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Patient-Provider Interaction: Person Centered Approaches to Patient Diversity and Evidence for Training

Hannah O. Allison
University of Arkansas, Fayetteville

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Patient-Provider Interaction: Person Centered Approaches to Patient
Diversity and Evidence for Training

Patient-Provider Interaction: Person Centered Approaches to Patient

Diversity and Evidence for Training

A thesis submitted in partial fulfillment
Of the requirements for the degree of
Master of Arts in Communication

by

Hannah O. Allison
Clemson University
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University of Arkansas

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Patricia Amason, PhD
Thesis Director

Lynne M. Webb, PhD
Committee Member

Robert. M. Brady, PhD.
Committee Member

ABSTRACT

This study investigates the role of culture in patient-provider interactions. Physicians in Northwest Arkansas were interviewed on their experiences with cultural differences in interactions with patients. Analysis using Grounded Theory methodology indicated that physicians define culture in various ways and the majority view culture as negatively impacting their interactions. The results from this study also reveal that physicians received minimal training in their medical education on how to handle these cultural differences and instead have learned on-the-job through trial and error methods. Finally, the research concludes that many of the physicians interviewed perceived deficits in training and offered suggestions on how to improve training and ultimately the patient-provider interaction through future communication.

Keywords: patient-provider, communication, culture

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Chapter One

INTRODUCTION

Medical studies reveal that 40-80 percent of patients do not remember any of the health information received immediately after the interaction with a health provider (Anderson, J., Doman, S., Kopeland, M., & Fleming, A., 1979; Kessels, R., 2003); furthermore, almost half of the remembered information is incorrect (Smith, 2013). This statistic is deeply troubling considering the rising health problems and treatment costs in the United States. In addition to pressure from citizens, long time residents, and today's increasing diverse and migratory world, an increased number of populations are settling in the United States. From big port cities, small farming communities, and every area in between, this influx of migrants impacts even the smallest medical clinics. Thus, the complex task of successful communication in the health field is becoming increasingly challenging with the added layer of non-natives to the area that easily become vulnerable to misunderstandings and may contribute to health care disparities (Smith, 2013).

Successful communication within the health fields serves a multitude of functions and is essential for successful and respectful care. Ruben (1990) described the large role communication plays in health care delivery: "Communication is the process through which symptoms are described and interpreted, and the means through which treatment is provided and compliance is encouraged. It is the mechanism through which scientific advances are shared within the research and professional community, the vehicle through which medical personnel are trained and patients educated, and the link through which caregivers from different specialties interact with one another on a daily basis" (pp. 51). The role communication plays in the successful delivery of health services across dyad types is clear. The current study focuses on the impact of culture on interactions between patients and health care providers. Existing literature is reviewed on patient-provider communication, inter/cross-cultural communication,

and narratives in health communication to explore what previous research addresses in each of these areas and to draw conclusions about how research in each of these areas can improve patient-provider communication.

Chapter Two
LITERATURE REVIEW

Patient-Provider Communication

Ruben (1990) discussed the multiple roles communication plays within the health care arena. One of the most important and heavily researched areas is patient-provider communication. Patient-provider communication occurs traditionally between the patient and provider face-to-face during a set appointment time to discuss current health conditions and symptoms that the patient is experiencing as well as the way treatment is explained and prescribed with adherence encouraged (Ruben, 1990). This initial discussion then impacts all other communication and treatment of the described health concern. Therefore, communication between the patient and provider is necessary not only to the patient satisfaction but also to the health care process itself (Thompson, 1990). Changes in the medical delivery model over the years have brought patient-provider communication into the spotlight.

In the past 15 years, the growth of research on patient-provider communication is not due solely to the work of communication scholars; health care professionals are publishing research in medical journals on this topic (Wright, K., Sparks, L., & O'Hair, H., 2008). This increase also correlates to the emphasis on managed care as the current standard and the negative results stemming from the model's downfalls (Wright et al., 2008). Managed care is the financial arrangement for provisions of health care services creating limitations on treatment and medication options, shorter time spent with the patient, and perhaps forcing a patient to switch doctors under certain conditions; each of these factors can hinder the already complicated patient-provider relationship (Wright et al., 2008).

Nonverbal cues. One sub-area of patient provider communication emphasized in research concerns the use of nonverbal cues (Thompson, 1986), to develop and maintain the dyadic relationship by conveying liking, warmth, immediacy, interest, emotion, and concern.

These cues also are used in persuasion tactics to enhance adherence to treatment plans using authority, power, credibility, and reinforcing desired behaviors (Buller & Street, 1992). Results from studies examining the relationship between nonverbal skills and overall patient relations suggest, “Nonverbally skilled physicians engage in more appropriate nonverbal behaviors, are more sensitive to patient nonverbal cues of distress or confusion, and are more effective in conveying emotional messages of caring and sincerity to their patients” (Roter & Hall, 2011, p. 62). These nonverbal behaviors also are incorporated into communication concepts and behaviors that influence patient satisfaction/dissatisfaction. The importance of these behaviors is supported by research correlating sensitivity, emotional awareness, and patient-centered communication, as discussed by Roter & Hall (2011).

Patient satisfaction. Patient satisfaction/ dissatisfaction resulting from patient-provider communication is a heavily researched topic and is another sub-area of health communication scholarship. Factors associated with patient satisfaction include warmth and friendliness, awareness of patient concerns (Thompson, 1990), attentiveness and empathy (Zacharie et al., 2003), as well as increased length of visit, increased nonverbal communication, more psychosocial discussion, and lower physician dominance (Duggan & Thompson, 2011). Linder-Pelz (1982) identified five social-psychological factors comprising patient satisfaction: occurrences, value, expectations, interpersonal comparisons, and entitlement. Dissatisfaction also influence patient-provider communication, including interrupting, listening, lack of communication with patient (Thompson, 1990), higher malpractice rates, and lower perceived social concordance rates (Thornton et al., 2011). Research on patient satisfaction reveals that health outcomes and goals are interconnected. Duggan and Thompson (2011) identified

treatment recommendations and treatment adherence as key goals of positive interactions between patients and providers and therefore increased patient satisfaction.

Patient adherence. A third sub-area of research regarding patient-provider communication is outcomes for both parties and patient adherence. The quality of communication between patient and provider is positively correlated with patient adherence (Zolnierek & DiMatteo, 2009). Communicatively, adherence includes information exchange/patient education, reaching common ground in expectations, patients taking an active role, provider empathy, positive affect, and encouragement (Brown et al., 2003; Farin et al., 2013; Gramm, & Schmidt, 2013). Patient education is critical to treatment adherence because health literacy is a significant factor in persons in lower income levels following treatment recommendations (Inoue, Takahashi, & Kai, 2013). Quality of patient-provider communication is associated with many positive provider outcomes including higher levels of cooperation (Thompson, 1986) lower malpractice claims, and a greater amount of time spent “chatting” with the patient, and an increased amount of feedback provided to the patient (Brown et al., 2003).

The first few minutes. The time spent talking with the patient at the beginning of the interaction is a fourth sub-area of health communication research (Thompson, 1986). The first few minutes of interaction between patient and provider are critical because research replicated in multiple studies found that most patients are interrupted on average within the first 23 seconds of the patient-provider interaction (Beckman & Frankel, 1984; Marvel, Epstein, Flowers, & Beckman, 1999). The majority of these patients did not finish their thought or description of why they scheduled the appointment which is an important concern considering this influences how providers determine what tests to run on the patient which can extend the diagnosis process and subsequent costs (Cegala, 2005). Providers tend to make assumptions and hasty judgments about

the routine nature of patients' messages or they are too busy to hear the patient out entirely, or they assume the patient is describing the symptoms incorrectly; these communication failures can negatively impact the patient (Thompson, 1986). To solve the problems encountered in the first few minutes, a patient-centered approach encourages better care and communication with no additional constraints on the provider. This approach is further discussed in detail later in the literature review.

Communication barriers. Often discussed in the context of patient-provider communication, a fifth sub-area in health communication consists of communication barriers specific to the health care system. In Thompson's (1990) discussion of interpersonal issues, she identifies such communication barriers as the following: patients' (a) reluctance to initiate communication because of awe; (b) fear of negative reactions; (c) patients' suspicions that they will not receive good answers; (d) having little time with doctors; (e) the patients' perceptions that doctors and nurses are overworked and have little time; (f) and cultural and class differences between themselves and the doctor. Addressing the patient-centered approach to health care would reduce problems and misunderstandings within the encounters of patients and providers.

Until recently, medical practice in the United States was not always concerned with the patient's perspective (Duggan & Thompson, 2011; Sitza & Wood, 1997). The paternalistic and biomedical model historically more common to health care delivery focused on the provider as the dominant rhetor in the interaction. This model of medical treatment is evidence based and focuses only on physically manifested systems diagnosed (Duggan & Thompson, 2011; Wright, Sparks, & O'Hair, 2008). Over time, the paternalistic and biomedical models evolved to become more patient-centered addressing issues and barriers (as discussed in the previous paragraph) arising in patient-provider interactions. In all the sub-areas of health communication discussed

earlier, the patient-centered model emphasizes improved patient-provider communication (Brown et al., 2003; Cegala, 2005; Duggan & Thompson, 2011; Farien et al., 2013; Roter & Hall, 2011; Roter et al., 2012). Patient-centered communication is one of the six primary aims identified by the Institute of Medicine to improve quality of health care in the 21st century (Shay et al., 2012). This approach to health care delivery emphasizes patient perspectives and preferences in care and increased information from the provider to the extent the patient needs or wants additional information to make medical decisions (Roter & Hall, 2011). Using this model, providers collect more information about the patient and ailments than if they use physician-focused models (Cegala, 2005).

Research by Epstein et al. (2005) identified four main focus areas of the patient-centered model: integrating the patient's perspective, acknowledging the psychosocial context, encouraging both shared understanding as well as shared power and responsibility. The patient-centered approach stresses the importance of communication and its association with visit satisfaction, recall of medical information, medication adherence, adoption of healthful lifestyle behaviors, and reduced risk of malpractice litigation (Roter et al., 2012; Shay et al., 2012). Research examining patient-centered communication identifies positive outcomes related to patient-provider model such as increased visit satisfaction, patient recall of medical information, medication adherence, diminished malpractice litigation, and reduced medical error (Roter et al., 2012). Interestingly, while the patient-centered approach positively contributes to improving relational and health outcomes, researchers' found this approach does not significantly increase the length of visits (Cegala, 2005).

Though the benefits of patient-provider communication are widely described in the literature, little research sheds light on providers' views of this model and what they deem as

successful patient-provider communication. Although the patient perspective is important and valued in the consumer-driven industry, interaction is dyadic and both participants' perspectives must be taken into consideration to enact successful patient-provider communication. Patient-provider communication relies on communication patterns and the knowledge of those patterns. Communication effectiveness largely is impacted by perceived similarities and differences in the dyad. Among those similarities and differences are cultural backgrounds. Culture and cultural differences then must be taken into account when discussing health care delivery.

Culture

The general concept of culture often is defined as a person's worldview shaped by their life experiences (Fuchs et al., 2012). Therefore culture includes a person's values, norms, patterns, and practices that are learned, shared, and transmitted intergenerationally (Leininger, 1997). Culture includes but is not limited to ethnicity, sexual orientation, religion, generational age, sex and gender, socioeconomic status, and health issues (Campinha-Bacote, 2003). Culture can be thought of as having two components (Kreps & Kunimoto, 1994): (1) the substance or network of meanings including ideologies, norms, and values as well as (2) the forms or practices where meanings are expressed, affirmed, and communicated to members (Kreps & Kunimoto, 1994). Taking the concept a step further, intercultural communication, therefore, is the interpersonal bridging of two different cultures (Kreps & Thornton, 1984) involving unique characteristic symbols, meanings, conventions, rule structures, habits, values, communication patterns, social realities, and "significant stories" shared by common members of that social structure and system (Ruben, 1990, pp. 57). Culture is important and intricately entwined in the health care process as culture shapes health-related beliefs, values, and behavior (Delgado et al., 2013). Beginning in the early 1990s, a discussion about the role culture plays in health care

gained traction and is now a widely discussed topic within the communication and medical disciplines (Voelker, 1995).

Cultural sensitivity is when providers are aware and respectful of a patient's cultural background and norms is receiving major attention in the health care field. Communication is more effective when the provider demonstrates culturally sensitivity (Brislin, 1993).

Furthermore, cultural sensitivity is considered an important factor in effective interactions (Bronner, 1994; Majumdar, 1995; Moore, 1992). The majority of literature on cultural sensitivity examines provider behaviors considered culturally sensitive or insensitive (Bloomer & Al-Mutair, 2013; Brisco, 2013; Chang et al., 2013; Porche, 2013; Woolley et al., 2013). Culturally sensitive care occurs when the patients' and providers' expectations, behavior, and attitudes align (Brisco, 2013) across values, empowerment, as well as inclusivity (Bloomer & Al-Mutair, 2013). In addition, quality of care involves cultural sensitivity by using culturally appropriate communication behaviors, medical knowledge, cultural knowledge, local health system knowledge, positive personality, and positive attitude while interacting with patients (Woolley et al., 2013).

Culturally sensitivity, as measured by Chang et al. (2013), includes interaction engagement, respect for cultural difference, confidence, enjoyment, attentiveness, and multicultural resources. The patient-centered perspective emphasizes the use of cultural sensitivity in practice to improve current patient-provider relations. These behaviors are incorporated in trainings sessions offered to providers (Brisco, 2013; Chang et al., 2013; Porche, 2013; Woolley et al., 2013). Findings from Ulrey and Amason (2001) indicate cultural sensitivity is an important factor associated with effective intercultural communication. If a provider is culturally sensitive, the next step is cultural competence.

Health Disparities. Unfortunately, persons from many cultural backgrounds fail to receive quality health care leading to great health disparities. The large differences in health status based on cultural factors including age, religion, race, ethnicity, geographic location, and socioeconomic status are referred to as health disparities (Ndiaye et al., 2011). Health disparities often are due to marginalization, the denial of privileges, rights, access, and power within an existing political system and social structure of a group of people (Ford & Yep, 2003). To counteract the likelihood of these disparities occurring, communication and medical scholars emphasize the importance of raising providers' levels of culture competence. In the health care setting, cultural competence refers to, "the ability of a person or structure to manipulate and customize communication for the purpose of reducing ambiguity among the triadic relationship of the patient, the caregiver, and the health delivery system" (Moore & Thurston, 2008 pp. 106). Effective communication aids in reducing such disparities when linked to improving persons' cultural competence and reducing health disparities. Cultural competence involves two types of competencies: personal and relational (Ndiaye et al., 2011; Thornton et al., 2011); such competencies impact health-related personal factors including education, race and ethnicity, socioeconomic status, group membership, sexual orientation, and previous health care experiences (Ndiaye et al, 2011 & Thornton et al., 2011). Relational factors include the relationship between patient and provider, family relationships, lifestyle factors within the family, and medical information decision-making (Ndiaye et al., 2011). Among the research examining the effectiveness of competence programs (Delgado et al., 2013; Renzaho et al., 2013), studies focused on assessing provider baseline levels of cultural competence, how providers adapt when they are from ethnic backgrounds different than their patients (Tavallali et al., 2013), and barriers to care when cultural competence is not demonstrated.

Barriers discussed by researchers vary in focus from individual providers to the actual health system itself. Moore and Thurstan (2008) identified five barriers: health care workforce composition (the lack of diversity within the organization); sociolinguistic competences (level of effective communication between patient and provider); patient-sociodemographics (diversity of patients, poverty- low socioeconomic status); access to care as well as insurance coverage, citizenship status, education, poverty and other factors. Focusing on patient-provider communication barriers, Taylor et al. (2013), found providers identified five barriers that impacted the interaction and workflow. The identified barriers were language, low literacy with anxiety, lack of understanding, attitudes and health beliefs, as well as retention of information (Taylor et al., 2013).

Language differences play a particular role in creating health disparities. Immigrants can enter a country healthier than native-born residents but after residing in the new, often more developed country, the immigrants' health status can deteriorate (van den Muijsenbergh, 2013). Often this is due in part to strained communication between patients and providers during visits (van den Muijsenbergh, 2013). Language concordance is essential for successful communication not only with the provider in their discussion of illness and treatment (August et al., 2011) but the health system as a whole to decrease health disparities (van den Muijsenbergh, 2013).

Culture's role in the delivery of health care is crucial for effective treatment and care. Its complex nature also complicates the patient-provider dynamic. Most research on patient-provider communication focuses on large differences typical of immigrants. By doing so, it overlooks smaller differences in culture (i.e. region) in the examination.

Training Programs

Communication scholarship acknowledges the need and importance of cultural competence and sensitivity. Additionally, medical scholars employ cultural sensitivity and competence concepts in creating training for providers; they then test the effectiveness of these training programs and analyze the effectiveness or current policies in place. Taylor et al. (2013) identified five barriers to accessible care (language, low literacy rates, lack of understanding, attitudes, gender and sex differences, health beliefs, and retention of information) that demonstrate the current policies and procedures regarding cultural competence are not effective in the practices researched. In an effective training program on patient-provider interactions and the impact of culture, these barriers would be successfully addressed and reduce care hindrance.

Delgado et al. (2013) measured the staff at a patient care unit prior to, three months after, and six months after a training session about cultural competence using the Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals –Revised. The staff members' self-report data indicated a statistically significant increase in cultural competence after training. In a systematic review of thirteen studies including cultural competence programs, Renzaho et al (2013) found increased practitioner knowledge, awareness, and cultural sensitivity after training in cultural competence and patient-centered care models.

Although it is important to increase knowledge and sensitivity, the programs are ultimately used and implemented to improve patient health through communication. However, current cultural competence training programs do not translate into significant improvement in patient outcomes (Delgado et al.). The current studies (Chang et al., 2013; Delgado et al., 2013; Renzaho et al., 2013; Taylor et al., 2013) regarding cultural competence provide data to consider

in designing new programs but no research is currently investigating why providers are not implementing the skills into practice in their patient interactions.

Health Narratives

Training programs emphasizing patient-centered care models and cultural competence also rely on narratives and their associations with listening, communication, and patient concern (Renzaho et al., 2013). The provider must exhibit active listening and concern for the patient while attending to the patient's narrative. To fully understand the role of narratives in current training, it is helpful to understand how narratives became a concern in the health communication field.

Social scientists in the 1980s first described narratives as a way of revealing how meaning is socially constructed. They later discussed how persons use narratives to better know, understand, and make sense of the social world in which we live (Hyden, 1997). Narratives function in the social construction process by revealing characteristics of the culture. Stories can be written, oral, visual, conversational or journalistic and individually focused, dyadically focused, or group focused (Sharf et al., 2011). Master narratives are reflective by both creating and ascribing to the culture (Sharf et al., 2003) and therefore important to understand how culture impacts health care practices and beliefs.

Furthering the social constructive concept in health, Craig's (1999) constitutive model of communication describes the tensions between scientific truth of disease with physical manifestations in the body and the human experience (emotional) of suffering. To help reduce the tension between truth and manifestations, narratives also create identification, provide implicit explanations, and help individuals make sense of an event (Sharf et al., 2003). In the patient-physician relationship, patients typically tell their provider a story about their symptoms

or problems. These stories were not viewed as a “narrative” until the past 20-25 years (Hyden, 1997).

In the medical context, the first narratives studied in the 1980s focused on identity and self (Hyden, 1997). Since then, the predominant study of narratives in the health context focuses on illness narratives, illness as narrative, narrative as illness, and narrative about illness (Hyden, 1997; Sunwolf et al., 2008). The benefit of hearing patients’ narratives about illness is that it allows the patient to exert control over the situation, cope, make decisions, and convey understanding about attitudes, feelings, and behaviors regarding their illness (Frank, 2000; Riessman, 1990; Sharf & Vanderford, 2003; Sharf et al. 2011; Werner et al., 2004).

When patients share their narratives, providers are better equipped to understand patients’ perspectives and sense-making processes, and therefore to aid in the decision making process in determining the appropriate treatment plan for the patient (Sharf et al., 2033). Patients also use narratives to compete with the health care system’s dominant narrative in defining the course and experience of illness (Wear & Castellani, 1999; Weinstein, 2009). These patient stories counter prevailing idealist medical thinking about treatment, denying death, provider carelessness, misdiagnosis, and negative relations with the health care system (Weinstein).

Less evident in the study of health narratives are provider experiences. In Mildorf’s (2002) research, the social construction framework is used to determine how patient interactions shape provider definitions and explanations of domestic violence through the telling of narratives. The stories provide insight into how providers relate to patient suffering, the experience or event, and express knowledge about the problem (Mildorf, 2002). Examining provider narratives is important because it allows researchers to understand how providers conceptualize, process, and understand a patient’s health issues and the implications for the

patient's life during the appointment time. To improve patient-provider communication, better training in how providers relate to patient differences will enhance the health care delivery process. To train providers, we must first understand how they conceptualize and relate to patient experiences.

Although a great deal of research focuses on the concepts of patient-provider communication, culture, and narratives in the health care context, these areas are rarely examined together (Ulrey & Amason, 2001). Research in these areas mainly focuses on the patient perspective and experiences; it rarely considers the provider's experiences. This is particularly in regard to provider social constructions evidenced in their narratives. Therefore, the present study will investigate providers' experiences communicating with patients who are from different cultural or religious backgrounds from the provider and how providers view these interactions. Specifically, this study examines providers' perspectives on the cultural issues they encounter in their medical practices, how well they believe they have been trained to manage the complexities of these interactions, and what aspects of cross-cultural communication they report needing to receive future training in their efforts to deliver more effective health care. The overarching research question in this study is: In what ways do physicians view culture as influencing outcomes of their interactions with patients? To this end, the following seven specific research questions are asked: ... (cant read rest of comment

RQ1: How do physicians define culture?

RQ2: What cultural differences do physicians experience with patients?

RQ3: To what degree do physicians view cultural differences as having a negative impact on the outcomes of their interaction with their patients?

RQ4: In what areas do physicians see improvements and or changes that could be made in their interactions with patients that would result in more positive outcomes?

RQ5: What training do physicians report receiving regarding culture (e.g., in medical school, continuing education, etc.)?

RQ6: What are the physicians' perceived deficits in cultural training?

RQ7: How could cultural training be improved?

Chapter Three
METHODOLOGY

Participants

This study focuses on physician perceptions of culture, cultural differences, provider training in patient-provider and intercultural communication training in regards to cultural differences, and how physicians believe physician training could be improved. The sample is nine Northwest Arkansas (NWA) area physicians. The use of regional providers is justified due to the large number of specialty and general physicians in the greater metropolitan area, a rapidly growing population, and the wide range of sub-cultures in the Northwest Arkansas area. The proximity of physicians to the researcher was important due to the amount of time allotted for this study to be completed. The following section will include a breakdown of the physician participant pool using the demographic questions stated in Appendix A.

Sampling

After obtaining approval from the University of Arkansas Institutional Review Board, all regional doctors of medicine were solicited for interviews. The sample was limited only to physicians holding the MD degree due to the limited scope of a Master's thesis as well as having similar general schooling requirements across all the participants. The initial pool of physicians focused on the yellow pages of the 2012-2013 local phonebook for the Northwest Arkansas area including Fayetteville, Springdale, Bentonville, and Rogers provided the possible participant pool. To solicit the physicians, a letter containing the premise of the study and a response postcard for the physician to mail back to the researcher agreeing to an interview with the researcher was mailed to their medical practice address. The postcard stated the interview was one-on-one at a time of their convenience and would last approximately 30 minutes to an hour. Physicians were asked to select their preferred method to set up the interview (phone, email, etc.). Space on the postcard allowed the physicians to state their willingness to participate and a

preferred time and date. To reach all qualified physicians in the phonebook, 361 of letters were mailed. The response rate from mailing after a total of two months was ten participants. From the ten responses, only six were successfully contacted and interviewed.¹

After further recruitment methods, the researcher successfully contacted and interviewed a total of nine physicians through the use of idealized, expanded and snowball sampling. Through the interviews of the nine physicians, saturation was reached through incident rich data and further recruitment was not necessary. Through the analysis of the interview data, no new themes appeared that were significantly different from those previously identified. In addition, the sample size of nine participants for a qualitative study on a specified population that is difficult to contact is typical for a study of this nature (Adair, C., Marcoux, G., Cram, B., Ewashen, C., Chafe, J., Cassin, S., et al., 2007; Mayer, D., Gerstel, A., Leak, A., & Smith, S., 2012).

Interview Protocol

Four categories of questions were posed (see Appendix A). The first category, demographics, collected data placing the remaining questions into context and providing information regarding the physicians' personal and educational background. The next section of questions, communication, gauged how much the physicians value communication and their views of the role it plays in their assisting patients. . This is important information to know because their value of communication will impact their answers in the remaining two sections of questions. The third section of questions, culture, provided data on what providers view as

¹ The researcher received 28 return mail letters stating wrong address. The researcher then used the Internet to search for updated addresses and re-mailed the letters. Due to the limited number of responses, additional convenience sampling methods were utilized that included hand-delivering letters, word-of-mouth from interviewed physicians, personal contacts, and expanding to D.O. degrees in addition to the M.D. degree requirement.

cultural differences between themselves and their patients and how often cultural differences impact their patient-provider interactions. The fourth and final section of questions, training, helped the researcher understand physicians' perspectives on and experiences with training regarding patient-provider communication as well as multicultural communication. This group of questions also provided data on the amount and types of training completed.

Interviewing Procedures

The development of the interview questions occurred over a period of weeks and included multiple revisions. The original interview questions were presented at the thesis proposal meeting and reviewed by the researcher's committee. The interview questions then were revised based on feedback regarding language and clarity. Next, the interview questions were then revised an additional two times with the researcher's committee chair. Due to the extensive period of question development and revision, no pre-testing was needed. In addition, no adjustments were needed to the interview protocol during data collection.

The physicians selected the location of their interview. The majority of the interviews took place at each physician's office but two interviews were conducted at the local public library. Before the interviews began, the physicians reviewed and signed consent forms verifying their agreement to participate in the research (see Appendix B). The interviews were audio recorded and the researcher took field notes during each interview. The questions were semi-structured and divided into sections regarding demographics, communication, culture, and training (see Appendix A). The interviews lasted from twenty minutes to over an hour with the majority being around 30 minutes. After the interviews concluded, the recordings were professionally transcribed and then analyzed for themes, according to grounded theory approach.

(Glaser & Strauss, 1967). The interviews total 51,884 words equaling 4,2029 lines and 96 single-spaced pages.

Grounded Theory

The methodology of grounded theory consists of three stages: open, axial, and selective coding. Open coding refers to the first step of the grounded theory analysis process. In open coding, “data are broken down into discrete parts, closely examined, compared for similarities and differences, and questions are asked about the phenomena reflected in the data” (Strauss & Corbin, 1998, pg. 102). Within this first step the use of “a constant comparison” process continually compares indicators for concepts with previous indicators (LaRossa, 2005). An indicator is a word or group of words in the text being analyzed (LaRossa, 2005) that can be thought of as the question being asked in the interviews conducted or as the unit of analysis. A concept differs from an indicator in that it is the label or name associated with that indicator or unit of analysis (LaRossa, 2005), which can be found in interview responses.

Axial coding, according to Strauss (1987), involves the concentrated analysis of one category at a time taken from the categories produced in open coding. The analysis of the particular category connects categories to their sub-categories. These themes answer the questions of “when, where, why, who, how, and with what consequences” to the themes (Strauss and Corbin, 1998, p. 125). This phase of coding emphasizes the social construction of these categories and themes through the shared reality participants’ experience (LaRossa, 2005). By further investigating the emerged social realities through axial coding, the researcher develops hypotheses and propositions about the relationships between variables (LaRossa, 2005). Where open coding focuses on creating those variables, axial coding focuses on exploring those

relationships specifically and begins to fill the theoretical purpose of theory generation using the grounded theory method (LaRossa, 2005).

Selective coding is the third phase of the grounded theory method. This step focuses on creating the narratives using the previous two phases of open and axial coding. These narratives are theoretical stories demonstrating how the complex categories and subcategories are interrelated (LaRossa, 2005). These second order stories about the relationships of the categories and subcategories frame the first-order stories as told in these participant interviews (LaRossa, 2005). In the selective coding process, the core variable also emerges which is “the one variable among all the variables generated during coding that, in addition to other qualities, is theoretically saturated and centrally relevant” (LaRossa, 2005, p. 851).

Grounded theory is the methodology of choice in the study due to the limited amount of research in this particular area. Due to lack of previous research, there was little information to use in furthering and expanding knowledge. This study was more preliminary because it provides a starting point for research in this area. This method allowed the researcher to identify questions previous research did not address/answer and ask those questions without knowing what type of information that would be gathered.

In analyzing the data using the grounded theory methodology, the researcher first read through the interviews three times to get a clear idea of the general responses to the interview questions and pick out general themes from the responses in all sections. To do this, the researcher used the constant comparison process as discussed in the open coding process above. For example, an indicator in the data is “what cultural differences do physicians experience with patients” and a concept that goes along with that indicator is “socioeconomic status”. The researcher then went through each interview looking for all the indicators and concepts that

create a pattern or theme in relation to the original research questions. The researcher used highlighters to color-code the patterns in the data.

Axial coding in the research consisted of closely examining one indicator and its concepts at a time looking for the variables, conditions, and consequences to find the subcategories as typical in the axial coding phase of grounded theory. Here the researcher broke socioeconomic status down into sub-categories such as “insurance type” and “does the physician relate to me.” Once the coding in this phase was complete, the researcher then began developing hypotheses about the variables. In the last phase of coding, selective coding, involved finding examples in the data that demonstrate the relationships identified in the previous step.

Chapter Four

RESULTS

Research Question Themes

The first section of the interview questions focused on demographic variables to help put the later questions into context for analysis. The participants self-classified as five males and four females and an age range of 37 to 59 years with the average being 48.78 years (SD = 7.81). Almost half of the participants (4) attended University Arkansas for Medical Sciences and the remaining participants attended: University of Missouri at Kansas City School of Medicine, Louisiana State University School of Medicine, Penn State Hershey College of Medicine, West China University of Medical Science, Kansas City University College of Osteopathic Medicine. All physicians practice in the NWA area and have hospital privileges to at least one hospital in the area. For more detailed participant breakdown see Table 1.

Table 1. Hospital Privileges.

1 Hospital/ Treatment facility	6 participants
2 Hospitals/ Treatment facilities	2 participants
4 Hospitals/ Treatment facilities	1 participant

The nine physicians have seven different specialties (see Table 2)

Table 2. Participant Specialties.

Family Medicine	2 participants
Psychiatry	2 participants
Radiology	1 participant
Neurology	1 participant
Infectious Diseases	1 participant
Pain Management	1 participant
Pulmonary/ Internal Medicine/Critical Care	1 participant

and an average of 17.1 years of practice following residency. The participant pool self-identified into four religious affiliations and culturally identified into four major categories. For a more detailed breakdown see Table 3 and Table 4.

Table 3. Religion/Belief System.

Christian	5
Judaism	1
Theist	1
None	2

Table 4. Cultural Identity.

White/Caucasian	6
American Mutt	1
Chinese	1
Judo-Christian	1

To be considered an established theme in the present research, the response appeared at least twice in the data in two separate interview transcriptions whereas the sub-themes can appear once if they are distinct enough to support their own section as standard in the grounded theory process (LaRossa, 2005). The responses were not stated verbatim but were noticeably similar. For example when asked about their training in medical school two responses that were coded the same way are, “on-the-job training” talking about they learned through experience and, “I didn’t get any formal what we would think of as formal cultural literacy...training”.

The first research question (RQ1) probed how physicians define culture. The themes connect with responses from the culture section interview questions regarding how physicians define culture and their experiences with cultural differences in interactions with patients. Seven

themes emerged that are: ethnicity (7 times), nationality (7), education level (2), religion (4), race (6), geo-graphic location (3), and illness populations (3). A common narrative for this question that involved the most concepts typically started with an ethnicity like “Hispanic” and then more specific geographic location of “not just Mexico but Central America... we have... Asian population”. Then the physicians stated nationalities as well such as “ Vietnamese” and “Laotian” and finally by race including, “African American” and “white.”

The second research question (RQ2) investigated what cultural differences physicians experience with patients through both the communication and culture sections of the interview questions. The seven emerged themes are education level (7), religion (6), treatment preference (8), socioeconomic level (3), language (7), distrust (6), and passive/persistence (3). A further breakdown of concepts and sub-concepts can be found in Table 5.

Table 5. Perceived Cultural Differences.

RQ2		
Themes	Subthemes	Illustrative Quotes
	Medical Jargon	“If I tell... somebody with a limited education or something that “Well, you know, the deal with asthma is that you have all these inflammatory cells and these, you know, polynucleotides and ribonucleotides in your lungs and so the medicines we give you are actually anti-inflammatories and they’re corticosteroids and they’re leukotriene

Education		antagonists... they're going to look at me like I'm speaking Marshallese"
	Patient Educational Level	"I...I don't have much school." But when I said, "Well, you went through the school of hard knocks, you know, the real life school" he said, "Yes I sure did."
	Patient Medical Education	"A lot of times know what's important and what's not important to tell you. So if they don't know that constipation is part of their disease then they may not ever tell you about it."
Religion	Religion	"...Jehovah's Witness, Catholic, Hmong..."
Treatment Preference	Alternative/Conventional (3)	"Cultural...anti-vaccine movement... that's been tricky..."
	Cultural Value System (5)	"Whether it's something like... the husband... is more used to making the decisions, whether it's manner of dress... There are some patients who don't want to see a male physician"

	Patient education (2)	<p>“I think it’s incumbent on all of us to help... educate people and think of good ways to.. to treat this issue so... people don’t just fold their arms and say, “I don’t want any, you know, talk of removing the ventilator.”</p> <p>It’s like, “I don’t want to no chemotherapy or Obamacare or whatever”</p>
Socioeconomic Factors	Communication (1)	<p>“Patients that are well-to-do. They’re doctors and lawyers and professors, and because of that they’re easier to communicate with”</p>
	Medications/Treatment/Tests (2)	<p>“I think it’s easy to get annoyed with patient when they don’t take medicines until you understand that their budget is incredibly unlimited. And yes, they’re only paying \$1.10 for the prescription, but that’s \$1.10 more than they can afford to spend.”</p>
	Phrases/Slang (4)	<p>“Even different terms about, you know, like spinal meningitis, sometimes they’d call it “smilin’ miny Jesus”</p>

Language	Interpreters/Translators (6)	“Not everyone speaks English and it’s... just so important to have a good interpreter”
	Language literacy (1)	“Interviewing a patient in Spanish and then after a while I realized she was less literate in Spanish than I was, and so we weren’t even using the same terms for things.”
Passive/Persistent	Asking Many Questions (1)	“Particularly our Caucasian patients...tend to want a lot more information before they’ll follow our recommendations”
	Not Asking Questions (3)	“Hispanic patients often...don’t tend to ask very many questions about what we’re recommending... I get the feeling that they’re coming to the doctor and want to know what the doctor wants them to do, and they’re happy to go home to comply. And most of them have a very high compliance rate”
Distrust	Distrust (6)	“They get this sort of suspicious, hostile kind of way about them, where they

		don't trust their health care providers"
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A common narrative for cultural differences focused on language use, which is emphasized by stories such as the “stoic farmer.” One physician stated that if he asks patients (of whom many are veterans and farmers), “Are you feeling depressed?” it translates to being weak or failing in the patient’s mind so they say things like, “Nah, I am fine.” Then if he rephrases the question a different way such as, “Have you been hunting this season?” the patient’s response is much more straightforward and will say things like, “Yeah, no, I just haven’t been interested in getting out and doing things”.

The third research question (RQ3) aimed to see if and how physicians view cultural differences as negatively impacting the encounter. Specifically, the physicians told the interviewer negative and positive stories of interaction as well as how the physician manages the cultural differences in their interactions. The seven themes that emerged were: educational level (5), language use (8), religious beliefs (4), cultural distrust (5), socioeconomic status (5), having to redirect (4), and cultural/value system in regards to medicine/treatment (6). See Table 6 for a further break down of concepts and sub-themes.

Table 6. Negatively Perceived Cultural Differences.

RQ3 Major Themes and Sub-themes		
Category	Subtheme	Illustrative Quote
	Religion (2)	“I had one person ask me... was pretty sure one patient was in a cult out in Colorado

Redirecting		and wanted me to come out to their little compound, and I'm like, "No, sorry... I usually redirect them"
	Politics (3)	"They'll call Obama bad names and... [I'll] and just sort of say, you know... back to your...urinary incontinence or whatever"
	Race (2)	"The other thing that's come up, not uncommonly, is racial things."
	Generally off Topic (1)	"You know, kind of dodge the question... and reflect it back."
Education	Not on Same Level (4)	"There are times when what you're explaining doesn't sink in and... it is frustrating for both people involved. Usually that happens when the person is just not grasping the whole concept."
	Literacy (2)	"In medicine, since there is a lot of jargon and sort of an elevated... degree of literacy expected"
		"You want to make sure that this person is making really... is making a decision with all

	Patient Education (4)	the information that they should have, rather than making an emotional decision and saying, “I don’t want chemo,” or “I don’t want..” whatever it is.”
Language	Phrases/Slang (7)	“Their chief complaint is going to be universally “Doctor, I am dizzy.” And the thing you have to understand is that may mean they have an ingrown toenail, it may mean that they’re infarcting the left side of their heart, they’re about to die.”
	Language level (2)	“I spoke at too high a level, sort of intellectually and academically”
	Accent (2)	“And so you hear somebody with a strong accent, and it’s almost like you’re hearing words but you’re not knowing what’s.. until they laugh or tell a joke or something like that that makes them feel more human, you know what I mean?”
	Interpreters/Translators (5)	“You know, here it was supposed to be in psychiatry interview, which to me is a very intimate and personal space. So I’m talking to the

		<p>translator, the translator's talking one language to her husband, and she's...the husband's talking on one language to her, and then ding-ding-ding...all the way back again?"</p>
	Different Language (3)	<p>"I said, "I want to know if she has any questions." And so he, you know, asked her, and uh, they had quite a lengthy conversation. I wish I had known what it was, but they had a lengthy conversation."</p>
Religious Beliefs	Match to Physician (1)	<p>"It means a lot coming in the door and they'll introduce themselves and they'll ask me if I'm Christian"</p>
	Barrier to Care (1)	<p>"That can interfere with... their sense of absolute... because those are just the rules, um, "I'm Catholic" or "I can't..", uh... all of the passionate, painful debates... having a lot to do with those sort of absolutes from... a religious point of view"</p>
	Treatment (3)	<p>"Some of the more religious patients, where, you know, I'm suggesting medication and they're saying that, "You know, I really need to pray</p>

		and trust in God that, um.. you know, my diabetes is going to be okay.”
Cultural Distrust	Under Reporting (1)	“They tend to under-report... You’re assumed to be lying...they don’t call it lying, but unless you can verify that your buddy killed next to you, then we’re [the VA is] going to assume since you’re a cook nothing bad happened to you”
	General Distrust of Provider (3)	“She didn’t feel comfortable and she didn’t feel safe”
	Race/Ethnicity Group (3)	“The African American population has distrust with physicians, and, you know, that was kind of brought upon by not doing very pleasant things to them in the 30’s, 40’s and 50s’, and so that certainly is understandable... it’s just difficult to know how to really convey bad information because they just don’t trust you sometimes.”
	Insurance (1)	“I saw a patient who had a lung problem that was going to require... an operation, and so it was at the Free Clinic and it’s only... people who have no insurance can come

Socioeconomic Factors		<p>there. They have to be below the poverty level and not have Medicaid or insurance or anything, you know. So this guy has no resources, basically. And he's got...something that's going to cost a lot of money on the order of, I don't know, 30, 40, \$50,000 if everything goes well"</p>
	Affordability (5)	<p>"Things we order aren't necessarily cheap...medicines aren't cheap, and you don't ever...always necessarily think about how that's going to... how they're going to pay for it"</p>
	Can Physician Relate to Me (1)	<p>"If it is a financial or economic issue and they...they say, "How is she going to know what I'm struggling with or what I'm dealing with?"</p>
	"Obamacare" (1)	<p>"So this fellow crosses his arms and says, "I don't want no part of that fuckin' Obamacare."... "You know, I don't know what your politics are, and that doesn't really matter, but you have... a serious illness and it's going to cost you a lot of money"</p>

Cultural Value System	Death/Dying (2)	<p>“And sometimes when we talk to family I think there are people who are horrified that you would...just that removal of life support would be a medical therapy or an accepted medical therapy”</p>
	Religion/Belief System (4)	<p>“With some of the more religious, I do tend to be prepared that... they’re going to want to try their ways before starting medicine”</p>
	Cultural Values (7)	<p>“I usually try and focus on her. Well, I could tell that was really making her uncomfortable, to have such direct eye-to-eye contact in the exam room and all that, so I did direct most of my comments to her husband”</p>
	Family/Spouse Involvement (2)	<p>“He... asked all the questions... and I presented all the options to him, and he was frustrated by that. He wanted me to tell him... He said, “You’re the doctor. I come to you because I want you to tell me what to do, and so please tell me what to do.” And so I said, “Okay, here’s what I think we should do.” And then I... and I said, “I</p>

		want to know if she has any questions.”
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When cultural differences negatively impact the interaction, common language themes emerge. One example highlighted the Filipino population and how they conceptualize illness and convey symptoms to health personnel. If asked why they are seeking medical treatment, the chief complaint is, “Doctor, I am dizzy.” This sentence doesn’t actually mean they are necessarily dizzy, but instead is used to describe everything from an “ingrown toenail” to “they’re infracting the left side of their heart, they’re about to die.” This points to the issue of making sure to ask the patients the right questions, to get past language, educational, and cultural barriers.

Research question four (RQ4) asked if physicians see improvements and/or changes to make resulting in more positive interactions. This research question asks about shared narratives and how they manage cultural differences questions. The five themes for interaction changes that emerged were: listening (6), sensitivity (6), patient autonomy (3), patient-focused (8), and trusting patients know their body (3). For a further breakdown of these themes and their sub-themes see Table 7.

Table 7. Interaction Changes/ Improvements with Patients.

RQ4		
Theme	Subtheme	Illustrative Quote
Listening (6)	General Listening (3)	“I listen to them”
	Patient Complaints (7)	“And so maybe if I had listened I could have saved him a couple of weeks of grief, if I had gotten, you know, the detailed story. And I think that part of the

		<p>problem is we have to be, um..we all come into these things with our own sort of .. almost, uh.. pre-judgments.”</p>
Sensitivity (6)	Respect (3)	<p>“You know, if.. if I will validate that they have a lot of experience, even if it wasn’t in school, then that seems to help the interaction”</p>
	Humans, Not Lab Values (2)	<p>“It was very frightening that it completely depersonalized himself and his friend in transaction, and so I don’t know if I made little promise to myself, like “Oh, please let me never do that.”</p>
	Illness/ Prognosis (1)	<p>“I was in there really early and nurse looked at me and said, “Does Ms. so-and-so know her prognosis?” And without looking up really, I said, ‘You mean that she’s going to die?’” And I looked back and the nurse had eyes that were this big because the patient was awake and she heard me say that.”</p>
	General Sensitivity (5)	<p>“I try to be as sensitive and understanding as possible, and I try to reaffirm and reassure patients about their beliefs or their research that they’ve done”</p>
	Patient Treatment (4)	<p>“Why don’t you think about it, you know, and give me a call Monday, or if I don’t hear from you I will call you Monday or Tuesday, something like that.” So he..he did, and ..but he</p>

Patient Autonomy (3)		decided, uh..to go ahead and proceed with some treatment”
	Time Frame (1)	In fact, there’s another patient...that wanted to wait until his granddaughter before he went in and had his surgery, and... I said, “You need to go in sooner.” And I said, um, “Do you want me to call the heart surgeon or do you want to do it.” And he said, “Oh, I’ll do it.” And so then I found out later that they had only postponed...had only moved it up like about two days instead of really, like, urgently like I had really wanted to.
	Trust in Patient (1)	“for example, with mental illness, I tend to trust when they know...you know, when they feel something’s not going right”
Patient- Focused (5)	Focus on Why they are Here (4)	“when somebody’s sick, everything about that illness should be about them, not about us”
	Expectations (2)	“If you know somebody, if you meet somebody who has a vastly different background from you, I think the best thing is to learn as much as you can about their background and what they..what they expect out of the relationship”
	Priorities (1)	“it’s important to address their agenda and priority as well as yours, even though

		that may be hard sometimes because you're thinking of like the most life-threatening problem that the patient has, but the patient is actually more concerned about something else that's not as life-threatening. So you have to balance both priorities.”
	Take the Time Needed (3)	“a lot of physicians will spend very little time providing them education whereas most of the visit at that time we will actually sit down and provide education, answer their questions, tell them what they need to know to go forward”
Trust in Patient to Know own Body (3)	Trust about Symptom Complaints (4)	“I do try to trust that people know their own bodies far better than I can know their body. Um, so even though it's very easy to dismiss somebody”

The narratives regarding RQ4 focused on lessons learned from previous experiences and how the physicians use those lessons with their current patients. Listening and trusting the patient are two of the emerged common concepts from the narratives. This is demonstrated in the Clorox narrative described below.

The Clorox narrative began when a patient had just been put on medicine for psoriasis and a few days later came down with pneumonia like symptoms. When trying to figure out the association between the medicine and the illness, exposures appeared. The patient stated he had sprayed Clorox on his windowsills but the physician quickly dismissed the idea of Clorox being

associated with his symptoms. The physician gave him various medications for the pneumonia like symptoms without sustained relief. The patient came back to understand his continued illness and the physician finally heard the whole Clorox story. It turns out, the patient had been spraying a Clorox solution on the windowsills to remove bird droppings and in the NWA geographic location, birds and bird droppings can carry an illness called. The physician stated that if he had just listened to the patient and trusted the patient's suggestions before prejudging the situation, it would have saved the patient weeks of suffering.

Research question five (RQ5) focused on cultural training the physicians received at various points in their medical careers. The training section of the interview questions informs RQ5 as well as six (RQ6) and seven (RQ7). The physicians reported receiving training from a variety of sources: medical school (6), residency (2), continuing medical education (CME) (4), none in medical school (3), none in residency (7), and none in CME (5). See Table 8 for a further breakdown of themes and sub-themes.

Table 8. Physician Training.

RQ5		
Themes	Sub-Themes	Number of Participants
Medical School	Awareness and Sensitivity	1
	Ethics	1
	Culture	1
Residency	Language Barriers	1
	Palliative Care	1
	Diversity	1
CME	Religion	1
	Sensitivity	1
	Culture	2
None in Medical School	Cannot Remember	5

	On-the-Job	2
None in Residency	None	7
None in CME	None	5

A common narrative among physicians' interviewed emphasized the lack of training or the lack of emphasis on cultural training. An example is when a physician stated, "I hate to say I cant... I mean, well, nothing's coming to thought quickly. So if we did, you know, it must have been a small part of something somewhere... It wasn't impactful enough to... translate."

The sixth research question (RQ6) is again informed by the training section interview questions. It focuses on physicians' perceived deficits in cultural training. The four emerged themes are: religion/belief systems (3), cultural norms (3), patient-level communication (3), and language (2). Refer to Table 9 for a further breakdown of themes and sub-themes.

Table 9. Perceived Deficits.

RQ6		
Theme	Number	Illustrative Quotations
Religion/Belief Systems	3	"Belief systems or things in their culture that would be an impediment to care or a barrier to care that I don't understand about, like, you know if they think that x-rays are very, very harmful."
Cultural Norms	4	"Mainly just to know... what different cultures expect. I mean otherwise you're doing your belief... you know, you're providing them

		information based on your beliefs, and. umm, that may not be really what they're looking for.”
Patient Level	3	“I wish we had maybe been taught how to, um...it was always so important to explain things in medical terms and not in patient terms. I wish that we'd had more practice in explaining things to patients on a patient level”
Language	2	“I wish I knew how to speak Spanish”

A common concept of perceived deficits in training among physicians is cultural systems and conveying information at the level of patients. An example narrative stated, “ There’s different values systems and... that if I were more attuned to those kinds of value systems I could be better able to convey things... I could catch or be aware of what are the values when somebody’s talking... that I could honor those and... not dismiss them or step on them by accident.”

In addition to deficits of cultural training, RQ6 and RQ7 focused on how training can be improved from their experiences and interactions. Two concepts emerged from physician responses with cultural norms/practices/values/beliefs related to seeking treatment (8) as the most common, and doesn’t know or feel the need for improvement (2) was also stated. . All but one physician brought up the concept of wanting to know more about cultural norms, values, and beliefs related to seeking treatment. For a further breakdown of the themes see Table 10.

Table 10. Training Improvements.

RQ7		
Theme	Number of Responses	Illustrative Quotations
Cultural Values, Practices, & Beliefs Related to Seeking Treatment	8	<p>“I think to understand and, you know, to have a picture of kind of their belief system and their cultural values. I might even be almost like what I would expect if I were some really big executive and somebody were going to send me to Sri Lanka to get a course on Sri Lankans, you know.. to have a database that I could pull out and say, “So tell me about these people.”...particularly as it relates to their health care and how they view their health and whether they are going to do what you tell them and if not how...”</p>
Don't Know or Feel the Need	2	<p>“Not that I can think of offhand”</p>

A narrative example of a suggestion for cultural training states, “Maybe like a... website, an ethnic... you'd have to be careful because it's all... you're talking about generalization and

stereotypes and all that, but... maybe something where I could pull up something that would tell me just what I needed to know in the same way that I might pull up to tell me just what I needed to know about, um... Coronary artery disease. You know, just a quick snapshot of who somebody is culturally and particularly their... values to their health.”

Additional Themes

Themes outside of the proposed research questions also emerged. In the training section of the interview questions, the researcher also asked physicians about the communication training in addition to their cultural training. All nine physicians stated their training was minimal, rudimentary, or more learn as you go. The communication themes included interviewing skills, simulated patient-interactions, and listening. The timing of the instruction varied with the majority in the second two years and in residency. An example quote from a training narrative illustrates these themes well and states the following: “When I was in medical school... we had a physical diagnosis course and we had a... kind of an interviewing course. And those were both, I think one was in the first year and physical diagnosis, I think, was in the second year. And those were both sort of concerned with teaching and interviewing skills, you know, like ask open-ended questions... as well as teaching of the elements of taking a medical history... and then teaching you some things about... redirecting the conversation if it got on to politics versus... how much wheezing was going on or something like that. So they were... rudimentary communications courses.”

A second theme concerns continuing medical education (CME) information. In NWA, there is a large Marshallese population. Multiple physicians stated the hospitals (where they hold privileges) required the physicians to listen to a speaker who educated them about the Marshallese population in regards to health care scenarios and illness. Another physician stated

his medical school also focused on immediate area populations that they may come across during clinic days.

The third theme is in regard to RQ4. The interview questions in the communication section all prompt information for overarching questions about communication. The physicians told stories of experiences in which they learned from and the importance of communication in the physician-patient interaction. They did not directly offer current ways to improve their interactions, although each physician did have a story that opened their eyes and remains with them today. They have learned from past patients how to better assist future patients.

An example narrative that demonstrates this concept is from a physician working in internal medicine at the time. The patient had leukemia and a problem with blood dyscrasia, which in turn made her immunosuppressed and lead to an interstitial lung disease. She had a high risk of dying and was very sick. All her tests came back without offering insight to her interstitial lung disease and which antibiotic would work. She was in and out of communication due to being so sick but she had mentioned her mouth hurt multiple times. The physicians didn't think much of it since many people who receive chemotherapy have mucositis and she was having chemotherapy for her leukemia. They gave her the mouthwash and meds for mucositis to ease the pain. She kept complaining about her mouth though and finally the physicians realized she wasn't saying her mouth hurt but there was a sore in her mouth. It was located back behind her tongue so not visible to the naked eye. In addition to finding the ulcer, the ulcer also indicated what type of lung disease she had, which was histoplasmosis so she received the proper treatment for both. Her persistent complaints are the thing that saved her life. The lesson the physician learned from this experience is clear: "It doesn't reflect well on the medical profession because... myself in particular, because it was, I think a learning experience that not only must

one listen to your patients carefully... the first time I heard her say it I guess I heard it and subsequently heard her say, "I have mucositis" you know, rather than I have a sore... so this was very educational for me."

The fourth theme to emerge outside the research questions was how important it is to become more interculturally more competent in communicating with patients. This stems from the very last interview question in the training section. The most common answer, (N=6) was that, the more you know about the patient through communication, the better care the patient will receive. An example narrative illustrating this concept stated, "On a basic level it helps you deliver better medical care. So it helps you take better care of your patients, and it makes your patients feel better about you as a physician, which I think is real important. I think they need to have trust and confidence in you". Two physicians also mentioned compliance to treatment and medication plans reflecting their specialties of radiology and infectious disease.

Chapter Five
DISCUSSION

Findings

Although the physicians interviewed stated they perceived NWA as relatively homogenous place in terms of culture in comparison to residency locations, the impact of culture on medical care was still present with the smallest of sub-cultures mentioned in the interviews. When stating the word “culture” many physicians mentioned nationalities, races, and ethnicities, but educational levels, geo-graphic locations, and illness populations also arose. The findings of this study suggest that regardless of how culturally diverse a population is perceived; culture can negatively impact the health of that population and the quality of medical care received.

Cultural barriers from the physician perspective as described in the literature review from Moore and Thurstand (2008) also emerged in the physician interviews in this study. The shared themes were: level of effective patient-provider communication, patient diversity, access to medical care, and education. In terms of how culture negatively impacts patient care, the assumed language and religion emerged in the majority of interviews. A surprising concept was educational level. This is not patient education regarding medical care, but instead refers to the traditional levels of general education of a patient. Physicians pointed to the fact of having to simplify explanations, ask different questions, and make good use of analogies to help patients understand everything they should for their condition. This concept, as discussed in the literature review, aligns with the physicians’ interviews in this study emphasizing concepts such as provider empathy and information exchange. Though these concepts were not taught in most

physicians' educations based on the interviews, the trial-and-error approach many mentioned paired with the rural and agricultural region of NWA shed light on the matching themes.

A second theme of how culture negatively impacts patient care that the physicians mentioned was cultural/value system with regard to treatment also emerged. The majority of physicians interviewed told a story about when culture negatively impacted care, many times the cultural differences manifest in language issues. This provides direction for work that needs to be done in physician training. Through these two examples of the seven cultural differences that negatively impact care, it is clear that culture can and does hinder the communication process in physician-patient interactions. Although highly educated physicians are able to understand complex diseases and determine correct treatment, they are minimally educated about cultural differences that ultimately create barriers to successful diagnosis and compliance with a successful treatment plan. This theme supports with research regarding cultural competence as discussed in the literature review. Personal and relational cultural competence as described by Ndiaye et al. (2011) and Thornton et al. (2011) highlight the areas which appeared in narratives told by the physicians but again are not covered in medical training. Certain physicians learned to handle these cultural issues but through the learn-as-you-go method thus placing patients at great health risks.

The third theme that emerged in multiple interviews was a lack of listening and trusting a patient to know their own body. These themes relate to previous research regarding the first few minutes of the patient-provider interaction. A common occurrence in medicine is physicians talk over patients or do not fully listen to a patient describing their symptoms. There are two practices that can lead physicians to make hasty judgments or assumptions that Thompson (1986) identifies, and both of these concepts emerged in physician interviews. The first is to assume that

the patient is incorrect or as in the interviews, describing an assumed symptom already noted, and thus not a new symptom or, the information is irrelevant based on the perceived illness at hand. The second practice is being too busy to spend adequate time with a patient to fully understand what they are actually trying to describe in laymen's terms and not medical terminology.

A fourth emerged theme that connects to previous research is the notion that patient narratives regarding their symptom descriptions are bound by culture. The patients use cultural narratives to make sense of and frame their symptoms to help them understand their illness (Sharf et al., 2011). This can be seen in the physician interview examples of the Filipino population telling doctors they are dizzy or how a patient frames their changes in sexual function. The physicians in this sample did not understand the patient narratives as culture-bound discourse; these stories framed from the patient's cultural understanding were perceived as language barriers and hindered understanding of the issue at hand. This finding is not surprising due to the lack of communication culture training physicians receive in their medical education. One possibility is the physicians view communication solely as an information gathering activity rather than at the core of the interaction during the appointment. By only viewing communication as the focus during interviewing procedures, context, depth, and further explanation of how the symptoms are present in the patient's life can be excluded. Whereas when communication is present throughout the interaction, the more conversations like situation gives opportunity for the patient to elaborate and expand on something that did not seem particularly important before.

A fifth theme to emerge addresses the patient-centered model. The physicians did not demonstrate mastery of the patient-centered model due to lack of training in their medical

education. However, hints of the perspective appeared in the interviews. Epstein et al. (2005) identified four main aspects of the patient centered model that focus on: incorporating the patient's perspective, taking into account the psychosocial perspective, fostering shared understanding, and accepting shared responsibility and power with the patient. Although no physician narratives incorporated all four, many physicians described events and experiences mentioning one or two of the four concepts, such as the patient's perspective and fostering shared understanding. Again this makes sense due to the physicians' lack of formal training in culture and communication. Such limited understanding more closely aligns with the learn-as-you-go method of knowledge acquisition many physicians mentioned in describing ways they have changed their interactions to increase positive outcomes in the patient-provider interaction.

The sixth theme to emerge from the data also clearly identifies the lack of communication and culture training in a third way. When asked how cultural training could be improved, eight physicians responded with information about cultural issues such as norms, practices, values, and beliefs related to seeking treatment. Based on the interview data, it seems physicians want training and information on how to better serve their patients. A few even offered suggestions on the best way to go about learning that information.

The results indicate that physicians are constantly learning from their experiences. Each interaction they have is shaped by how they interacted with previous patients. Although this is a positive sign that physicians attempt to improve interactions with patients, the progress is still limited and fails to increase effectiveness to the desired level. When faced with new experiences, physicians may find it is still difficult to know how to communicate in an effective manner spontaneously. By training physicians to understand culture on conceptual terms and then practicing cases study scenarios, the communication and cultural understanding skills could

enhance patient outcomes without the learn-as-you-go trial and error method of acquiring regarding communication and culture concepts.

Implications

Patient-provider communication emphasizes effective communication in the health context. Many times these parties are perceived to be at unequal levels educationally due to the nature of the relationship (Inoue, Takahasi, & Kai, 2013). Although current research stresses and is striving for a more collaborative relationship, many patients perceive as their physician is superior or more dominate during the interaction (Duggan and Thompson, 2011). In the data collected for this study, educational level (as in the amount of schooling received not patient education on illness) surfaced as a cultural component that negatively impacts interactions. Physicians are interacting with patients from different educational levels on a daily basis and need to tailor their communication to that patient for the greatest degree of understanding. At the surface poor communication based on the patient's level of schooling seems unlikely for negative outcomes because the physicians should be tailoring illness explanation to the patient. Although, if the patient feels that the physician is talking down to them or mocking them, stress is created and may result in distrust of the physician. Currently, physician training based on the data collected does not sufficiently incorporate communication or culture in any phase of the education process. The communication emphasis overall, not just information gathering, has to change if physicians are to provide better care to patients from all cultural backgrounds.

Patient adherence in patient-provider communication, as discussed earlier in the literature review, is an essential component of the health care process. If a patient does not follow through with the treatment plan, resources are wasted and the patient's health is negatively impacted.

Multiple physicians interviewed emphasized that compliance gaining depends on effective communication with patient. The physicians interviewed also stated that they saw religion as one of the many barriers to care. In situations like this, patient-centeredness is the key to turn what was a barrier into a way to increase compliance to the physician-preferred treatment. By incorporating the patient-centered medical model into current training, it may improve compliance of patients whose cultural practices at first glance inhibit proper treatment. Physicians could incorporate the patient's religious beliefs to increase compliance resulting in satisfaction from both parties and proper treatment of the medical condition.

Through the use of narratives, physicians told lessons they learned from previous patients and emphasized how they now apply those lessons to interactions with current patients. This seems positive and hints that physicians are always learning and improving their craft. One issue, however is that many of these stories and situations easily could have been prevented with proper communication training including that across cultures. The simple concepts of listening, sensitivity, and being patient-focused among others could be taught in communication training, not when a patient's life is on the line. By using these concepts in addition to narratives of these situations in future training, patient outcomes have the ability to improve without a patient's health being negatively impacted being the lesson learned.

Previous research regarding training physicians on communicative and culturally appropriate health care practices with patients asked why the training is not translating to practice. Through analysis of this study's interviews of physician training in culture and communication, the learn-as-you-go learning environment is revealed. A total of 15 "none"s appeared when combining medical school, residency, or CME responses. A total of 12 answers appeared for at least minimal training in medical school, residency, and CME. The majority of

those received training in medical school before the emphasis on cultural issues in medical care was identified as a major issue. This theme paired with the minimal CME education regarding culture, puts mid to older physicians interviewed in this research study at a disadvantage with their patients. This may point to an entire group of physicians are not providing optimum medical care to their patients if they received similar training as the participants.

If we want physicians to conceptually understand emerged themes from a communication standpoint and engage in improved interactions with patients, a fundamental overhaul of information dissemination is key for the physicians interviewed. By treating this information as secondary to scientific aspects involved in medicine, it may lead to physicians and medical students not taking it as seriously. One possibility is for training to be integrated and emphasized continuously through undergraduate and medical school experiences beginning with the first semester. By infusing it into the curriculum and interactions, it may become the normal and obvious way to interact with patients instead of the preferred way of playing catch-up. As one physician stated when asked the degree of importance regarding communication in their medical practice, “gosh...there’s not much more important.” If practicing physicians see the importance of these concepts on a daily basis but are not being taught to appropriately handle them starting with the first medical school interaction, there is a long and potentially deadly learning curve they have to go through on their own.

Physician specialties may have impacted the particular themes identified in the present research. The participants interviewed were from a wide range of specialties. When analyzing the data, it became clear that depending on the type of specialty, the physicians reported different cross-cultural experiences. Family practitioners and psychiatrists generally told more stories emphasizing educational differences with their patients whereas the critical care physicians told

stories regarding major life or death cultural misunderstandings that many times revolved around language, and trusting the patient. This has implications for future training and research regarding physician training and conceptualization of culture. These implications concern how future physicians operate in an ever-increasing culturally diverse world. As migration and immigration change populations, physicians need to adjust more quickly to the shifting cultures and health care beliefs that come with patients to their practices. When deciding on a specialization, physicians should be aware of the most common cultural differences that will impact their health care delivery.

A final implication regarding the findings from this study concerns the conceptualization of communication. In the communication field we discuss and study communication as an interaction and transaction occurring between senders and receivers, in this case a patient and their provider. In the medical field, communication is viewed simply as data gathering. In current medical school coursework, “communication” largely involves the interviewing skills needed for determining what the patient’s complaint might be and the follow-up diagnosis and treatment recommendations. Communication scholars studying patient-provider interactions view communication as a continuous and transactional process involving the entire interaction and every subsequent interaction thereafter. This is important to take into consideration when thinking about improving physician training. Since the patient-centered model focuses on not just the biomedical, physically manifested symptoms the patient presents but rather takes into account the patient as a whole, it is vital to consider training physicians in ways to improve their improved communication practices. By listening to how that illness or those symptoms impact the patient and are most likely bound by the patient’s cultural values, the physician will have a much better understanding of that patient and the illness. They can adjust communication

strategies and constantly communicate with the patient by adapting to patients' levels about all their concerns, not just asking the patient about their presenting symptoms. Health care delivery is more than symptoms; it is about improving a patient's life as well.

Limitations

There are multiple limitations with the current study. The first involves the lack of diversity in the participant pool. The target participant pool included all of NWA with the goal of trying to target diverse participants and the patients of the participants. Of the physicians interviewed, all had practices in Fayetteville, AR (7) or in Lincoln, AR (2) so the physicians' patient pool was more homogenous than ideal.

The second limitation involves the sampling methods. The original methods had to be expanded to interview enough physicians for saturation. The original method recruited patients by sending them information and having them select into the study. Due to a harsh winter season with bad weather and an outbreak of influenza in NWA during the interview timeframe, the convenience methods was expanded via physician "snowballing" with other physicians.

A third limitation also involves the participants; the physicians self-selected to participate in the study. They were willing to share both positive and negative narratives regarding cultural implications on health care. Physicians who chose not to participate may also have had experience with culture impacting the interaction to a greater degree but did not opt to participate possibly because of hesitancy to recall negative health care outcomes.

A fourth limitation is with the questions included in the interview protocol the researcher used with physicians. The questions prompted stories about specific experiences with communication, culture, and training received. Although the interview questions correlate and correspond to the research questions, it is inevitable that certain stories and situations were never

brought up during the interviews. The data are bound by only the questions in the IRB approved interviewer protocol. Another contributing factor limiting my data collection was interview length. Since physicians are very busy and typically have little down time during the workday, the researcher purposely kept the questions limited in number to facilitate a thirty-minute interview. The time-limited interview was an attempt to increase participation among physicians that could easily fit into their lunch break.

Strengths

This study focused on the use of a new perspective not previously emphasized in research. Investigating the physician perspective using narratives has not been previously studied in patient-provider communication in regards to culture and training. Although much research regarding the patient perspective, as well as narratives in the health context exists, the physician perspective is desired to further enlighten researchers about the patient-provider interaction. By studying these variables together the collected findings will contribute important about physicians' perceptions of the biggest barriers impacting their communication with patients of different cultural backgrounds. This investigation also identifies additional aspects of the physician perspective to investigate in future research.

A second strength of investigating the narratives associated with the patient-physician relationship in regards to culture is the richness and depth of information produced. Not only does the research inform us of how the physician views cultural differences, the narratives provide detailed descriptions of contexts when these differences occur. These narratives provide a snapshot of the physicians' realities, which, taken together create the shared realities of how culture impacts the patient-physician interaction and relationship.

Because the narratives reflect real-life scenarios and include context, these narratives can turn into case studies to train future physicians about intercultural encounters. The applicability of the narratives to future physician training and workshops can facilitate updated content coverage about the cultural norms and beliefs that were the most emphasized in the narratives. For example, one physician discussed his/her experience with a Middle Eastern couple coming in for a breast cancer diagnosis. Since this is a more private area of the body and the patient's culture navigates the patient-physician role differently than a typical American patient, barriers arose. This could be an example scenario used to train physicians on how to effectively and respectfully navigate the situation to reach a positive outcome.

A third strength of this study is the participants all had experience in diverse populations regarding culture and the sub-cultures located in NWA as well as their residency locations. The physicians provided rich samples with multiple narratives regarding their experiences with culture influencing or impacting the interaction in some way. They also offered honest narratives at times stating that certain ones did not reflect very well on themselves or the medical field.

Further Research

The next step in researching patient-provider communication in regards to culture is to complete the study with a more diverse participant pool. This study took place in NWA and it has a fairly diverse population due to industry and higher education in the mid-south United States. To emphasize greater physician and patient diversity, a more diverse geo-graphical location with larger urban areas would be ideal. A second step for further research is to investigate communication training in medical school. The "learn-as-you-go" technique specifically mentioned by physicians would be one example needing further research on what

and when it occurs, how it impacts patients, and when physicians believe they have mastered that technique compared to physicians specifically trained in medical school.

A third area for future research is highlighted in the participant breakdown. Most of the participants were in their 40s and 50s and went to the same in-state medical school. Their shared experiences and narratives point to a lack in training in communication and cultural issues. Since the average time out of school was over 17 years, the field of patient-provider communication would benefit from research looking at younger physicians. By interviewing younger physicians about their training and experiences, researchers could get a better idea of how much training has improved in recent years, if it has improved at all.

A fourth area for future research regards the paradox of physician versus patient religiosity. The majority of the physicians interviewed identified themselves as religious but when telling stories of cultural differences they see in their patients, religious beliefs often were viewed negatively; at times these beliefs were described as hindering the interaction and the goal of the appointment. Further research should focus on how physicians conceptualize their religious beliefs and any differences in their beliefs in comparison to those of their patients and any influences these beliefs have on their interactions and the outcomes of those interactions.

Conclusion

This study contributes to the field's current understanding of the complexities of the patient-provider interaction and specifically offers insight to how physicians view culture and how prepared they are to interact with patients from other cultures. This research study addresses previously identified gaps in current patient-provider communication research in hopes to continue improving the relationships between patients and healthcare personnel through the perspective of culture and physician training. Although NWA is perceived to be a fairly

homogenous area, even small cultural differences present difficulties when interacting with patients from use of slang language to religious practices to level of education of the patient. The physicians interviewed viewed communication and culture as important aspects of the interaction but many times do not know how to effectively manage these patient interactions. The physicians currently use learn-as-you practices to effectively communicate with patients. Although the physicians learn from their past interactions, it not the ideal way for physicians to learn about cultural differences in health care.

In addition, this research adds to the understanding of the provider perspective. Physicians from this study viewed culture, as negatively impacting the interaction but that does not have to be the case. With well-designed training and practice, providers can use previous barriers to work in their favor. By recognizing how providers' conceptualize culture and communication, we can understand the deficits and needs for current CME and medical school training. Such insights also provide a lens to frame the important concepts relevant to the patient in a positive way and use the techniques to increase positive outcomes instead of barriers hindering care.

The present study also offers new insight to the emphasis physicians place on the education (schooling) level of their patients. Such studies are lacking in extant in patient-provider research. Additionally, the finding that although physicians may identify religiously, they also view patient religiosity as a negative component on the interaction is absent in current research.

Finally, the present study reveals that most physicians want to be prepared for treating patients from different cultural backgrounds in order to achieve the most optimal health outcomes. Although physicians desire this understanding, they are often times are not properly

trained to effectively adapt their communication behaviors to achieve such as goal. By understanding where any deficiencies exist in physicians' skills to effectively adapt how they communicate with persons from different cultural backgrounds, training could target removing those deficiencies. Training could occur in workshops as continuing medical education (CME). Practicing physicians must fulfill a certain number of CME hours annually to maintain their medical licenses. Specialized courses could be integrated into medical school curricula or units of study emphasizing patient-centered communication skills beyond interviewing could be added into existing courses.

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APPENDIX A

Interview Questions

Demographics

Sex:

Age:

Where you are currently practicing:

Medical school attended:

Hospital Privileges:

Specialty:

Years practicing:

Religion:

Cultural identity:

Communication

Describe the degree of importance of communication in your medical practice.

Tell a story of a positive experience where the patient's communication skills lead to a positive outcome for your patient. For you.

Tell me a story of an interaction where your communication skills lead to a negative outcome for your patient. For you.

When did you realize the degree of importance communication plays in your medical practice?

Culture

What are some of the cultures of which your patients are from?

Do you experience cultural differences in your day-to-day interactions with patients? If so, in what ways? (If no prompt what cultural backgrounds are most of your patients?)

What are some cultural issues between patient and providers?

Tell me a story of an instance in which culture played a role in the interaction with your patient.

How do you manage cultural differences in your medical practice?

Training

How much training did you receive in communication practices with patients? Where?

At what parts of your medical school curriculum were communication issues addressed? What issues were presented? How were they presented? Did you have opportunities to practice communication skills in any courses in your curriculum?

Describe any communication training you have received in continuing medical education. What issues were presented? How were they presented? Did you have opportunities to practice communication skills in training programs?

Was there any information addressed in your medical school courses regarding multicultural communication with patients?

Was there any information addressed in your continuing medical education courses regarding multicultural communication with patients?

What do you wish you knew about multicultural communication?

To be as competent of an intercultural communicator, what do you wish to learn more about? Describe the importance you see in your learning to be more interculturally competent in communicating with patients.

APPENDIX B

Informed Consent

Title: The Role of Religious and Cultural Beliefs in Patient-Provider Communication

Principal Researcher:	Hannah O. Allison University of Arkansas Department of Communication 417 Kimpel Hall Fayetteville, AR 72703 email: hoalliso@uark.edu phone: 479-575-3046	Compliance Officer:	Ro Windwalker, CIP IRB Coordinator Office of Research Compliance 210 Administration Building University of Arkansas Fayetteville, AR 7270 email: irb@uark.edu phone: 479-575-2208
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Description: This study will investigate the aspects of patient-provider communication when the aspect of culture and cultural differences are involved in the interaction. Specifically, the research will focus on religious and cultural differences between patient and provider and address the following aspects that have not been fully investigated: patient-provider communication from the provider perspective, provider interpretation of the interaction, physician provided stories regarding their conceptualization of culture, and their thoughts and experience in patient-provider communication training. You will be asked to participate in an interview.

Risks and Benefits: The benefits include contributing to knowledge of how patients and providers from different religious or cultural backgrounds communicate during interactions. In addition, you may gain a greater understanding of your own patient-provider interactions as a result of reflection prompted by completing the interview. There are no anticipated risks to participating in the study.

Voluntary Participation: Your participation is completely voluntary. There are no payments for participating.

Right to Withdraw: You are free to refuse to participate in the research and to withdraw from this study at any time. Your decision to withdraw will bring no negative consequences – no penalty to you.

Confidentiality: All responses will be kept confidential to the extent allowed by law and University policy. If at any time you would like to see how your information has been used, please contact the principal researcher.

Informed Consent: I, _____, have read the description, including
(please print your name)
the purpose of the study, the procedures to be used, the potential risks, the confidentiality, as well
as the option to withdraw from the study at any time; each of these items has been explained to
me by the investigator. The investigator has answered all of my questions regarding the study,
and I believe I understand what is involved. My signature below indicates that I freely agree to
participate in this study and that I have received a copy of this agreement from the investigator.

Signature

Date

APPENDIX C

October 25, 2013

MEMORANDUM

TO: Hannah Allison
Patricia Amason

FROM: Ro Windwalker
IRB Coordinator

RE: New Protocol Approval

IRB Protocol #: 13-10-161

Protocol Title: *The Role of Religious and Cultural Beliefs in Patient-Provider Communication*

Review Type: EXEMPT EXPEDITED FULL IRB

Approved Project Period: Start Date: 10/25/2013 Expiration Date: 10/24/2014

Your protocol has been approved by the IRB. Protocols are approved for a maximum period of one year. If you wish to continue the project past the approved project period (see above), you must submit a request, using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. This form is available from the IRB Coordinator or on the Research Compliance website (<http://vpred.uark.edu/210.php>). As a courtesy, you will be sent a reminder two months in advance of that date. However, failure to receive a reminder does not negate your obligation to make the request in sufficient time for review and approval. Federal regulations prohibit retroactive approval of continuation. Failure to receive approval to continue the project prior to the expiration date will result in Termination of the protocol approval. The IRB Coordinator can give you guidance on submission times.

This protocol has been approved for 100 participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu

