrative, I conducted semi-structured interviews that proceeded naturally through give-and-take conversation. Eight of the interviews took place in the participant's clinic office while one interview was conducted at the University of Houston. With each participant's permission, I audiotaped and transcribed verbatim all interviews. The interviews lasted between 20 and 80 minutes and resulted in 110 of transcribed single-spaced pages.

The interviews were guided by a set of preplanned, open-ended prompts regarding the participants' experiences with patients:

1. Describe a typical office visit when meeting with a patient.
2. Walk me through the process of how you take notes when listening to your patients.
3. Describe the ways that you communicate with your patients.
4. What perceived barriers prevent you from communicating with your patients effectively?
5. How do you build relationships with your patients?

6. What do you think is the most important aspect of the patient-physician relationship?

I encouraged participants to include storied examples in their responses. I also asked follow-up questions for clarification or elaboration. The complete interview guide is included in the Appendix.

Data Analysis

I used a constant comparative method to conduct a thematic analysis of the transcribed interviews. Using this method enabled me to establish themes from the data and then link the themes together to create a larger story. To do so, I moved back and forth among the data to look for commonalities, differences, and emergent themes (see Tracy, 2013). The initial analysis began with transcribing interviews. Once I completed transcribing, I printed and read each transcript individually for a general review of the interview. I then read through the transcripts a second time and manually coded the data. These codes were marked with category names to identify particular themes and aspects of the interviews. Coding continued until I satisfactorily collapsed the various codes into categories that best described the patterns and contradictions in my data (see Table 2). Once I finished coding and making notes of emerging patterns, I identified and evaluated two major themes, which I discuss in the next chapter.

Table 2: Preliminary Codes

Barriers	Communicative Behaviors	Communicative Aids
Time	Rapport building	Accompanying patients
Language	Encouraging talk	MyChart
Computer	Open-ended questions	Help Line / translator
Uninformed patients	Consent	Personal cell phone
Agenda	Proxemics	Email
System	Agenda setting	Meeting outside appts
Immediate transcribing	Nonjudgmental	Preparation
Location	Following up	Follow-up appts
Socioeconomics	Assessing	Referrals
Doctor as perceived enemy	Patient-centered	Experience
Fee-for-service model	Nonverbal cues	Taking notes
Social support	Reassurance	Social support
Psychological distance	Paying attention	
	Informal / relaxed	
	Listening	
Patient Education	Patient-Provider Relationship	
Drawing	Trust / comfort	
Visual aid	Teamwork / patient involvement	
Diagram	Continuity	
Brochure / pamphlet	Respect	
Explanation	Transparency	
Layperson's terms	Genuine emotion	
Teaching back	Perspective taking / empathy	
Booklets	Valuing / acknowledging patient	
Providing knowledge		

CHAPTER IV

RESULTS

To answer the research questions, I collapsed the codes into two primary themes. The first theme includes the perceived barriers – system and patients – that inhibit physicians from fostering therapeutic relationships with their patients. The second theme illustrates the communicative strategies physicians employ to enhance patient-centered care with their patients, including (a) ensuring appropriate proxemics, (b) connecting with the patient, (c) being transparent, (d) demonstrating empathy, and (e) involving the patient. Table 3 illustrates these themes, which I then discuss in detail with numerous examples from the participants’ own words.

Table 3: Primary Themes

Physicians’ Perceived Barriers to Patient-Centered Care	
System	Time Computer / Note Taking Medical System
Patients	Language / Culture Patient Education Socioeconomic Status

Physicians’ Communicative Strategies to Enhance Patient-Centered Care	
Proxemics	Spatial Behavior during Appointment Availability between Appointments
Connection	Rapport Building Encouragement / Support
Transparency	Consent / Confidentiality Honesty

	Trust
Empathy	Perspective Taking Authenticity / Genuine Emotion
Patient Involvement	Encouraging Talk Partnering with Patient Continuity of Care Patient Education

Perceived Barriers to Patient-Centered Care

The participants revealed two main barriers – system and patients – that challenge therapeutic relationships with their patients. An examination of each barrier follows.

System-Related Barriers

The participants expressed pressure they experience from the system that they have to work within to treat their patients. According to the participants, the main systemic barriers include: a) time, b) computer / note taking, and c) the overall healthcare system. A major systemic issue that participants experience is the issue of working for a large organization, and all participants expressed the frustrations of treating patients within these systems.

Many healthcare systems have implemented a fee-for-service model, which requires physicians to see a large amount of patients in one day. “A lot of the system demands, like the fee-for-service model that focuses on the output and not about the quality of care, are really hindering these relationships with patients,” said Dr. O. “There is a push for bill, bill, bill services and just churn [patients] in and out, rather than, okay, are the patients actually getting any better?” Other participants agreed, stating the overall healthcare system has increasingly focused on the quantity rather than the quality of care.

A direct result of adhering to system demands is the added pressure that physicians experience when they have to follow their organization's policy but also want to provide the best care possible for their patients. "These high demands are placed on the providers just to produce and they are so nervous about meeting their numbers for the month that time is then taken away," said Dr. F. "They gotta go, they gotta move." Dr. F believes that the slim time slots allotted for appointments prevent her from having the appropriate amount of time necessary with her patients. She feels that she has to adhere to the strict appointment schedule: "Appointments are scheduled every 30 minutes. Mine typically last 40 to 45 minutes. So, by the end of the morning, I'm behind. It's added pressure for sure. I don't like the 30 minutes – I really wish it was 45 minutes." When Dr. F continues to see patients longer than the allotted 30 minutes, the nurses will start to put tags or sheets on her door to let her know that patients are waiting. "When I see my door is building up with two or three, or even four patients waiting, I start to get stressed," she said.

Dr. H, who has been practicing for 44 years, noticed, "Over the years, the biggest barrier I see gradually getting worse and worse is time." As a result of the time constrictions that physicians face, patients can be left with a feeling of confusion. There is not enough time for the physician to provide the diagnosis and also make sure the patient fully understands what is happening. "What ends up happening a lot, especially in primary care, is that [providers] are rushed," explained Dr. O. "They have to go really quick because they have a ton of patients to see, so it's really like 'you have diabetes, you have to take your metformin this many times a day, stop eating this food, do this,' and

that's it. Then the patient says 'well, what can I eat? The doctor said no fried foods, no McDonalds, no chips, no fries, but I don't know what I can do.'”

Time constrictions impact a variety of aspects during appointments with patients. One way that healthcare systems have tried to reduce the amount of time spent in appointments is the way in which doctors take notes. The computer system allows for healthcare professionals to easily fill in automated forms in regards to symptoms and medical history. While the computer can help with streamlining the note-taking process, it can also hinder the communication between the patient and provider. Dr. P believes the computer takes away attention from her patients: “I feel bad because when I'm talking, I am on the computer. So I am talking, but there is no eye contact, which I don't like.”

Participants looked at their computer use from the patient's perspective. Dr. A often wonders “if it is strange to the patient that I am transcribing almost exactly what they are saying,” while Dr. P knows that “as a patient on the other side, I want the doctor to look at my face when they're talking.” The computer can provide a barrier between the patient and provider by preventing the provider from focusing solely on the patient. Dr. L explained that patients value the attention they get from their provider, stating, “I honestly think that when they have signed up for an appointment, they say 'I want to see a physician and I want to know that all the time is there with them.'”

Large healthcare systems can also hinder the quality of care that patients are receiving. Participants explained that a complicated system can make it difficult for patients to obtain the care that they need. Dr. B discussed that facilitating care and moving patients through a large system can be challenging. “The complexity of the system makes it harder for the patient,” he said. “Patients lose momentum, and I don't

want them to lose momentum. Once we say we are going to do something, I want to make sure it gets done.”

When there is a large department, patients can get lost. Dr. L felt that connections slow down when “the patients aren’t fully plugged in, then they may get a little run around and go to some other providers before they actually come back to us.” When patients continually get passed around to other providers, the quality of care they receive is hindered. “The best care is to see your own patient,” said Dr. J. “That’s called continuity of care. But it doesn’t happen all the time.” Larger systems can prevent this type of care, an issue that Dr. J believes is a big one. “Not seeing our patients . . . losing track of seeing my patients, that’s the issue,” she said. “If I’m seeing someone’s patient, someone else is seeing my patient. I saw a patient after eight months and he has been here but he saw someone else because the patient couldn’t get an appointment with me.” Continuity helps to foster a relationship with the physician, an aspect Dr. H explained that patients have come to value: “They meet the doctor, they’ve established some relationship, and they know who he or she is. They absolutely love it.”

Patients may also experience trouble when trying to get in contact with the doctor. Dr. A acknowledged that “our system is hard” and feels that physicians must realize this and advocate for patients to get them what they need. She recognizes that patients “are not going to be able to call and reach me; they’re not going to be able to call and find the cardiologist; they’re not going to be able to call because they can’t and the system is horrible. [The patients] get the phone number . . . and then you’re on hold for an hour, and it’s terrible, like who wants to do that?”

Patient-Related Barriers

Many barriers that providers experience come not only from the system, but also are a direct result of their patient population. The participants cited three main barriers stemming from patients: a) language and culture, b) patient education, and c) socioeconomic status. Providers must contend with external barriers that prevent their patient from coming to see them or obtaining the healthcare that they need.

First, many of the participants experience barriers when working with patients that speak a different language or come from a different culture. Although all participants have access to some type of interpretation assistance, language was still an issue. The majority of patients that Dr. P works with speak another language so she often utilizes the Help Line. Although she said this is extremely helpful, she still feels that language is her biggest barrier, explaining, “I know the Help Line really helps, but I still think it’s not as perfect as being able to talk with your patient in person.” Further, using a third party to facilitate communication between the patient and provider may result in psychological barriers. “If somebody knows English, they’re more open about their problems,” explained Dr. P, “because I see a lot of issues that may be embarrassing for the patient, so it’s kind of weird talking to somebody else about that.”

Different cultures can influence the relationship between the patient and provider, whether that is, according to one participant, “an academic culture, an educated culture, a high health literacy culture, an Indian culture.” Patients are aware of the cultural differences between themselves and their provider. Dr. B discussed how cultural differences can come into play, explaining, “Sometimes it’s the patient who comes from a different culture but sometimes it’s the doctor who may be from a different country and they weren’t necessarily raised in this country by American parents so they have one foot

in their traditions and then an education and experience here.” Depending on the patient population, some patients may not feel comfortable with the physician’s culture.

“Patients are pretty sensitive to that, and not always in a good way,” said Dr. B.

“Sometimes it’s awkward for them to have someone from a different culture take care of them.” Dr. F has experienced this first hand, revealing that she has seen patients “who have seen [a physician] of the Indian descent and they won’t go back. So there are some barriers between veterans and non-American descent. They’ll tell me ‘I don’t want to go back to the person I saw last time. I want to see you.’ And I have to say that’s fine.”

Second, the level of understanding or education that the patient has can interfere with the provider’s ability to diagnosis and help the patient. Dr. J experiences issues with her patients not understanding their diagnosis. “I have patients having trouble understanding me because of a lack of knowledge or information,” she said. “A lot of patients don’t know how many medicines they are on, why they are taking them, or when they’re supposed to take them.” This may be a result of the patient’s education level or because of the lack of information they received from their previous physician. “If someone is sent to me with type 2 diabetes, I’ll spend the first five minutes just assessing them. ‘Do you know what that means? Tell me what you know about diabetes.’ And most of the time they say, ‘I don’t know. They just told me I have diabetes and they sent me to you,’” shared Dr. O. Similarly, Dr. B explained, “I ask them if they know why their doctor sent them. ‘Why did your doctor have you come to a cardiologist?’ Many of them have no idea. They do not understand.”

Finally, socioeconomic issues can be extremely pervasive. According to Dr. H, “Some of my patients don’t have a place to stay, or don’t have money to pay for gas to

make the visit.” Working with a low-income population can prevent physicians from providing the quality of care that the patient needs. “When [patients] come from a sort of hard-knock life, you have a hundred other competing priorities like getting money for food, or even getting transportation to come see me,” explained Dr. A in regards to her patient population. Similarly Dr. O said, “A lot of our patients, what happens is, [physicians] will give them a prescription and they will say ‘go fill it’ and our patients don’t have Medicaid, they don’t have coverage, they don’t have the finances to go get them.”

In regards to location, Dr. B explained that he has a lot of patients who, because of where they live, have difficulty returning when he would like them to. “[Patients] may be limited, such as this is a big city and they live 100 miles away in the country and it keys them up too much to drive into the city,” he said. “It’s exhausting for them, it’s time consuming, it’s expensive – and these are not rich people.” The patient’s location can change constantly, particularly when they are homeless. Dr. O works with the homeless, and because she works with a very transient population, “[the patient] could be in Houston right now but then in a month they could be in a different state,” which can interfere with the ability for the physician to follow up with the patient.

Getting in contact with the patient proves difficult when the patient’s resources are limited. Participants are unable to utilize their organization’s online messaging system if the patient doesn’t have access to a computer. Calling the patient is not always an option either. According to Dr. A, “They don’t always have working phones. They have phones that their number works for one month and it doesn’t work for the next month.” Not having a phone is a characteristic of homelessness, explained Dr. O, which she says

is a product of their environment. Even when patients do have access to a phone, the physicians still limit communication. “I try not to utilize the phone too much because they have a set number of minutes every month and I want to be respectful and not use their minutes,” said Dr. O.

Communicative Strategies to Enhance Patient-Centered Care

The interviews revealed several distinct strategies that physicians use to initiate, build, and maintain interpersonal relationships with their patients. Overall, five communicative strategies emerged from the data: a) proxemics, b) connection, c) transparency, d) empathy, and e) patient involvement. Each strategy enhances patient-centered care in a variety of ways.

Proxemics

Face-to-face communication with patients is a critical component to not only establishing a relationship or forming a connection, but also gauging how the patient is emotionally reacting to a new diagnosis or treatment plan. Being able to see the patient’s reaction is something that participants found extremely valuable. Dr. B explained that when he is giving a patient information over the phone, he feels like he is not able to grasp how the patient is truly reacting to his news. He explained that he likes “seeing how people react to things . . . you get a chance to see if they are startled or pleased,” which allows him to decide if he needs to further elaborate or reassure his patient. Similarly, Dr. F also prefers to see her patients’ reactions, noting that “you can tell if they’re pleased with the treatment plan or not – especially if there are options.” Working with patients in person allows the physician to get a feeling of their comfort and to shape the consultation accordingly.

Having patients sitting next to them or in their line of view when communicating was important to the participants. Dr. F is required by her department to use the computer to take notes, but she keeps a piece of paper by her during the appointment to “just scribble some notes so I don’t forget something.” This way, she doesn’t have to turn away and look at the computer while talking to patients. “I try to actually listen to the patient first, and then turn towards my computer to type,” she said. “I don’t want to be facing the computer while I’m talking to the patient.” When meeting with the patient, Dr. H feels that it is important to demonstrate active listening to the patient. He will “make it a rule to take the computer, put it to the side, try and swing my chair and face the patient, and then have a face-to-face conversation.” Then, when he needs to make a note of what they are saying, he gets consent from the patient to break that eye contact by asking, “You’re mentioning some very important information, would you mind if I just take a minute to make some notes so that I don’t forget later on?” Asking permission to look away lets patients know that they are being heard and that the physician is taking the time to take their feelings into consideration. Although Dr. M believes she should take more notes while in the exam room, “there are just some things that a lot of time I feel like I just need to look at the patient.” She explained that she “likes to think that they think I’m really listening to them and not just playing with the computer.”

Maintaining eye contact helps the physicians demonstrate that they are listening to the patient. As Dr. J explained, “When the patient is talking to me, I try to look at them – make eye contact – and listen to them instead of them looking at me and I’m looking at the computer.” She believes this is especially important when working with a new patient: “I try to make sure that I’m listening to them and that they don’t feel like they’re

being ignored.” Dr. P also said, “I’m in front of them, so they feel more comfortable. I don’t have my back or side to them.” By taking the time to sit down with patients, physicians can help them feel acknowledged and valued. “I think sitting down is one of the key elements,” said Dr. L, “including having a chance to basically sit down and be at their level or sometimes even being below their level so they are looking down and we’re seeing eye-to-eye.”

Connection

Establishing strong rapport and offering encouragement and support helps the participants feel that they are connecting with their patients. Dr. L tries to connect with patients right away, explaining that the first visit is his opportunity to really capture their attention. According to him, “That first impression, that first visit is the moment we decide if we are we going to make a bond that’s going to lead to lifelong care.” Similarly, Dr. B recognizes that psychological barriers may stand in the way of forming a connection: “Thinking that you’re superior is a barrier to people accepting your advice, your recommendations, and pursuing care.” Dr. O likes to connect with patients to help them realize their physician is on their side and “not just making me stop eating this because they want to be mean to me.” Instead, she explains, it’s to “really add more years to your life and increase your quality of life . . . all of this is really for you.”

Participants indicated that they work to connect to their patients on a personal level by talking about something that is non-medical, something that Dr. F learned from a book she read. As she explained, the “author says to ask the patient one thing about them that’s non-medical, that has really nothing to do with the visit.” This advice has helped her take steps to try and relate to her patients. “I will try to ask them something as simple

as ‘Where do you guys live? Do you live far out?’” she said. “I had a guy who had a Michigan shirt on and I say ‘Go Michigan! That’s where I lived!’” and of course it was immediate bonding.” Dr. B also attempts to relate to his patients, feeling that this helps put them at ease:

If I have a relevant story that will help them identify with me as a human being, then I will tell them a story. To give them a sense that they are talking to another person who also has a life and has experiences and maybe they can relate to those experiences. So when they sit down on the exam table, then at least I don’t feel that we’re as much strangers as we were when we walked in.

By talking about something non-medical, “such as their hair or their bag,” Dr. P finds that her patients become more comfortable and open up more. Building rapport and learning about the patient’s life outside the hospital can contribute to better health outcome because patients can become more motivated to speak up during the appointment and then follow the treatment plan after it. Dr. O uses her patient’s goals to decide on treatment plans, stating:

So I try to reframe it for them that this is all to help get them back on their feet with whatever goal they want. ‘I want to have housing,’ ‘I want to have a job again,’ or ‘I want to have custody of my kids again.’ Whatever it may be, I try to identify with what their goal is and shape the consult around it. So when I tie it that way, that’s when I can build those lasting relationships. Just by that visit and having them feel heard makes a huge difference.

When meeting with a new patient, physicians can begin to form a connection by introducing themselves and then gradually opening up to their patients. Dr. J recommends physicians do the following with a new patient:

Introduce yourself and what you do. A lot of patients don't know if you're a doctor or if you're a nurse or what you do. So you try to explain to them that this is what you have been doing for years and you have the knowledge to help [the patient's] problems.

Introductions were shown to be an important aspect of the participant's conversation with new patients. Dr. O makes it a point to start the appointment off by "introducing myself and what I do, so [the patients] aren't wondering 'Who is this person talking in here and why are you talking to me?'" Dr. H shared a similar process of greeting the patient, sharing, "Typical office visits start with me going to the waiting area, getting the patient, and welcoming the patient to come in. I introduce myself and greet the family." Once introductions between the patient and physician are complete, physicians then have the opportunity to learn more about the patient. Dr. B explained, "I often say 'Well, where do you live? Who lives with you? Tell me a little bit about your hour or your farm.' So we talk about their life basically."

An easy, yet extremely valuable, tool for building rapport is listening to the patient and showing an interest in their life. According to Dr. L:

I prefer having at least a 45-minute block to sit down, get to know the patient, figure out what are their concerns about life . . . I want to know what they are planning for college. Are they considering what their major is? Are they doing

any internship to stay plugged in? I want to make sure they have as good a quality of life that's possible.

When the physician is able to demonstrate a sense of caring for the patient, patients will feel more of an obligation to take care of themselves and follow through with treatment plans or listen to health advice from their physician. "When the patient feels connected to me, well maybe they will actually take their high blood pressure medicine," explained Dr. O.

Dr. B recommends encouraging and congratulating patients "as if they are part of your family." Doing so helps with relating to the patients on a personal level so they feel comfortable. He explained, "If they lose 5 pounds, and now they weigh 305 instead of 310, you tell them 'Great! You're going in the right direction. Keep it up!'" Dr. J also makes sure to reinforce the patient's contribution to his or her success: "Suppose a patient is telling me, 'Oh, my sugar is so much better, you did such a good job.' I will tell them, 'No, you did a good job. I only told you what to do – you actually did it.'" Physicians also connect with patients by acknowledging what they may be attempting to do. Dr. A does this with patients who are trying to lose weight. "I always connect with them on that because I'm also trying to lose weight and I always just recognize how hard it is," she said.

Connecting proves to be an effective way to help build relationships with patients and also to get them to open up more. Although participants expressed the ways that they communicate in terms of their professional career, they also shared the benefits of communicating something non-medical to patients. Dr. F begins her clinic appointments with a non-medical question, which helps the patient feel more comfortable. "Then my

second question is usually open-ended like, ‘How are you feeling? What’s going on with you? Tell me why you’re here?’” she said. Dr. M shared a story from her residency that she still remembers to this day and tries to apply in her everyday work:

When I graduated from residency, someone stood up and was talking about what we had been told at the beginning of our residency. They said, “Thank you so much for teaching us about all those rules about how we don’t touch our patients, don’t get personally involved, and don’t share personal information.” Then they reminded us to break all of them as much as we could all the time, because after a while, it really does become a relationship with the patient.

Transparency

Establishing trust, being honest, and obtaining ongoing consent from patients contribute to the physicians’ transparency with their patients. Patients value honesty, and Dr. B honors this by explaining to his patients what he finds:

I don’t have any secrets from patients. I am not trying to hold back any information, and I prefer to inform them as we go along. The screen in the room is not a big screen but is always facing so that both the patient and I can see it . . . I don’t hide anything from them.

Dr. P ensures honesty by explaining to the patient, “Okay, I’m going to be your doctor, and I’m going to follow-through with you,” which helps the patient to understand what is going to take place. “I try to have them know what we’re going to do and what exactly we’re doing, so it’s more of a relationship,” she said.

Maintaining an honest relationship requires telling the patient everything, whether good or bad. “There should be a good verbal communication explaining exactly what

problems the patient has,” said Dr. H. “Tell the patient, ‘Here’s the problem. Here’s how serious it is and this is what you take for this problem.’ Explaining things in detail helps create that bonding relationship.” Another issue that may arise is that the physician may not know what is wrong with the patient. When this happens, Dr. M suggests “being honest with your patients” and “trying to explain what’s going on.” She believes, “If you don’t understand what’s going on, tell [the patient], I’m not quite sure what’s going on but we are going to do these tests and figure it out.””

Honest communication brings patients into the therapeutic relationship by helping them understand their health. Dr. O likes to take the time to tell her patients why she is asking them to manage their health and explain what can happen if it is not managed. “It’s your choice if you want to take your medicine and it’s your choice if you want to eat McDonalds everyday,” she said. “I give them both sides. If it’s controlled, this can happen. If it’s not controlled, this can happen.” By giving her patients all the facts and framing them in a way that gives them control, patients may feel more empowered to follow through with treatment plans. Then, when patients come back for a follow-up, physicians can reinforce that trust aspect by explaining that what the patient is doing is producing positive results. According to Dr. J, “I go over their labs and [the patient] sees that things are getting better. Then they start trusting you and say ‘Okay, the doctor did make me feel better.’”

Sometimes, patients may be unaware of their health issues, which Dr. B handles by asking what they know about their condition. He does this because “I don’t want to reveal things that they haven’t been adequately informed about by their own doctors.” By allowing patients to reveal what they know about their health or what they feel

comfortable discussing, the physician can obtain consent to further explain what is happening or proceed with medical decisions. Consent acts as a way to help the patient gain a sense of control over their health. “I will always check in with the patient to make sure that is what they wanted to talk about,” said Dr. O. “Sometimes the doctor really, really wants the patient to quit smoking or to manage their diabetes better or change their diet, but the patient is on a completely different page where they don’t want to talk about that.” Dr. O uses this tactic because she likes to “always ask permission before I present something. I don’t want to just preach to [the patient].” Dr. P also wants her patients to open up to her, explaining, “privacy and confidentiality is the main thing, because [the patient] knows they can trust me with anything . . . feel comfortable, you can tell me anything you want, and that’s how I am going to treat you.”

By gaining consent from the patient and ensuring confidentiality, the patient and the provider can establish trust – an aspect of the relationship that all participants agreed is most important. “It’s really about trust,” said Dr. B. “There has to be confidence that there is a caring relationship between the two people.” He explained that both the patient and the physician then “understand there is a bond between them and that they are working together to get this done.” Although both the physician and the patient need trust, the responsibility for establishing that trust often falls on the physician. “Doctors need to make the patient comfortable so they can talk openly, because communication is very important,” explained Dr. J. “Trust that your doctor is going to make you feel better and make your health better.”

When trust is established, physicians can reassure patients about any concerns they may have. Dr. L makes it a point to “reassure [patients] and gain their trust and say,

‘Look, you can have that quality of life. You can have a family. You have a lot of things you are told you can’t have and I want to dispel those myths.’” Trusting the doctor means that the patient will fully participate in treatments and let the physician help them, explained Dr. L. “Trust is most important and how you build trust,” he said. “If they don’t trust you, it doesn’t make a difference. You can have the best hands of a surgeon but if they don’t trust you, they’re not going to be in the operating room.” He further explained that “patients have to believe that the profession of medicine and healthcare providers are in it to improve the quality of care for patients.”

Primary care physicians, in particular, need to ensure the patient trusts and believes in them. Dr. J tells her patients, “If you don’t like your primary care doctor, especially if you don’t trust your primary care doctor, then it’s time to change or find another doctor. Because this is someone you need to really trust and be comfortable with.” She explained that when the patient is comfortable with the physician, then the patient will open up. However, Dr. L explained that it can be a huge challenge to overcome:

If the patient has mistrust, that they feel there is secondary gain, that [the doctor] is running up a bill, that [the doctor] is just ordering tests and not listening to [the patient], or the patient has to repeat themselves multiple times and we were off thinking about something so we didn’t get the appropriate history.

He feels that physicians “have to be on your ‘A’ game and be working for the patient’s benefit.”

Empathy

Demonstrating a sense of empathy and expressing genuine emotions to patients help participants develop a meaningful relationship with their patients. Dr. A emphasized the need for physicians to have empathy. “I think it comes down to us listening to what the patients say . . . and having empathy,” she said. Although she admitted that she is “not the best listener,” she explained, “but I’m reasonably good at empathy. This patient population has a really hard life and you just have to acknowledge that. It’s not easy for anyone to take pills every day . . . having empathy is really important for these patients.” Participants demonstrate empathy in a variety of ways, such as expressing genuine emotions, being authentic, and keeping the patients’ perspective in mind. Dr. P confessed that at times she feels “like I’m just seeing one patient after the other,” so she makes it a priority to take a couple of minutes to talk to the patient, “so they know that I’m not just doing my job. I do care for them. If I don’t show it, then they don’t know. So I give a little more.” Connecting with every patient is difficult, participants confessed, so they will utilize other ways to connect with them. For those patients, Dr. A explained, “I cannot connect on a specific topic but I want to help them. So, I connect on that.” Dr. O uses a similar approach: “When I think I can connect to that patient, where all of what we are doing is really to add more value to your life, I phrase it that way.”

When physicians are able to demonstrate that they care about the patients, and are not badgering them, the patients will usually respond to the relationship. Dr. B does so by tailoring what he says to patients. For example, he will tell his patient:

I’ve been trying hard to take care of you and it’s disappointing that you don’t do any of this stuff. Not for me, but because I care about you and I know that by not doing this, your health is getting worse.

He feels that this is the best way to encourage patients to take care of their health, explaining, “It’s to make them remember that I’m doing this because I care about the outcome. And I think that once they get that sense, in one level or another, more is likely to get done.”

Recognizing and acknowledging what the patient is experiencing is critical when working with patients. Dr. B discussed the need for trust and the importance of physical exams in the patient/provider relationship, saying, “It’s an odd thing for you to imagine yourself going into a room with a stranger and taking your clothes off. So that’s one of the reasons that I take more time establishing the relationship with the patient.” Thinking from the patient’s perspective and considering what the patient is going through helps to gain a better insight of patient preferences in order to best decide on treatment plans, Dr. O suggests. When working with homeless patients, she understands how “they are just kind of passed around from agency to agency,” and so she makes it a point of “centering the appointment around them and having the patient feel heard and validated. Because I cannot imagine being in their shoes.” Participants found that finding ways to accommodate their patients’ needs not only demonstrates how they care for their patients but also ensures that the patients get the medical care they need. Dr. H recalled a patient he was able to help once he took the time to accommodate her:

She didn’t show up for her appointment and when I spoke to her on the phone I realized she lives in Schulenburg, TX. And then I realized, Gee, it’s really a burden for her to come here just to talk to me. We can talk over the phone and get some information that we don’t need to have her drive two and a half hours for.

Then I was able to facilitate an appointment with her gynecologist so that she could have all her appointments on one day. And to her, that was great.

Participants believe that allowing patients to express their emotions and then taking the time to respond to those emotions is critical. Dr. M shared how she does this, stating, “I try and acknowledge the patient by saying, ‘I hear what you’re saying and I understand that you feel no one is listening to you about your pain.’” Letting patients know that their feelings are being heard allows them to feel valued. Dr. B finds ways to comfort his patients and show that he values them and their time:

When a patient comes in and they are upset because their appointment is late, I say ‘I know, I’m really sorry I’m late. But you’re going to have as much time as you need to tell me what’s going on. I will take the same time with you.’

Being empathetic towards patients can be accomplished in a variety of ways, such as human touch, providing emotional support, and advocating for the patient. When discussing sensitive topics, such as end-of-life matters or challenging surgeries or procedures, Dr. L feels that “personal contact and the appropriate amount of touch in empathetic situations is key in those moments.” Dr. B echoed this, expressing:

When you are communicative, when you’re instructive, when you show warmth and caring – indicating that you care about what’s wrong with [the patient] and you are going to try and make it better – then there is buy-in on that part of the patient.

Providing emotional support is a large part of the relationship, Dr. H believes. “I feel like sometimes I am providing not just the patient care, but I’m also a friend to them.” Physicians often end up not only medically supporting their patient, but also

emotionally supporting them. He has personal experience with this, recalling patients who have cried in front of him, “telling me about how they were alienated by their father who they haven’t seen since they were seven years old.” Participants believe that demonstrating that they genuinely care for their patients can be used to connect with their patients. Dr. A mentioned one patient, in particular, whom she cannot connect with on anything but still truly cares for him. “We have nothing in common to connect on, but he has been dying to see someone and needed to see someone to assess why his speech is a little off, and I just feel like his advocate,” she said.

“I take into consideration that a lot of these people did not expect the thing that I tell them – and some of them are scary,” said Dr. B. Envisioning the appointment from the patient’s perspective and acknowledging his or her experience reinforces the physician’s motives to the patient. Dr. A acknowledges her patient’s struggles and praises her patients for their hard work:

I have one patient who has had so many unbelievable health problems, but she is the strongest woman. I’m stressed out that she has all these problems but she is such a strong woman. I’ve told her too that she’s my role model and I hope that if I ever had health problems that I would be as strong as she is. I admire her so much.

Making the extra effort and taking the time to express genuine emotions contributes to a trusting relationship between the patient and physician. Dr. L shared how he ensures this aspect in relationships with his patients, saying, “Everything we do in terms of sitting down, communication, education, letting them know that we are an available resource and being affable and friendly so that you’re approachable.” Having a

good bedside manner is crucial to Dr. L. “You have to be able to bring [the patient] on in and get them to believe that what you’re telling them is going to help them the most,” he said.

Patient Involvement

Participants recognize that patients may be nervous and also intimidated by doctors. In terms of different levels of knowledge between the patient and physician, Dr. B hopes that patients “are impressed that I know something – but I don’t think they need to be intimidated by the knowledge.” By understanding that both the patient and the practitioner bring something to the table, they can then mutually appreciate each other. Dr. B further explained:

I am somebody who has information. They are somebody who has information. For example, they are somebody who does welding art. I can’t do welding art; I wouldn’t have any idea how to start. They don’t know anything about medicine. If I had a question about welding art, I would go to them and I would expect an explanation and demonstration and I would be very impressed that they know it.

When both the patient and the physician come to the medical encounter as their authentic selves, the physician is able to bring the patient into the relationship as an equal, explained Dr. B, and make the relationship about the people, rather than the knowledge. By understanding that both the patient and the practitioner bring something to the table, they can then mutually appreciate each other. “So, we try to make sure that the relationship is not about the knowledge but is about the people – and I think that is the most important part of developing the relationship,” he said. “It’s an absolutely essential thing.”

By involving the patients in their care, participants feel they are able to build meaningful relationships with their patients. Participants strive to engage their patients by partnering with them when making medical decisions, encouraging them to voice their thoughts, establishing a long-term relationship, and educating them on their health. By involving patients in their care, patients will be able to complete the therapeutic aspect of what their physician tells them, believes Dr. B. “You have to bring them in to the relationship – it should be a relationship of equals,” he said. By letting the patient feel that this is a relationship, physicians can elicit from the patient, “What do you want out of this?” Dr. O explains to her patients, “If you don’t want this then I don’t want this.” Asking patients what they want allows them to feel like they have some control over a situation that can be extremely non-controllable.

To have a good, trusting relationship between a physician and patient, Dr. H explained, “There should be adequate time provided for the patient to voice their concerns.” Allowing the patient to talk and fully listening to what they are saying can often provide more information than a lab test would reveal. In regards to patient communication, Dr. M tells her residents, “It’s trust, communication, and listening. 90% of the time you can figure out what’s wrong after you take their history and actually listen to the patient before you even lay hands or order a lab test.” Encouraging patients to talk allows them to feel comfortable to express what they are feeling and also enables the physicians to ensure they understand their issues correctly. Dr. B elicits information from his patients by trying “to get them to clarify what they mean,” something he does because he wants patients to tell him how he feels, and not just a diagnosis. To do so, he takes patients “through their symptoms as though it is an episode and then have them tell me

the story of the episode.” Once they share with him, he then tells his patients, “Let me review that with you.” He explained that by going back over what the patient has said, he is able to make sure “I haven’t said anything wrong or I don’t remember something incorrectly and it accurately portrays the episode.”

Allowing patients to contribute to the conversation about their healthcare can often lead to patients being able to self-help. According to Dr. O, “I elicit from them what’s worked in the past, what hasn’t worked in the past,” which then leads to patients revealing something they didn’t realize could actually help them. “Sometimes they need someone to illuminate it like ‘Oh, I did have the skills, I just don’t use them as often as I probably could.’” Prompting the patient to contribute to the conversation can be extremely beneficial, said Dr. B, “because sometimes later in the conversation they’ll remember something or they will be able to more completely describe something.” Participants felt that allowing their patients to ask questions and speak up helped to remind patients that their physician is available to talk both during and also after the appointment. Dr. H takes time at the end of the appointment to tell his patients, “You may have forgotten some things or forgot to ask some questions . . . that is what my card is for. Call me if there are any issues we forgot to mention.” Making sure patients know this is important, Dr. L added, “It’s important that you’re available. That you can be reached in case there is any urgency or emergency.”

Encouraging participation from the patient sometimes means encouraging not only the patient, but also their supportive friends or family. Dr. B utilizes the other person to help the patient, explaining that he will “direct the visit to the patient but I encourage the other person in the room to participate. I’ll bring them in a responsible way so that

they have a sense of their part in the situation.” Importantly, he makes sure they know that “they are not allowed to be making decisions about the person’s healthcare themselves.” Participants have experienced patients who are not fully aware of their health, and they will often rely on their family to help better understand the patient.

According to Dr. H:

A lot of my patients are male, and most of them are older males accompanied by their spouses and in this setting the spouse takes the role of caregiver, so, a lot of times the spouse is more familiar with the patient’s circumstances than the patient himself. They know their medication; they know what they’re taking. And sometimes, patients may not even know how grave their situation is and the spouse may have a better sense.

“I try to involve [patients] in the care . . . I’ll show them the note about the goals that they set previously, just to bring them in as part of the process as best as I can,” explained Dr. O when discussing how physicians can involve their patients. Both letting patients voice their concerns and also partnering with them can help involve them in their healthcare. Participants revealed ways in which they try to work as a team with their patient, something that Dr. L feels is an essential aspect to healthcare. He used an analogy to explain how he involves his patients:

We try our best really to let them be the quarterback of the team even though we’re the coach. Once they’re on the field, they’re the quarterback and they have to be the one who runs the play. They have to call it audible and if they make a change of plan, we got to run with that.

Working with patients and involving them in their care as much as possible leads to better health outcomes. Participants felt that they can tell patients what to do but unless they agree to it or believe in it, they won't follow through with treatment plans. Dr. J shared how she ensures her diabetic patients take care of their health. "I tell my patients, 'If you have diabetes, I cannot make it better alone, you need to work with me. We need to work as a team to make your diabetes better,'" she said.

Establishing a continuing relationship provides patients with a physician they know is familiar with their case. Dr. F helps promote this type of relationship by beginning her appointments with open-ended questions, followed by a question about their previous visit. "I'll go, 'Well, last time we started Amiodarone, how do you feel on that?' And as soon as you bring up something that you did last time, they're like 'Oh, she knows exactly who I am,'" something she notes "puts a lot of people at comfort." Making sure that the patient has a follow-up, no matter how big or small the issue is, can help the patient feel at ease and taken care of. According to Dr. P:

I always see patients again in two or four weeks. For the chronic issues that are not really, really important, I'll say 'Okay, let's do physical therapy, and then I'll see you in four weeks. If anything, I'll do an x-ray.' I give them another appointment and then they're very happy.

Often, Dr. P worries that patients can get lost in the system, so to prevent this from happening, she "continues telling them they'll definitely come back. I try to make sure they have an appointment with me."

Participants believed that bringing the patient in as a partner allows them to practice patient-centered care, something that takes time to accomplish. "My objective is

to build an individual relationship with the patient and start it as quickly as possible and bring them into the picture as a partner in the outcome,” Dr. B shared when discussing how he builds relationships. Trusting relationships between the patient and physician happen over time, explained Dr. H:

I ensure this by making sure I see the patient the next time they are in, to ensure they see the same person . . . my patients value the continuity element, because they’ve established some relationship. They know who the doctor is and then they want the same doctor to follow.

He experienced this firsthand, sharing:

They absolutely love it. When I tell them I am going to do the heart cath myself they say ‘Wow, great. Thank you.’ And then when they see me in the cath lab they feel more relaxed because it’s not a whole new doctor again that they need to meet.

Ensuring continuity does not only have to take place in the clinic or hospital.

Participants revealed that they follow up with their patients in one way or another. Dr. O explained, “I typically like to follow-up with them in some way, whether it’s face-to-face or over the phone.” Other times it takes using another source, such as a case manager, to make sure patients receive the healthcare that they need. According to Dr. A:

I have a really good case manager and I’ll go to them and say, ‘Look, I’ve referred this patient to cardiology, can you please help follow through to make sure that an appointment actually happens?’ Just help them get whatever they need.

Reminding the patient to reach out to their physician was another way that participants fostered relationships. Dr. H makes sure his patients understand this by saying:

I would like to see you in six months, but if something happens in between that time, I don't want you to think that if you are having chest pains but your appointment is the next week that you should wait. So please call me if there's something that requires attention earlier.

Informing and educating patients about their medical situation helps involve patients in their care. Dr. H explained that he tells his patients, "The reason you're here today is because your referring physician wanted a heart doctor to see you," something he does because:

It's my job to make sure to communicate that. I like to make sure to go over the medical problems with them after I meet them and tell them the reason for the visit, so they are at least familiar with what their medical situation is.

Educating patients on their medical condition allows patients to feel confident when making medical decisions. "I just want to break down challenging complex subjects into simple mechanisms and certain concepts," said Dr. L. "I think if the patient understands that level, they are going to take a lot more ownership and more investment in their condition." Dr. L emphasized the need to educate the patient, saying, "We have to give [the patient] that trajectory as to why the medicines are important, what interventions do we have that are available, and what do they really want out of their life."

Participants felt strongly about educating their patients in terms of what is going on with their health. "I try to teach [patients] because it's important," said Dr. J. "If the patient doesn't know what their health problem is and what it can do, they won't care."

She reinforced this notion by stating, “Seeing a patient and not educating does not complete a visit.” Dr. O expressed similar thoughts, explaining, “My role as the health provider is providing knowledge to the patient.” Educating the patient and making sure to explain things in detail is critical, but participants also recognized that they have to explain things in a way that the patient understands. “Whatever level that person understands things on, it is your job to get to that level and then be able to explain things well, despite the fact that you can’t use your normal vocabulary,” explained Dr. B. “You have to be flexible and you can never be impatient about it.”

Participants believe that the explanation they give is something patients find extremely valuable. Dr. H stressed the importance of educating patients, stating, “I spend a great amount of time explaining in detail what the patient’s problems are and try to explain in them in lay terms. I make sure that they understand what the problems are.” He makes a point to do this for every patient: “A lot of patients have said, ‘You know what? Nobody has ever spent time to explain what’s wrong with me before. They’re always in a hurry, typing on the computer. I don’t feel like I got a visit.’” After the patient understands what is going on, participants felt that they are able to decide on a treatment plan that best fits what their patients want and need. Once Dr. L feels that he has spent the appropriate amount of time educating his patients on their condition, he feels that he is able to ask his patients, “How can I best guide the care that you want? There are certain medicines but they are very high doses of medicines. Let’s reevaluate what you want out of life.” Educating the patients involves them in their care and allows the physician to encourage them to speak up. Dr. B provided additional insight into the importance of educating the patient, stating:

I use the computer to call up images or pictures that I can use to explain things. I have to say; this explanation at the end is probably the thing that patients like the most about the visit. So the explanation at the end, the education if you want to call it that, and laying out the plan and exactly what the plan is going to be, this I find to be remarkably effective in relieving anxiety. People know that they're there because they're sick. To understand that we have identified something and that we have a plan to evaluate it further or to treat it and they can have a picture of it in some way; whether you draw it or have something they can see, is very good.

Participants revealed a variety of methods they utilize when educating their patient, including analogies, the teach-back method, visual aids, and writing out instructions. Different patients require different learning methods. According to Dr. L, "Many people tend to be visual so I am a sketcher. I love to draw pictures of heart, what their heart looks like and walk through in real time what is the flow of blood through the heart." He also uses analogies when appropriate "so that people understand a more down-to-earth, real-life representation of disease models." He finds it beneficial to have a variety of options for teaching. "So if they like pictures, they can see it. If they like analogies, then they can say, 'Aha, that's kind of like what my heart is doing,'" he said.

Providing visual aids to patients has proven extremely beneficial for many of the participants. They use handouts, pamphlets, pictures, and props to help educate their patients. Dr. F prefers to use props and the hospital's booklets for her patients. "I have defibrillator samples and then I can show [patients] how it works and how it goes in and everything else," she said. "We have booklets that I think help and are written on a lower

education level. The patients seem to really like the booklets – one patient even comes in with it highlighted.” Dr. H also likes the hospital’s booklets because “they are in lay terms and we have them for a variety of procedures.”

Providing a hand-drawn visual aid or a printed image from the computer for the patient to view was also a popular choice among participants. Dr. P explained how she is a visual learner and feels that her patients are as well. “At times, I draw. I’m very visual. That really helps, since they’re also visual,” she said, “so for my diabetic patient, I drew for her what the insulin does.” Using the computer to pull up an image and then printing it for the patient also helps. “I use the computer to call up images or pictures that I can use to explain things,” said Dr. B. Participants also like having a physical copy of the patients’ medication lists or labs when talking to them. Dr. A uses her computer for printing out lab results or medication lists for patients she is worried might be confused:

I print out their labs. I don’t just tell them ‘okay, your CD-4 is this and your viral load is this,’ because it would be hard for any of us to remember. So I print out their labs and with a pen I will circle the lab I’m trying to talk about, point to it, and then tell them what the goal number was.

A method known as teach-back was the preferred approach to patient education among other participants. This method is not only beneficial in terms of educating patients, but also for encouraging patients to speak up and participate in their healthcare. Dr. O shared why she favors this method, explaining:

I use teach back . . . you can use it for patients with both high and low literacy. It’s basically assessing their level of knowledge on that particular topic and filling in the blank for what they are not aware of. Then once you fill in that blank,

having the patient kind of give a rundown, like ‘Tell me what I just taught you.’
It’s having them go through everything.

This method provides an opportunity for physicians to assess the patient’s understanding and determine how they should proceed with education. “I explain things in pieces. So I kind of tell them the first part and I ask what they understand about it and get them to repeat things back to me,” said Dr. M. “Some patients I want to self-monitor their insulin. So I will tell them how to do that and then say, ‘Okay, so tell me what you have to do now.’” Dr. H uses teach-back with his patients, explaining, “Sometimes in the clinic setting if I feel like they don’t know what I’m referring to, I just ask them, ‘Can you tell me what I just told you about your health?’” This helps to ensure that the physician gets confirmation that the patient got the message. “I try very hard to make sure it’s a level they understand and I don’t assume that they get it the first time,” explained Dr. B, “so I’ll ask them to repeat things back to me to make sure they understand. I don’t assume that they get it the first time. Education requires more than one repetition of the information.”

CHAPTER V

DISCUSSION

After almost a year of physical therapy, I was eventually told that I would probably never walk again. I was told that I would have the chance of not using a wheelchair at some point, but I would need either the help of a walker, crutches, or a walking boot to help me get around. This devastated me, and I quickly spiraled into depression and gave up on my recovery plans. That is when Dr. K stepped in.

Guided by qualitative, narrative research, I sought to understand what physicians are purposely doing to enhance patient-centered care. My research questions explored the communicative strategies that physicians use to enhance PCC and the perceived barriers that prevent them from using these strategies. As the nine participants reflected on their personal choices in initiating, building, and maintaining relationships with their patients, they spoke passionately not only about ways they are individually trying to make a difference, but also about the barriers that prevent them from doing so. Through my research, participants revealed communicative strategies that support previous research in regards to the six functions of PCC that are essential for patient-provider communication (Epstein et al., 2005; Epstein & Street, 2007). Specific to this study, participants employ proxemics, connections, transparency, empathy, and patient involvement in order to promote PCC. Participants discussed both systemic and patient-caused barriers preventing them from employing these strategies.

As previously stated, a framework that contains six communicative functions are essential for PPC: a) fostering relationships between patients and providers, b) exchanging information, c) responding to emotions, d) managing uncertainty, e) making

decisions, and f) enabling patient self-management. Within this study's communicative strategies theme, the five subthemes provided insight into the individual-level steps participants take to provide PCC to their patients. Participants acknowledged not only the ways that they felt they benefited from PCC, but also how the patients benefit from PCC. Each of these functions shows how providers in all institutions can initiate PCC. However, two obstacles prevent this type of care from taking place: systemic and patient barriers.

In regards to the first function, fostering relationships between patients and providers, participants utilize empathy, transparency, and connection to build relationships with patients. In order to demonstrate empathy, participants express genuine emotions to their patients and acknowledge the patient's individual experience. By taking a few extra minutes to talk to patients about non-medical topics and acknowledging what the patient is experiencing, physicians are able to demonstrate that they care for their patients. A successful relationship needs both the patient and the physician to be completely honest and trust one another. When asked about the most important aspect of the patient-provider relationship, all nine participants either brought up trust or felt that trust was the most important aspect. Trusting physicians means patients are comfortable with their doctors and will then open up to them. Once physicians have demonstrated empathy and are transparent with their patient, a connection can then form. Although there are numerous benefits for both the patient and physician by fostering relationships, systemic barriers prevent this from taking place. Due to an increase in demand for billable hours, physicians must adhere to a strict time schedule when meeting with patients, which has resulted in the use of electronic note taking. Participants explained

how they are given a short amount of time to meet with patients, hindering any meaningful relationships from forming. Healthcare systems would have to be rigorously transformed to allow for more time to be spent with patients.

The second function, exchanging information, ensures that patients understand information regarding their health. Physicians do this by involving patients in their healthcare, such as educating and partnering with the patient. All participants discussed how they educate their patient, sharing that the explanation of their health that patients receive is one of the most important parts of the exam. Participants explained that adequately educating the patient results in patients feeling confident in their healthcare decisions. Patient education is accomplished through a variety of methods, such as analogies, teach-back, and visual aids. Providing this information to patients allows physicians to partner with their patients. When physicians work with the patient, rather than just simply treating them, better overall health outcomes are achieved. Physicians experience barriers that prevent their patients from understanding their health, such as lack of patient knowledge. Patients can have a difficult time understanding their physician due to their lack of knowledge or information. When patients do not know what medicines they are already taking or do not understand their pre-existing health condition, physicians can struggle to help them understand everything that is occurring in regards to their health.

The third function, responding to emotions, is accomplished when physicians are empathetic and display appropriate proxemics. Conversations with patients often include sensitive, and sometime scary, topics that can lead to emotional distress. All participants revealed their preference for having the patient in their line-of-view when they are

talking. Looking at the patient ensures that physicians not only show that they are actively listening to the patient, but also helps physicians gauge how patients are responding to the information they are receiving. When physicians notice that patients are responding negatively to the news they received, physicians can alter their approach to their patient and display empathy by expressing emotions and perspective taking. One participant felt that the appropriate amount of human touch is critical when expressing empathy, particularly in end-of-life conversation. All participants felt that taking the perspective of the patient and acknowledging their concerns and what they are experiencing reduced levels of distress. In order to respond to emotions, physicians must be able to be looking at their patient and have the time to respond to concerns. With healthcare organizations implementing tight appointment schedules, physicians must take their notes on the computer. All participants confessed that looking at the computer while talking to patients automatically created a barrier between them and their patients.

The fourth function, managing uncertainty, requires physicians to be transparent with patients and involve patients in their care through encouraging conversation and patient education. Patients may feel uncertain when a diagnosis or treatment plan is scary, complicated, or unfamiliar. Participants emphasized the need to be honest with their patients in regards to their healthcare, whether that means reassuring them that they can take care of them or admitting that they may not know what is going on. Participants shared that they are honest when they do not have a full understanding of what is wrong with the patient. Being honest with the patient will help bring the patient into the relationship and encourage the patient to talk. When patients speak up about their concerns, physicians can understand what they need to explain better to patients.

Physicians experience resistance to this from patients who may speak a different language or come from a different culture. In terms of language barriers, physicians experience patients not completely opening up when a translator is needed, particularly when discussing issues that the patient may perceive as embarrassing or private.

The fifth function, making decisions, varies depending on patient preferences. As explained in previous research, physicians can help the decision-making process by actively listening to patients and checking their level of understanding, promoting patient involvement, considering patients' preferences, and expressing empathy. Three subthemes of the communicative strategies brought up an aspect of these concepts. Patient involvement allows physicians to encourage patients to talk, resulting in a better understanding of the patients' levels of knowledge regarding their health. Once the physician understands this, they can educate their patients and shape the consults accordingly. When physicians express empathy, patients receive a caregiver who is not only there because it is their job to take care of them, but someone who is looking at the situation from their perspective, acknowledging their preferences, and valuing them as individuals. Looking at an experience from the patient's perspective and helping with decision-making can be difficult when there are cultural differences. Patients are typically aware of not only their own culture, but also the physician's culture, which can lead to patients not feeling comfortable enough to open up about their health. If patients are not willing to share information, physicians are unable to determine the patient's preferences when it comes to decision-making.

The sixth function, enabling patient self-management, has a higher chance of being accomplished if physicians not only involve patients in their healthcare, but also

connect with them, according to participants. As Dr. O explained, when patients feel connected to their physician, they are more likely to follow through with treatment plans. This is accomplished by involving the patient through education and teamwork. Often, there is little that patients can do to feel in control when it comes to their health, something that participants tried to reduce by taking the time to make sure their patients understand what is happening with their health. When physicians implement PCC, patients feel empowered to make healthcare decisions, something that can only be done once they have been fully informed and educated regarding their health. Letting patients contribute to their healthcare results in patients who are more likely to follow through with treatment plans and have overall satisfaction. Although physicians can employ strategies to help enable patient self-management, sometimes lack of self-management is caused by the patient's socioeconomic status. Physicians working with low-income patients experience difficulty when trying to provide the quality of care needed by the patient. Patients who might lack financial stability can have issues getting transportation to a clinic or they lack coverage to fill prescriptions or buy necessary medical equipment.

Limitations and Suggestions For Future Research

Limitations of the study include the sample population's characteristics. Participants are all employed through large public health systems rather than smaller private entities, influencing the type of patients they treat, the treatment they can provide, and the systemic barriers they experience. This sample was limited to nine doctors, which may not accurately reflect the communicative strategies or perceived barriers of a larger group of physicians. All participants work in the same geographical area, resulting in a

reduction of variation. Additionally, since the sample was recruited through personal contacts that knew the purpose of the study, participant responses may have been biased.

Despite the limitations, this research provides a foundation for future research concerning PCC and the steps that physicians are taking to implement it. Although this study focused on physician perspectives of PCC, future research focusing on the patients' perspectives may provide a deeper understanding of what needs to change in order for PCC to become the norm for all healthcare organizations. As healthcare organizations continue to evolve over time due to the Patient Protection and Affordable Care Act, the need for effective patient-provider communication will continue to grow.

Future research may examine the education that medical students receive regarding communicating with patients and the professional development offered to healthcare providers regarding patient-provider communication. Additional topics that may prove to be beneficial include interviewing physicians regarding PCC who work in small, private, or rural healthcare organizations. By further developing research in this area, PCC can help both patients and physicians achieve mutually satisfying medical encounters.

Conclusion

Overall, providers are working very hard to implement PCC with each of their patients, in this case specifically through various communicative strategies. By using appropriate proxemics, establishing a connection, being transparent, expressing empathy, and involving the patient, physicians are able to exercise PCC with their patients. However, many problems still persist that make practicing PCC more difficult for physicians. Healthcare institutions and individual providers must work together to

establish methods for implementing widespread PCC. Without both groups working in tandem, PCC does not stand a chance and, therefore, neither does the future of patient health.

Dr. K motivated me to start working harder than I had before, so I switched physical therapists and went to a nutritionist to work on strengthening my bones. I was motivated by the idea of dancing at my wedding one day, and showing Dr. K that I was just as strong as he thought I was. Six months later, while at school, I took my first three steps. I had left my walker in the bathroom stall, and walked to the sink. I can still remember the pure joy that I felt and the pride that swelled inside of me. Later that day, I called Dr. K that day when I got home and left the good news with his nurse. I received a call later that night, where the first thing that Dr. K said after I answered the phone was, "So it looks like we'll be dancing at your wedding, doesn't it?"

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APPENDIX

Individual Interview Question Guide

Good Morning / Afternoon. As a reminder I would like to ask you a few questions about actions physicians are taking to address the barriers to adopting patient-centered care. Is that alright? Is it alright for me to audio record / video tape our discussion? Do you have any questions for me before we begin?

1. Please describe a typical office visit when meeting with a patient.
 - a. What questions do you ask your patient?
 - b. Does the visit differ depending on who is in the room? How so?
2. How do you take notes when listening to your patient talk?
 - a. Please walk me through this process.
 - b. What do you think are the benefits/setbacks of this process?
3. How do you communicate with your patient?
 - a. In what ways do you communicate with them? Multiple ways?
 - b. How do they contact you in case they have questions?
 - c. Do you provide your patients with support group information?
4. What barriers prevent you from communicating with your patient effectively?
 - a. Do language differences play a role in your communication efficiency?
 - b. How do you help patients with low health literacy understand the information?
5. How do you build relationships with your patients?
 - a. Can you tell me about one of your most memorable patients?
 - b. Do you keep in contact with patients outside of their appointments?
 - c. Do you keep in contact with previous patients?

6. What do you think is the most important aspect of the patient-physician relationship?
 - a. Why? How do you preserve / ensure that aspect?
7. Is there anything else you would like to add before we finish up today?

Thank you so much for your time today. If you have any questions, please feel free to contact me. My cell phone number and email address is at the bottom of your consent form.