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I'm a Patient, Not a Problem:

An Exploration into the Roles Assigned in the
Doctor-Patient Relationship

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A thesis submitted as part of the requirements for Honors in Anthropology

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Table of Contents

Chapter One: Introduction	6
Literature Review	11
Research Question	20
Chapter Two: The Approach, Study Design and Methodology	23
Analysis	23
Recruitment	25
Participant Social Demographics	27
Interviews	30
Limitations	31
Looking Ahead	34
Chapter Three: Results and Discussion	36
A Tentative Model	36
Physical Negotiation	37
Intellectual Negotiation	43
Emotional Negotiation	47
Applying the Model	55
Chapter Four: Narratives through a New Lens	57
Ruby	58
Ashley	65
Jean	70
Conclusion	78
Summary	78
Looking Forward	81
Bibliography	85

Appendix A	87
Appendix B	88
Appendix C	91

Chapter One: Introduction and Background

Background

A quarter-mile before the finish line of a half-marathon, 20-year-old Ruby suddenly collapses. The next thing she remembers is arriving to an ER in an ambulance full of male paramedics. Amidst her immense bewilderment, some feelings of discomfort and awkwardness flash in as she notices that her shirt and sports bra have been cut off and her chest is now lightly covered with a hospital gown. The paramedics inform her that they think her heart had caused the collapse. She arrives to the hospital and is eventually placed in the cardiology department.

Interns or residents come to Ruby's bedside imploring her to recount what little she knows of her own story over and over again simply trying to solve the medical mystery or problem in their own minds. Frustrated with these interactions, she and her parents finally demand to see only the head cardiologist. However, on the rare occasions he does visit, he never asks how she is feeling or takes her opinions into account either. She voices disagreement with the physicians' presumption that something was wrong with her heart because, as a runner of ten years, she feels as if she would've known. However, the cardiologist pays this little mind

and seems to only wish to address her parents who voice no such disagreement. She begins to feel like a “problem” instead of a “person” and feels constantly confused and bewildered as to what is happening and how the physicians plan to address her situation.

Despite her misgivings, she undergoes the cardiologist’s suggested cardiac stress test. She is made to wear her hospital gown with the opening in front in order to perform the test and, as a result, feels a level of discomfort verging on violation as her technician is male and quite rude. When she mentions her unease, the male technician responds by saying that this is the test they give patients who complain of chest pain. Although angered by this assumption and his tone, she continues with the test. As she has been made to lie in a bed for 24-48 hours after running almost 13 miles, she begins limping up the increasing incline. By the time another health worker walks in, her legs are visibly cramping and the health worker exclaims to the technician to abort the test. Add to this that when she returns to her room, her chest is left with red marks from the equipment. When a nurse returns and begins hooking her up for another stress test, Ruby explodes, refuses to comply, threatens to leave, but is finally placated when they agree to let her take a shower when she wants. Shortly thereafter, Ruby is discharged from the hospital. Upon checking-out, she is finally informed that her condition has nothing to do with her heart, but is given very little information besides, should she run or drink alcohol, she could collapse again. Although she now laughs, “I was like, ‘Omigod, I’m going to die!’” her tone in recounting her experiences and feelings is quietly desperate.

There are some aspects of Ruby’s experience that are all-too-common for many patients who go to the hospital or otherwise engage in the healthcare system. Patients feel ignored, uncomfortable, bewildered, judged, objectified, are given misinformation, and become so disempowered that the recovery of some portion of autonomy or voice, like being able to take a

shower whenever one pleases, is counted as a victory. Luckily, biomedicine is in the midst of a transition that seeks to address these issues as part of a larger goal to improve the quality of care and health outcomes.

Biomedicine has always been a balance between the hard science of a disease (what causes it, what must we do to treat it) and the softer experiences of the individual's illness (how does it feel to be sick with and treated for this disease, how will the disease fit into the individual's life context and favorite hobbies, how much the patient understands their disease and treatment). However, the importance of the latter aspects of disease has increased partly due to the rise of chronic diseases in the global population, such as heart disease and diabetes where the individual's day-to-day decisions factor heavily in the outcome, severity, and development of the disease. Over the last fifty years, as healthcare organizations, policymakers, health workers, and patients come realize the importance the latter aspect of medicine in healing, there has been a movement towards and focus on the "softer" qualities of patient-care in order to increase treatment adherence, lower costs, and improve outcomes for patients across the board.

One recent event demonstrates the breadth and direction of this change. Before the alterations made in February of 2012, the Medical College Admission Test was divisible into a biological science, physical science, writing, and verbal reasoning section. Starting in 2015, the exam will include a social and behavioral science section, omitting the writing section. Medical schools, hospitals, and clinics have also started using a particular buzz word—patient-centered, an offshoot of the bio-psychosocial model of medicine and disease (Engel 1977), which emphasizes the "softer" aspects of a medical culture that has historically been characterized by a focus on the "hard" scientific, technological and reductionistic aspects of illness, disease, and treatment. In a New York Times article that describes this transition for medical schools and the

MCAT (April 13, 2012), Elisabeth Rosenthal quotes Dr. Charles Hatem, a professor at Harvard Medical School and an expert in medical education, as heartily acknowledging that the scientific approach has demonstrated immense success through medical advances. However, in response to medicine's reductionistic tendencies, as Dr. Hatem comments, "...patients are crying out saying, 'Sit down and listen to me.'" Biomedicine, as even now medical schools recognize, seems to be in the midst of a paradigm shift that has been taking shape over the last forty or fifty years.

As part of this revitalized focus on the quality of patient care, the development of an ideal doctor-patient relationship has been an object of much study and debate. It has been found that relationships or interactions that involve more personal, engaging, and cooperative communication between patient and provider can lead to, not only patient satisfaction, but also positive treatment outcomes such as increased treatment adherence and fewer diagnostic tests and referrals (Stewart et al. 2000). What this type of relationship looks like and how to develop it, however, remains relatively unclear. Much of the literature seems to agree that the paternalistic model, one in which the doctor acts as an authoritative guardian and the patient is relegated to a passive object, is, in most cases, the wrong approach. The "right" approach seems to be one characterized more as partnership, but even this characterization is vague and its meanings remain disputed.

This study critiques and adds some significant qualifiers to one of the more popular models researchers endorse—the patient-centered clinical method. The patient-centered clinical method, which zooms in on the interactions between the physician and patient, is a derivative of a larger movement—the patient-centered care model. The more expansive patient-centered care model is a nearly fifty year-old movement that has become one of the most popular approaches emerging from this transition and debate on partnership models. In 2001, the Institute of

Medicine's report *Crossing the Quality Chasm* made the patient-centered care model one of the key components to a new and improved U.S. healthcare system. Now patient-centered care has almost become a buzz word among health professionals, organizations, researchers, policymakers, educators, and students alike. Its approach is expansive addressing all aspects of the healthcare experience including work environment, waiting room environment, posters campaigns like "Just Ask [your question]," staff-patient interactions, and staff-family interactions. Despite the model's and associated clinical method's popularity, its implementation has been difficult in such a healthcare system that values quantity over quality. To contribute some meaningful analysis and more fully illuminate a part of the problem, this study zooms in on the patient-centered clinical method, in which some of the aspects of the clinical and workplace environment of healthcare will be excluded for clarity's sake. Instead, the doctor-patient relationship, what it should look like and it should be developed according to the method, is the focus.

This study analyzes the stories and sentiments of UNH students on their doctor-patient relationships in order to elicit some of their conceptions of an ideal relationship and how it was developed. This will be compared to the literature selected on the patient-centered clinical method and other related models. By exploring how these particular students, with at least some significant exposure to the doctor-patient interaction, conceived of the ideal clinical relationship, these models of the clinical method can be cross-examined and critiqued. This study seeks to add to this conversation on the quality of patient care by exploring the development and characterizations of doctor-patient relationships and highlighting particular aspects of the relationship that have only been partly addressed in previous models. In exploring and cross-examining models of the patient-centered clinical method and the relationships patients

themselves endorsed, it was found that the model fails to address some of the principal bases of poor quality care. Before addressing these proposed shortcomings, however, what the literature supposes to be the ideal models of the doctor-patient relationship will be explored. For it is from this exploration that the study's research questions arose.

Literature Review

Models of the Doctor-Patient Relationship

There have been a variety of models or approaches that seek to describe the ideal doctor-patient relationship aside from the patient-centered care model. Ezekiel Emanuel, M.D., Ph.D, from the Program in Ethics and the Professions from Harvard University, and Linda Emanuel, M.D., Ph.D., a Teaching and Research Scholar of the American College of Physicians, define four models—the paternalistic, informative, interpretive, and deliberative model—that have defined the medical profession over the last several decades, emerging at individual, day-to-day, and circumstantial interactions (1992). Throughout each of these models, there are various foci on power or control for both the physician and patient and, consequently, different roles for each member in this interaction are emphasized. Although the latter three models can be seen as part of the larger movement towards more “partnering” approaches in the doctor-patient relationship (which will be expounded upon later), the paternalistic model, a more traditional conception of the physician role, will be used as a counterpoint to these more widely advocated approaches.

In the paternalistic model the physician discerns what is best for the patient based on what are assumed to be objective criteria towards the patient's well-being and health, sometimes to the detriment of patient choice and patient autonomy as patient values and preferences for treatment are not explored. The agenda, goals of the visit, and overall interaction is determined

by the physician (Emmanuel and Emmanuel 1992; Mast 2004, 354). Currently, it is rarely promoted as the ideal approach except in times of emergency when taking the time to elicit such nuanced information might compromise the health of the patient. Some studies suggest that this model, which calls for the patient to take on a more passive role in the medical consultation, is preferred by older patients, patients who are less educated, or by patients with more severe and acute conditions (Benbasset et. al 1998; Ende et. al. 1989). However, data show that this preference is in the minority among patients (Frosch 2012). The paternalistic model is also associated with what has come to be characterized as a “physician-centered” model which is defined by an emphasis on what values or outcomes the physician deems important while what the patient wants is assumed to be congruent with this. It is generally accepted that there is a power imbalance in this approach that greatly favors the physician.

There have been a variety of models and approaches over the past several decades that have developed in response and opposition to this model. Although perhaps useful in acute care, in an era and environment where the most prevalent diseases are chronic illnesses, many now view the paternalistic model as inadequate (Mast 2004, 355). Some advocate a “consumerist” model in which the power asymmetry swings in favor of the patient where the physician is merely “a basis of information” and the patient is the one who actually makes the decisions (Mast 2004; Emanuel 1992). More recently, the ideal doctor-patient relationship has shifted to a more patient-centered approach and is usually characterized more generally as a *partnership* (Donnetto 2010). Although the emphases of these more recent models vary, generally, researchers advocate for some level of recovery of the patient’s autonomy or voice in decision-making. They call for a power-shift.

As mentioned, one of the most widely advocated models that have emerged from this transition or power-shift from a physician-centered interaction is the patient-centered clinical method. Like the larger movement of patient-centered care, the implementation of the patient-centered *clinical method* or *model* has also shown some concrete results. The various flavors of its implementation have been shown to lead to a decrease in the average length of stay, improved patient satisfaction, and, through efficient and effective treatments, lower costs of care (Jayadevappa and Chhatre 2008: 15-16). In a comprehensive literature review performed by Ravishanker Jayadevappa and Sumeha Chhatre from the University of Pennsylvania, amid the various definitions, contexts, and approaches associated with patient-centered clinical method, it was found that the core of this approach in the doctor-patient relationship is the focus on the value of information and the process of shared and informed decision making (Jayadevappa and Chhatre 2008). The information related to the patient's illness experience, knowledge of the disease, and their symptoms is more greatly valued not only as a way to extract information, but also to involve the patient more in the interaction and the course of action. It is this transfer of information from patient to physician that accounts for the power-shift in the partnership of an ideal doctor-patient relationship.

The clinical model's basic tenets that have been embraced and endorsed by healthcare organizations, hospitals, clinics, policymakers, regulatory, and research agencies since the late 1970's, involve increasing patient power in the relationship through informed decision-making and treating each patient as a person with a larger bio-psychosocial context. The power in the relationship shifts from the physician to the patient as the value of the information that the patient provides about this context gains greater importance and as the patient is given more of a voice in the decision-making process. However, beyond this, the model lacks conceptual clarity

which Jayadevappa and Chhatre argue has hindered its implementation (2011: 15). Also, they add that policymakers have found it challenging to implement its values into a healthcare system that reward providers for the quantity, not quality, of interactions and resource use. However, there may be other, additional, reasons the ideals of this model have failed to have been realized. There are some aspects of a personal, communicative, and open doctor-patient relationship that are not adequately addressed or emphasized in the patient-centered clinical method.

The Place of Power in the Patient-Centered Clinical Method

The first problem lies in the supposed power-shift that is supposed to occur using this model in doctor-patient relationships. To approach this problem, the clinical method must first be explained in a little more detail. Focusing on the method of communication between the patient and the provider in the patient-centered clinical method, in the ideal interaction, the provider and patient,

“[1][explores] the patient’s feelings, ideas, fears, expectations, and the effect of the illness on their functioning,

[2] formulate[s] an integrated understanding of this bigger picture, and

[3] negotiate[s] a ‘common ground,’ an agreed course of action toward outcomes,

including the treatment approach, disease prevention, and health promotion.”

(McWilliam 2009, 279)

After eliciting the patient’s experience, knowledge of their disease, and feelings associated with their experience, the physician negotiates a treatment plan with their patient that they both agree upon. As part of the patient-centered clinical approach, the shared-decision-making model, which the last step illustrates, emphasizes the negotiation of the treatment plan between the

doctor and patient. The shared decision-making model generally promotes more patient autonomy and say in the treatment plan and is realized when patients feel free to ask more questions, discuss preferences, or disagreeing with a recommendation (Frosch et. al. 2012). It is facilitated, in the patient-centered clinical model, by a process in which the “physician’s knowledge is transferred to the patient, who then has the knowledge and preferences necessary to make a decision” (Jayadevappa and Chhatre, 2011). This approach centers around the core of the problem in the clinical interaction, the power imbalance between the doctor and patient.

To juxtapose this description of the model with the crux of the issue, we turn to a recent case study. It illustrates the pervasive power imbalance that exists almost inherently in this relationship and how such a dynamic can quite easily have a negative effect on the quality of care. Conducted among relatively affluent and well-educated patients in the San Francisco Bay Area, a study found that although participants seemed to have a strong desire to engage in shared decision making and collaborate with their physicians about their treatment plans and choices, many also felt compelled to defer to the authority of the physician by asking fewer questions—relegating the relationship that becomes more physician-centered. Many patients voiced a fear or concern that to ask questions or disagree with the physician could hurt the relationship and thereby compromise their care in the long run. As a result, the patients settled for directives from the physician, risked misunderstanding the information or directions given to them by the physician, and risked compromising their care because of this power imbalance and their perceived vulnerability (Frosch et. al. 2012). The researchers claim that the fact that such a privileged population felt this way towards their physicians speaks somewhat for the widespread presence of this phenomenon. And there seems little that even a privileged population such as

these participants could do against an authoritative physician. This fact reflects the reality that patients are, in most cases, at the mercy of the physician's interaction style.

This is not to say that all doctors abuse this power; only to say that there simply *is* a power differential. There are many doctors who are able to bridge this differential skillfully in the consultation, leaving patients feelings heard, listened to, and cared for. However, despite the popularity of the patient-centered clinical method, it would seem that it is not by adhering to this model that they overcome the inherent power imbalance. There must be other aspects to a successful consultation.

Although eliciting the patient's experience as information necessary to diagnosis and treatment plans somewhat restores the patient's autonomy in the patient-centered clinical method, even here, it is still the professional's responsibility and within their power whether or not to create patient-centered care. The patient is left with the role of relating their symptoms, personal context, and adhering to, what are hopefully, the *negotiated* plans to improve their health and manage their disease only on the condition that the physician elicits such information. Even if it is accepted that this is an unavoidable aspect of the doctor-patient relationship, how the physician can elicit such information is not explained in this model. And to elicit the patient experiences, their curiosity, and their feelings seems to be the key to empowering patients to share and create a more balanced power distribution and, therefore, more effective partnership. The study concluded that physicians must recognize these fears and "create a safe environment for open communication for patients" in order to "persuade patients that it is not just acceptable but...desirable that they ask questions and voice their preferences." (Frosh et. al. 2013, 1035). A call for a simple transfer of information does not adequately address the larger and more pervasive, multi-factorial tendency of this relational dynamic to be physician-centered. Some

propose that the patient-centered care model is inadequate to address this issue and have begun to advocate alternative models that seek to address the imbalance. One researcher approaches the problem by seeking to alter or target the environment or relational dynamic of the consultation itself.

Carol McWilliam, a faculty member of Health Sciences from the University of Western Ontario, approaches and explains the problem theoretically. She claims that the imbalance of power is perpetuated by patient-centered clinical methods because “patient involvement is invited, guided, and...shaped by the professional, who seeks input, asks questions, negotiates solutions and” tries to “educate and motivate” the patient (McWilliam 2009, 280). She points out that the subject of the interaction, the person doing all these things and controlling the relationship dynamic, is the physician. Also, she challenges the approach in its ‘functionalist perspective of power’ that relegates the relationship to a transfer of power, in the form of knowledge and support, from physician to patient and leaves the patient to decide whether or not to use this power (knowledge and support). (McWilliam 2009, 280). She claims this is an oversimplification of the ideal relational dynamic between a doctor and patient.

McWilliam proposes a theoretical model that focuses on the relationship as the act or process of relating between the patient and provider. She proposes the empowering partnering approach which, instead of just leaving room for the patient to relate their experiences, feelings, and negotiate their care, or eliciting these aspects solely to balance a sense of power in the doctor-patient relationship, focuses on the relational process that erases the prescribed roles for patient and provider and replaces it with a “mutually constructed partnership.” The researchers from the California study seem to be agreeing when they suggest that to address these “deeper attitudinal barriers” physicians need to work to create a safe space for patients to feel

comfortable to engage in as equal partners in clinical decisions along their preferences (Frosch et. al. 2012). Although it seems as though it is still the provider's responsibility to construct the dynamics of this partnership, the provider is actually facilitating a *process* to construct the relationship *with* the patient. The focus is not on an exchange of information, but a dynamic and fluid ways of relating, that is, an inter-subjective a relationship, a partnership that is co-created and exists "at the hyphen of a single I-Thou unit" (McWilliam 2009, 281). It is not a transfer of power or knowledge but a way of being with both the patient and provider where the provider actively seeks to engage with the patient on even ground. One of the ways the physician can do is by engaging in 'unknowing,' or decentralizing one's own perceptions of the world and allowing them to be 'eclipsed' by the patient's using open-ended questions and critical reflection (McWilliam 2009, 281). This conscious effort to remain open-minded can lead to the use of the patients conceptions and understandings of disease, even if they seem technically incorrect, to communicate—de-emphasizing the physician's reservoir of knowledge to be imparted and focusing on meeting the patient where he is and moving forward together. Unfortunately the implementation of this approach and the critique of the patient-centered clinical method is merely theoretical—it seems that since this process looks different for everyone, McWilliam feels justified in remaining vague on exactly *how* to implement the model. Even an approach with such an individualized, relational, and constructivist flavor has some structure, some semblance of a method in communication and this study sought to explore student perceptions of this approach in order to illuminate some of the elements of the relational process.

Individualizing the Approach to the Doctor-Patient Relationship

Although merely theoretical, McWilliam's implications toward a more fluid relational process to remedy the balance of power in the doctor-patient relationship do seem to address another issue that the clinical model fails to adequately address or explain. The focus on fluidity in the doctor-patient relationship has gained increasing attention as researchers have begun to realize that these partnerships are constructed differently for each person and circumstance. Both McWilliam's analysis and Jayadevappa and Chhatre's findings agree that, although the patient-centered care clinical method counts, as one of its strengths, the transfer of power from the provider to patient in decision-making, another problem is that patients differ in how much they wish to be involved in decision-making (how much power they wish to have) or how "patient-centered" they want their doctor-patient relationship to be. Sometimes, a strictly patient-centered approach to doctor-patient communication is not sought or preferred by the patient.

Studies seem to show that well-delivered and satisfactory care that causes a patient to trust and endorse his or her physician looks and feels different for everyone. A study found that physicians who were determined to be patient-centered, or who favored patient participation and a sharing of power and information between the patient and physician, were only marginally more likely to be trusted by their patients. The researchers took this to suggest that not all patients preferred more power, control, or information from their physicians. They proposed that, instead, patients prefer physicians whose beliefs were similar or complementary to their own and were, as a result, more likely to trust and endorse those particular physicians that matched-up (Krupat et. al. 2001). Instead of trying to match every patient with their complementary physician, the results imply that, in order to create a trusting and successful relationship, it is the physician's and patient's role to negotiate their views and beliefs on medical practice, or

facilitate a “meeting of minds” (Krupat et. al. 2001). Although other studies have sought to incorporate this individualizing approach in the patient-centered clinical method (Jayadevappa and Chhatre 2011), it is not an inherent aspect of the patient-centered clinical method. An active negotiation process not only addresses the need for an individualizing approach with its fluidity but may also assist in balancing the doctor-patient relationship by expanding the expected relational dynamic of the patient-centered clinical method.

The relational dynamic partially described by McWilliams not only describes a more adequate approach to bridging the power imbalance, but leaves room for a more organic and individualized approach to relating and establishing a relationship between the physician and the patient. This way of “being with” the patient in the medical consultation implies a more fluid relational dynamic that depends on the individuals and circumstances and accounts for the doctor-patient relationship as a relational process or development (McWilliam 2009). Despite the fact that McWilliam proposes, what is for many clinics and situations, an unrealistic and vague implementation of the empowerment model, since patients find varying degrees of power and control in the consultation relationship optimal, there is the need for a process of relating that is fluid enough to allow for such individualization. Additionally, the results could also imply that the transmission of power and information is only part of the solution—how to elicit the transfer of information, how to engage in the relational process of an effective doctor-patient relationship is not adequately described in the patient-centered clinical method. Despite the fact that that the patient-centered clinical method does advocate for some individualization (Jayadevappa and Chhatre 2011), in order to be considered “ideal” by patients and to balance the asymmetric power distribution through a more symmetric exchange of information, some aspects seem to be missing from previous definitions of the patient-centered clinical model.

Research Question: What Kind of Care Do Patients Advocate?

So what does ideal doctor-patient relationship look like? How can the patient-centered clinical method and empowering partnering approaches be further qualified to more accurately reflect the development of an open, communicative, and balanced doctor-patient relationship. Based on the literature above, it would seem that patients would advocate for a doctor-patient relationship where they felt engaged in a way that elicited their input, as the patient-centered clinical method suggests. However, instead of merely asking for patient information, patients may emphasize the various ways in which they were engaged in a “relational,” dynamic process rather than one in which they received adequate amounts of power, in the form of knowledge. This relational dynamic will be illustrated or described in a way that allows for a co-construction of a relationship by both physician and patient that allows for the flexibility of an individualizing approach, taking into account that each relationship is unique to the individuals. By relating and analyzing the stories and sentiments from health students and patients, this study determined if the emphases above seemed relevant to the participants and illustrated how some students felt that the ideal physician-patient relationship was or could have been developed. Both the issue of maintaining the power imbalance by a physician-controlled relationship and the call for an individualized, mutually constructed relational dynamic indicate the necessity for a relational process or negotiation. To illustrate what this process looks like, this study turned to patient conceptions of the ideal doctor-patient relationship and how such a relationship was developed in their personal experiences.

Although many of these studies have tried to determine the ideal developmental process, this study is distinctive in its approach to the answer. Many studies fail to center around the ideas and preferences of patients in constructing the roles involved in that relationship. Those that take

steps in this direction, towards a constructivist and inductive approach, do not effectively illustrate their theoretical models and methods in a way that is clear or comprehensive (Jayavappa and Chhatre 2011; McWilliam 2009). Although this study sought to address these issues, it has certainly not accomplished this lofty goal entirely. This study does, however, add to the conversation by giving a more detailed account of the patient's perspective in constructing the doctor-patient relationship thereby elucidating characterizations in the wider context of the situation or circumstance. Through student narratives and the sentiments related by the participants of this study, a model is imparted. This original model adds to the patient-centered clinical method some of the approaches suggested by the empowering partnering approach. It addresses the issues of the maintenance of an asymmetric power distribution in the relational dynamic of the clinical interaction and the call for a more fluid relational dynamic through a process of negotiation. Student narratives were used to more concretely illustrate this model and its related approaches. How these narratives and their related sentiments were elicited and how they were analyzed in order to create this model will be described in the next chapter.

Chapter Two: The Approach, Study Design, and Methodology

Analysis

To examine ways patients saw the development of an ideal doctor-patient relationship and further develop the patient-centered clinical method and empowering partnering approach, qualitative interviews about the perceptions of the roles involved in the medical consultation were sought. The roles ascribed by the patients, adhering to a constructivist approach, were the focus because the roles patients assign to the physician and themselves affects their attitude and expectation. These attitudes and expectations, in turn, affect the health-seeking behaviors and doctor-patient communication (Frosch et. al 2012, Fishbein 2010). As a result, this method elicited more normative responses as to how the development of a doctor-patient relationship *should* be approached. In providing these characterizations, the conversation becomes less about which *model* is ideal and more about *how* to facilitate the ideal and most effective doctor-patient relationship. Although normative in approach, the participants were asked to recount the development or dynamic of their own doctor-patient relationships to support their claims. These descriptions, the participants' reflections, and their sentiments were used as evidence to illustrate

approaches, either supportive or obstructive, towards creating a relationship that pleased and satisfied the patients.

The tensions in constructing an ideal physician-patient relationship and the resolutions of these tensions from the patient's point of view were re-contextualized and illustrated using the participants' narratives and characterizations in "as much of their voice as possible." This adheres to the conception of a medical ethnography posed by Joan Engebretson, DrPH, AHN-BC, RN from the School of Nursing at the University of Texas Health Science Center in Houston (2011). By giving background and analyzing the narratives of the students' stories, this study sought to adapt a model of communication for "ideal" doctor-patient relationships through an inductive analysis of the interviews.

To narrow down the multitude of themes that arose from the semi-structured, open-ended interviews, the focus of the analysis was on themes of power or sentiments reflecting the inherent hierarchy that exists between patient and provider and how this was overcome. These themes of power imbalance were chosen for their prevalence throughout the interviews and supporting literature (Donnetto 2010; Frosch et. al. 2012; Jayadevappa and Chhatre 2011; Krupat et.al. 2001; Mast et.al. 2004; McWilliam 2009). Themes of power were operationalized as patient attitudes, feelings, or beliefs that conveyed the perceived vulnerability and helplessness of the patient and the perceived dominance, condescension, or privilege of the physician. Other themes included the continuity of care, hospital or clinic physical environment, efficacy of electronic medical records, knowledge, chronic illnesses as identities, liking, hospital bureaucracy, age, and engagement. However, these themes were only explored to the extent that they related to the themes of the perceptions of power which was central to this research. These themes and the themes that the students perceived as important to address were considered more important than

the accuracy of the accounts or what actually transpired because studies have shown that perceptions and attitudes inform patient beliefs and, in turn, affect their behavior or actions (Frosch et. al 2012, Fishbein 2010).

Recruitment

To ensure accuracy, breadth, and depth in eliciting student responses to the research question, the method of recruitment was adopted with the aim of recruiting participants who have had more extensive interactions with healthcare providers as a result of chronic illness, a recent acute illness, or professional training. By focusing on the perception of the physician role among these particular university students, it is hoped that these stories, depictions, and perceptions of the ideal doctor-patient relationship and how such a relationship is demonstrated in practice will be more sophisticated and developed. The method of recruitment attracted a largely uniform applicant pool in terms of social demographics and, according to some studies, perceptions of the ideal doctor-patient relationship—one that adheres to the patient-centered model. The implications of the demographics of the participant pool will be discussed momentarily; however, first the recruitment process that led to this participant representation will be outlined.

Where and how participants were recruited was determined with this purpose of recruiting participants with as much doctor-patient interaction and experience as possible without compromising the privacy and right of choice for the participants. Although two participants were acquaintances or friends of the researcher, the other seven participants were recruited through passive programming at the university's Health Services and through the personal contacts of Judy Stevens, the community health nurse. The population or demographic that use

these services are overwhelmingly female, Stevens claims. It should be noted that Judy Stevens is often the nurse with whom students with chronic illnesses come into contact with to receive counseling and participate in a wellness support group for students living with chronic illness. However, it was not made known to the researcher whether the current participants were recruited via this relationship. The process of recruitment, approved by the associated institution's IRB, was performed with utmost care to protect the privacy and identity of potential participants and ensured a high participation of students experienced as patients or gaining experience as providers.

Recruitment materials advertised the study as a project exploring patient-provider relationships, or experiences with doctors, nurses, and other healthcare providers. It also offered a \$20 Simon gift card (American Express) as compensation for an interview which was estimated to take between 30-60 minutes. Potential participants who saw these posters or were given these posters by some of the Health Services staff, were encouraged to contact the researcher, whose email address and phone number were provided, to express interest. The poster also had the official heading of UNH Health Services. To secure such a designation, there was an informal process. As a senior honors thesis, interview questions were approved by the IRB, as mentioned. However, as an undergraduate internship project with the Office of Health Education and Promotion at UNH Health Services, the questions and the projects were also approved by the researcher's internship advisor, Judy Stevens who is the Community Health Nurse, a Wellness Educator and Counselor at UNH Health Services, and Kathleen Grace-Bishop, the Director of Health Education and Promotion. With the permission of Ms. Grace-Bishop, recruitment materials had the official headings of the university's health services institution (see Appendix A) and were designed with the help of Dawn Zitney, the Health Services

Communications and Information Coordinator. This increased the project's apparent legitimacy to potential participants. Health Services staff who had these posters to give out to their patients or clients were asked to adhere to an ethical approach to recruiting participants via email (i.e. avoiding the use of guilt or pressuring the students in any way to participate in the study). Some students were also recruited through the forwarding of the poster or its contents from previous participants; however, the participant who did this did not do so at the request of the researcher.

In order to ensure that the decision to participate in the study was an independent decision as free as possible from outside relationships or influences, especially from the UNH Health Services staff, in all cases, it was the students' prerogative to reach out to the researcher. Once contact was established, potential participants were sent a copy of the consent form for perusal (see Appendix B). After confirming their choice to move forward, the researcher and potential participant set up an appointment for an interview. No measures of eligibility were used aside from being students at the university. The researcher accepted participants as long as there were enough gift cards to reimburse them. The method of recruitment ensured that a participant population with at least some history of more serious or intimate experiences with healthcare providers was present in the study.

Participant Social Demographics

Students with some type of chronic illness made up the bulk of the study's participants (66% or six out of nine). Although this designation brings with it some particular considerations, such as the prospect and challenge of eliciting self-care management (McWilliam 2009), only aspects of the students' illness experience that illuminated sentiments concerning physician and patient role ascriptions in terms of power, dominance, and resulting patient vulnerability or fear

of engaging in shared-decision making were explored in this study. Other students' experiences in biomedicine were slightly different. Two participants were providers or providers-in-training—one was a nursing student and the other was a peer mentor for an eating concerns group. The last student was neither a provider nor chronically ill, and had a more routine relationship with her primary care physician as someone she would see at least once a year for physicals or acute illnesses.

Another characteristic of this participant pool was its asymmetric and almost uniform social demographic representation. The setting of the recruitment process largely accounts for the distribution. Though largely unanticipated, it may have allowed for a more credible critique of the patient-centered care model.

Eight out of nine participants (88%) were white females while the remaining participant was a white male. The ethnicity of the participants can be explained by the university's demographics as only 8% of the entire student population identified as some minority ethnic group during the semester in which students were recruited. The gender of the participants probably has something to do with the location of recruitment and, by extension, the different health-seeking behaviors of college men and women. In 2012, 68% of UNH Health Services visits were female students and according to Judy, the usage of extra programs, such as chronic illness support groups and consultation with the Office of Health Education and Promotion, the staff of which aided in the recruitment of this study, is even more female-heavy. Interestingly, it has been found that the most likely demographic to advocate patient-centered beliefs, or a preference for information and control, were educated white, young females with a higher level of income (Krupat 2001). This seems to suggest that a more uniform participant pool was acquired, however, since this study simply seeks to illustrate the ideal doctor-patient relationship

based on patient preferences, the model or emphases that are revealed were not taken as gender-specific.

The social demographics of this participant pool may have increased the likelihood that the students would advocate for a model similar to the patient-centered clinical model in their conception of an ideal doctor-patient relationship. As the patient-centered care model is one of the models the study wished to critique, this suggests that the critiques, sentiments, and evaluations these participants offer would aid in this endeavor. The setting of recruitment and the resulting near uniformity in both social demographic and, supposedly, clinical model advocacy may have contributed to the aim of this project in a way—the patient-centered clinical model may be critiqued in similar ways to how it was evaluated in the literature.

The makeup of this participant pool was not preferable and largely unforeseen. Although, as mentioned earlier, the reasons for this lopsided representation lie in the recruitment setting, the method of recruitment is also to blame. Since direct solicitation of university students with more involved healthcare experiences might have been difficult to describe clearly and ethically and could have discouraged involvement. As a result, no indication of this aim was included on the recruitment poster. Also, the researcher did not wish to screen potential participants based on the lack of involved healthcare experiences. Instead, in order to attract and recruit students with some substantial experience with healthcare providers, recruitment focused on UNH Health Services as a clinical setting. Unfortunately, the staff members involved in the recruitment for this study dealt largely with female students. To have received a more varied participant pool, recruitment should have been performed in other areas on campus and a screening process accounting for age, sex, race/ethnicity, socioeconomic status would have been necessary to find more varied and representative participants with substantial medical involvement or history.

Interviews

After securing particular participants with the proper qualifications, qualitative one-on-one interviews were performed. Nine transcripts, which were generated from semi-structured, open-ended interviews, were analyzed along their most emphasized themes. Interviews were audio-recorded with consent and ranged between 17 to 75 minutes long, averaging to a little over 34 minutes each. After being transcribed, transcripts were noted and highlighted connecting phenomena, stories, and themes across interviews. To protect the privacy of these participants, the participant names have been omitted from the study and participants have been assigned fictional monikers unrelated to their actual name. Also, some more specific details from their narratives have been omitted or altered as long as they did not change the sentiment or drastically alter the circumstance in which their sentiments were presented.

While one interview took place in a private study room in one of the student housing buildings, most interviews took place in private conference rooms in both the Dimond Library and the Memorial Union Building. The researcher attempted to follow Herbert and Irene Rubin's recommendations on qualitative interviewing (2005). The interviews were semi-structured in that there were a set of guiding questions, however, many of the questions, especially at the start of the interview, were open-ended and more casual. At the beginning of each session, after a couple minutes of 'chit-chat,' the researcher asked a general question to ascertain the general experience of the participant with healthcare providers. The researcher used phrases such as "stood out" or "most memorable" to try to key on more important or recent experiences with healthcare providers and jumpstart a discussion. The interviewer would then ask about these relationships in turn, leaving space for the interviewee to follow the track of their own story. Throughout their story, the researcher asked the participants to elaborate on their feelings towards a particular

provider or experience, or clarify any specific words, terms, or phrases. Towards the middle of the interview, following the three stage interview plan of Rubin and Rubin, after asking about any other experiences that they remember particularly fondly or found somewhat upsetting, the interviewer asked the participants what they felt was integral to the satisfaction of their experience or what behaviors would have improved that interaction. This usually helped distance the participant emotionally from their experiences in a more removed reflection. Finally, to further lessen the intensity of the interview and help close the session, participants were asked what they perceived their role to be as a patient. For a list of guiding questions see Appendix C.

Limitations

Two methods that could have been useful to this study and expanded and varied the data set were the use of focus groups and participant observation at the sites of the participants' clinical interactions. Focus groups would have helped both bring out and condense the themes brought out by the participant narratives. It would have been easier to find the sentiments that the participants felt should be emphasized. Also, if focus groups had been used at the beginning of the study, the researcher could have more accurately picked out specific informants to interview in depth at a later date. As it was, there was no checkpoint to screen potential participants and, as a result, resources were depleted for participants who did not or only marginally met the specific more in-depth clinical experience or background desired for this study. Unfortunately, coordinating finding a time for more than a couple university students to meet would have proved difficult given the rigor of many of these students' schedules. In addition, the amount of compensation that would have been required for the increased number of participants would have reduced the amount given each because of the lack of resources on the part of the

researcher. This also might have reduced participation. However, as a result of not using focus groups, themes brought forth in these one-on-one interviews were sometimes difficult to connect and the researcher was forced to interpret themes more widely in order to draw connections.

Another method that proved difficult to implement was the use of focused participant observation. Although it would have been preferable to directly observe the physicians who the participants described in their clinical interactions and, perhaps, triangulate the narratives and their descriptions, this proved to be difficult given the time and geographic constraints. This study, rather, relied on the perceptions and description of the patients. As Loewe writes in his study of narrative analysis of physicians and how they deal with the chronically ill, since narratives are, by definition, evaluative, or “embody the narrator’s viewpoint or interest...” there seems to be “no Archimedean point on which to test correspond[ing] theories of reality” (1998). In other words, since the study and its questions are limited to how the participants perceived the interactions and what the students emphasize in their own narratives, triangulation was not as necessary—what mattered in this study was less the accuracy of the narratives and more of what the students perceived as important themes to address for these inform patient beliefs and attitudes and, in turn, affect their behaviors and actions regarding their health and the doctor-patient interaction.

Although the relative uniformity of the group, in terms of demographics, may have allowed for a cross-examination of the literature that posits young, college-educated, female participants as advocates of the patient-centered model, it limited the generalizability of these results and sentiments, especially across the sexes. As the statistics from UNH Health Services show, there is a marked difference between the health-seeking behaviors of university male students and female students. By extension, this could also indicate different expectations for the

doctor-patient relationship. Most studies combine the results of both males and females and use age or ethnicity as divisional characteristics. Although this would suggest that the responses received could be taken to speak for both sexes, with such a disparity in the use of UNH Health Services between the sexes, it is difficult to say so. Despite this, the lone male's perspective will be integrated into the analysis as this study's research questions were not gender-specific.

The last limitation to this study that should be mentioned is that in exploring the doctor-patient relationship focusing on the patient's perspective, an important member of this interaction has been relatively silenced in this study—the physician. Although there is substantial literature on the perceptions of the relationship from the medical students' and physician's point of view (Donnetto 2010; Lutfrey 2005; Loewe 2001), it would have been fair to elicit the perspective of the other member of this dyad in the same way to explore how providers perceive this power differential and how to overcome it. Originally, it was planned to involve ten participants of each, ten patients and ten physicians in in-depth qualitative interviews. However, the time and resources required to elicit adequate depth from twenty participants was extraordinarily difficult to acquire and so the researcher chose the most accessible population—UNH students. The researcher, being a female UNH student may have also benefitted from the sense of camaraderie from the participants who were of the same demographic and may have elicited more honest and open responses as a result.

In the future, recruitment for the study should be performed in places with a more balanced gender ratio. Although the researcher had misgivings about denying a potential participant from taking part in the study due to a lack of significant exposure to a healthcare environment, such a screening process would have been necessary to keep the depth of experience of the participants high and to keep the other social demographics balanced. Finally,

to get a more well-rounded view of the issues involved in the doctor-patient relationship, the perspective of doctors, in addition to patients, should be included. However, acknowledging the narrow demographic involved in this study and recognizing that these patients and their sentiments may not speak for everyone because of the uniformity of the sample, the sentiments and nuance the student participants add to this discussion of sharing power and control in the medical consultation through their stories can offer a critique on the above-mentioned models of the clinical interaction.

Looking Forward

All participants added qualifiers to the patient-centered care model and empowering partnering approach that have not been previously proposed or included. Although the exchange of information highlighted in the patient-centered clinical method remains important in their descriptions and illustrations of the ideal doctor-patient relationship, the participants' sentiments also supported the hypothesis posed at the end of the first chapter. Participants emphasized, demonstrated and explained, through their stories, a fluid process that 1) focused more on the construction of a relationship rather than an exchange of information, 2) was adaptable and individualizing to that particular patient and his/her context, and 3) constantly responded to the power imbalance inherent to the doctor-patient relationship. This was accomplished through a process that will be referred to generally as "negotiation." The process of negotiation occurred on three levels—physical, intellectual, and emotional negotiation. These levels also reflect levels of tension included in the inherent power imbalance of the doctor-patient relationship. The levels of negotiation and their respective recommendations and approaches posed by the students address these levels of tension. How the process of negotiation surfaced in response to these

tensions in the student interviews will be discussed in the next chapter. However, the presentation will be somewhat backwards.

The model gathered from the narratives will be provided first with some of the more illustrative excerpts to introduce its concepts. These excerpts were often student responses to the follow-up question to their narratives such as, “What could have made that experience better, or what made a particular experience more positive?” Once the framework proposed has established and understood, in the next chapter, in order to more fully demonstrate the model, it will be applied to a few of the study’s most significant and involved narratives from which the model was partly inspired. This will illustrate *how* students saw a safe and welcoming environment could be developed over the course of consultation and how such a relationship could be developed despite the inherent power dynamics and its related tensions.

Chapter Three: Results and Discussion

A Tentative Model: Levels of Tension and Negotiation

There were several themes that the participants consistently emphasized in this study as key to the development of an ideal doctor-patient relationship. Each of their recommendations and sentiments reflected a call for further interpersonal engagement through different aspects of ‘negotiation.’ The different avenues of negotiation were usually brought up as a response to the various tensions felt in the relationship as a result of the power dynamic. These physical, intellectual, and emotional points of *tension* were also viewed as points of opportunity for constructing what participants considered to be an ideal doctor-patient relationship. Therefore, the three points or levels of tension can also be viewed as three levels of negotiation. Although this model incorporates the transfer of information-as-power proposed by the patient-centered clinical method, its focus, instead, is on the various ways in which this negotiation between doctor and patient reflect McWilliams’ metaphorical “meeting of the minds,” finding common ground and building up from it. By characterizing the different avenues patients expressed

satisfactory or unsatisfactory engagement as physical, intellectual, and emotional levels of negotiation and tension, important aspects are highlighted that more adequately address the inherent power dynamic in the clinical consultation and the individualized *process* required to overcome it. This chapter will present representative case studies of each in a way that allows for a neat categorization of the negotiation process. In the next chapter, however, the category divisions will be blurred as the reality of the process required to develop the type of relationships the students wanted will be explored revolving around the narrative itself rather than the construction of the model.

Physical Negotiation

The first theme, physical negotiation, is quite visual and directly responds to the power imbalance inherent the doctor-patient relationship. The call for a physical “leveling” or negotiation in the doctor-patient relationship was best illustrated by sentiments from Nancy, a nursing student. As her and several other students’ descriptions demonstrate, the physicality of the doctor-patient interaction is also a point of tension that she and other students felt providers sometimes neglected to address or consider. This physicality of the doctor-patient relationship allows an opportunity to diffuse the sense of dominance from the physician and resulting vulnerability of the patient, or to enhance it. Unfortunately, because participant observation was not conducted with the subjects of the interviews themselves, some of the more illustrative aspects of this level of tension and negotiation likely have gone unrelated in this study. However, it is clear by the data that was gathered that this is a significant piece of the doctor-patient and, more generally, the healthcare provider-patient relationship.

Nancy has dealt with a variety of providers through both her own personal experience and through her training. “Primary care providers, nurses, LPN, and nurse practitioners” are all characters in her stories. In trying to ascertain her most memorable or important attitudes towards these interactions, she is asked, “...were there any [practitioners] really integral to making you choose to become a nurse?” She responds,

“I think my, the nurse practitioner I liked over my primary care providers because they were just more open and I felt like they listened more to like different aspects of your health, not just focusing on you’re coming in here, you’re getting your physical and you’re out, I felt like they were just really interested...Like I went to the appointment and I felt like [the nurse practitioner] would talk to me more about like the issues um...and the issues I was having, health in general even though I was only there for my pap smears and you know, all that. Um, whereas I went into my doctor’s appointments it was like the quick head to toe, let me look into your lungs, yep you’re good, and see ya later. So it was like, not as much of a personal interaction I guess.”

Nancy, in keeping with the patient-centered clinical method, voices a preference for her provider to elicit more information about her experience, knowledge, feelings, and “other aspects of her health.” She prefers nurse practitioners because the interaction is more personal as they “listened” to a variety of aspects of her well-being, suggesting there is more engagement. Whereas in her experience of doctor-patient interactions, the doctor was more focused on the physical manifestations of her well-being, looking into her lungs, giving a “quick head to toe” or cursory look-over. When asked to talk about some of her more memorable or positive interactions with nurse practitioners she responds,

“I remember talking about...just like health in general...like making sure you’re getting your calcium and just the different things they talk about, things that like eye level with you and talk to you...”

In addition to the more general aspects of her health, in what could be construed as physical demonstration of concern and engagement, the nurse practitioner sat eye-level with her. Whereas with the primary care physician,

“You’re sitting in that little exam room up on the chair and they’re like asking you questions but they’re still like typing ...I understand the importance of documentation, but it’s very much like, ok I’m typing on the computer as you’re talking and this is what I have to get done whereas the nurse practitioner is just like they really care what, they sat eye level to me and, had a piece of paper and a pen but they weren’t sitting in front of the computer typing the entire time...”

The nurse practitioners were able to demonstrate to her their compassion for her care by putting the computer away and sitting “eye level” to her. For Nancy, these physical and visual demonstrations were a very important part of establishing a good relationship between patient and provider and feeling as if her provider actually cared about her and her health.

When asked about her more memorable experiences or interactions in her clinical observations as a nursing student, she mentions this refrain again, for the fourth time in the interview,

“...You can just tell the ones that really care about what the patients think and...what they’re focusing on is what the patient wants...it’s hard to explain but like instead of me saying to you... ‘You don’t manage your diabetes well and you...need to do this,’ it’s more like, ‘Well, what do you see as your ...barriers to not taking your insulin?’ Or like

sitting at...eye-level and not like standing over them and like giving some eye contact, cuz I've had some doctors come in with...my patients and then look into the charts, say like two words, and then just leave."

Nancy poses both an authoritative, almost accusatory, and disengaged, disinterested style of interaction in direct contrast to a style that involves an open communication style or one that elicits information about the patient's experience through open-ended questions and that involves a physical leveling or negotiation of patient and provider in the engagement. While this type of open questioning is sometimes addressed in the patient-centered clinical method as a way to elicit information from the patient, the physical negotiation is not. Physical negotiation, for Nancy, is another important response to the inherent power dynamic that helps create a clinical environment more conducive to the development of an ideal doctor-patient relationship. When asked to recount an interaction or a health provider who epitomized the ideals she felt should be included in the ideal relationship, she mentions a neonatologist and describes her interactions with parents,

"I felt like her interactions with...with parents were very um, awesome. She was just... the eye contact thing I think is huge and not being in their face and demanding, it's just a calm, truthful, this is what's going to happen, this is what I think...do you have any comments, concerns...the parents were standing up, so eye-level with them, I feel like that's such a huge thing like not standing over them, with a clipboard, you know, she didn't have like a clipboard right in their face, she had her computer down, or whatever it was and just talking, I guess, like, literally just good communication."

Her consistent juxtaposition of a "demanding" and "in their face" authoritative and overly dominant physician with one that engages with patients and elicits their "comments" and

“concerns” with level eye contact illustrates one way in which she thinks the power dynamic in this relationship could be further balanced.

However, the physicality of a consultation, as both a point of tension and an opportunity to address the power dynamic, is manifested in other ways. In fact, there are some physical demonstrations in doctor-patient interactions can give the impression of accenting the asymmetrical power distribution. When asked about the worst interaction she witnessed in her student observations, Nancy describes one particular physician,

“I remember him because I had this patient that she was like 86 or something, she was really old, she was dying and she was on a lot of oxygen. She just knew too, and um, he came in and said...like two words like, ‘Hi,’ and said, ‘This, this like patient like—’ I dunno, just like 4 or 5 sentences and just...ripped down the Johnny to listen to the heart, ‘Can you turn over,’ listen to the lungs, and then said ‘Ok!’ you know ‘I’ll be back.’ And then, just kinda left and we were kinda left like ‘Who, what?’ That was...I understand you have like limited time but um...even you can make that 5 minutes more like, respectful. And um, same with I—when I was at...a different unit with the neonatologist, there was a surgeon who came in and never said one word to even the parents, never said anything to the um, uh the nurse, just was like ‘I’m here to do my job,’ you know...He was there...checking on bleeding, checking the site...and it was very much like...who are you? Just walking up, not even really saying much, touching this person’s child, not really introducing yourself and then...walking away.”

When asked, “Did either the...elderly woman or the...parents say anything? As [the physicians] left?” Nancy answered,

“Yeah, the nurse, the patient, when—well, she looked just kind of like, you could tell on

her face she kept like covering herself back up, just felt like very expo—you know um, violated almost. Not violated like in a horrible way just like, you know, pulling her stuff back...and the parents were more taken back and the nurse like apologized, 'Sorry that was one of our surgical residents,' like, you know, she just had to like, apologize for him.

The physicality involved in doctor-patient interactions is often a point of tension when a patient is in a hospital or clinical environment. In the midst of dramatic stay for the elderly woman, a doctor comes in, says very little, and without asking for permission and without warning, pulls down the hospital gown to listen to the patient's heart, then leaves. In the next story, a surgical resident comes into a patient's room, checks the newborn child, then, without a word, leaves. Nancy seems to be protesting against a disengaged, purely functional, coldly mechanical interaction style, which seems to be quite physical—treating the patient as only a body. By emphasizing the need to physically “level” the interaction, she is also acknowledging the inherent power dynamic in the doctor-patient relationship and the need for the physician to actively breach this sense of distance and balance the relational dynamic by sitting “eye-level” to the patient.

The first story encountered in the introduction of this paper with Ruby also demonstrates how the power imbalance between provider and patient and the patient's resulting vulnerability can be accented by small and seemingly inconsequential physical interactions. (The nuances of this story and how it relates to this theme will be discussed in the next chapter). Because of the phenomenological flavor of this level of negotiation, it was also an aspect that was not as prevalent in verbal accounts of the other student narratives. Despite this, it is insinuated throughout each narrative, embedded in other levels of negotiation. It is clear that a physical negotiation that helps address these reductionistic tendencies and the sense of vulnerability for

the patient, however, this seems to be only a small part of the ideal engagement or interaction process. In order to include more aspects of creating a clinical environment conducive to the development of the ideal doctor-patient relationship, more points of tension must be addressed, more levels of negotiation are necessary.

Intellectual Negotiation

One of the sources of the inherent power imbalance in the doctor-patient relationship is the asymmetrical distribution of knowledge. It is the source that receives all the attention in the patient-centered clinical model. And although it is given due attention in this model as well, it is merely a part, not the focus, of the negotiation process. The asymmetrical distribution of knowledge is recognized as a point of tension for doctor-patient relationship in this model because it is acknowledged that the physician, in a sense, holds all the cards—the physician can deal out information as he or she chooses. If the physician chooses to emphasize some facts over others or forgets to address a key aspect of the patient’s health, the patient is not in a position to hold him or her accountable unless the patient knows a great deal about their condition, having acquired a more balanced distribution of knowledge, or they seek the opinion and knowledge of another professional, where they are placed in the same predicament. The physician is the expert while the patient comes to the physician’s office or practice in order to seek that expertise. However, this tension is also an opportunity for an enactment of a level of negotiation. One way that another participant, Beth, saw intellectual negotiation taking place was when the effort was made to make the patient feel that they were talking to a “peer” rather than a professional. Her sentiments highlight this point of tension a way it was resolved for her. Both she and, another participant, Jack both contribute ways this intellectual tension could be negotiated.

When describing a pediatrician she did not much care for, Beth says,

“I feel like my pediatrician, she made me like really uncomfortable, cuz she was like an older woman and just kinda like, like she knew she was wicked smart and...I don’t know how to put it...pompous I guess.”

When asked what she meant by “she knew she was smart,” Beth replies,

“I don’t know she just like...sulked me, like whenever I would say something she would look at me and be just like, “Alright...” she...never smiled or said anything...”

For Beth, the asymmetrical distribution of knowledge was felt more distinctly in her doctor-patient relationship when the physician made little effort to engage her, not responding or commenting on her responses. The proper response to such a dynamic, she felt, was reflected by her primary care physician. When asked how her primary care physician compared to her pediatrician by giving an example of a representative interaction, Beth responds,

“I guess like something that would [demonstrate] why I was so comfortable with her...obviously you’re [at the doctor’s office] and you’re like getting ready for an exam and it’s...awkward, they’re...touching you, and so...we were...in normal conversation...as she was touching she was...telling me...different parts of...what muscles she was touching...talking about them, so I was like more or less like learning while she was—it was like really interesting...I like stuff like that...I like learning new things. She was...talking to me about everything...she was doing...as she was doing it, like I think that’s one of the reasons why I started like respecting her because she knew....so much, like obviously, she’s awesome, she always knew what to like...while she was like talking to me, I would...understood too which I think is why—she talked to me like we were on the same level is what I think it came down to.. We just talked.”

Beth recounts the vulnerability raised by the physicality and discomfort raised by the unaccustomed “awkward” touching of the clinical encounter and the knowledge and age distance between a young adult and a mature physician. The physician whose interaction seemed to address or respond to this talked with Beth as if she were teaching her and put it in a way that allowed Beth to understand her. As the physician in some partnership models is regarded as a source of information, the delivery of this information can either accent the sense of power imbalance or redress it. The physician engages with Beth on an intellectual level congruent with Beth’s way of thinking and her knowledge base. This allowed Beth to feel free of judgment and more comfortable to share information or “just talk.”

Another participant, Jack, also spoke to the idea of intellectual tension and negotiation. Although Jack, who suffers from severe Attention Deficit Hyperactivity Disorder (ADHD), mostly emphasizes systemic problems in healthcare such as the slowness of the bureaucracy and the ineffectiveness of certain network database systems, he also points out a way in which this intellectual tension can be negotiated. He mentions that one of things he enjoys about his current physician, who he has had for the past eight years, is that “...we’ll talk about um, random things when I go in...not just the ADHD stuff...random things that I’ve been looking up or stuff like that, generally.” When asked what he meant by things that he has looked up he admits,

“...On my spare time I tend to Wikipedia surf...[for example] I found some little fact about some specific mineral...and I have a question about that...[just to] clarify [the information] in my mind.”

As an example, Jack mentions, “I recently found out that honey has a specific bacteria that can actually cause paralysis in babies.” When asked if the doctor confirmed the information, Jack says, “I haven’t talked to him since I found that out [I just found out that] on the bottle it said,

‘Should not give to babies under 1 years old,’ and so I...was like, ‘Wait...what?’” Jack also mentions that although he hates getting his blood drawn, he asked for the only one he has ever had to satisfy, “a curiosity of mine.” He had heard that “there have been links to ADHD and potassium levels” and so, at 16, he had asked his physician if he could get his blood tested for abnormal levels of potassium. After eliciting approval from his mother, his doctor “approved it and was like, ‘Yeah. Let’s do that and I’ll get back to you with the results.’” Jack seems to enjoy exchanging information he has discovered on his spare time with his physician. As a characteristic he emphasizes the most in this relationship, it seems that being able to communicate in this way with his doctor was a point of pride and helped construct a relationship about which he had very little to complain. His emphasis may have also been related to the associations of his disease to a lack of intelligence. When describing the testing he had to undergo as a child to diagnose his disorder, he says,

“...in that testing she was like giving me math questions and I, was like what 98th percentile and then she had math questions with little background noise and I was below 50...I was like ‘Screww you.’ Like I’m not below 50th percentile goddammit.”

When asked who he was frustrated with, however, he did not blame his psychiatrist.

“Umm, she was nice, it was fun...playing games...Mostly it was the people locked in the background that I hated it was like a basic crowd of people making, like a cafeteria noise.”

The exchange of information he shared with his physician may have contributed to or helped express his sense of identity as an intelligent person despite the difficulties his condition can sometimes impose. Their way of communicating also created a space in which Jack felt

comfortable in suggesting a course of action he was curious in undertaking—the blood test for potassium levels.

Jack uses his physician as a resource for information, not unlike some partnership models such as the consumerist model in which the function of the physician is to merely provide information. However, he also emphasizes the fact that the information exchanged wasn't just about his condition—it was about other things he was curious about such as the relationship between the bacteria in honey and the digestive tract of newborns and other factoids he had discovered. This may have contributed to the quality of the doctor-patient relationship in which Jack felt comfortable enough at age 16 to take initiative and ask for a blood test to satisfy his curiosity about his condition. The exchange of information and being able to communicate information both related and unrelated to his health actually contributed to the quality of the relationship for Jack and to his own sense of well-being, reinforcing the fact that he was an intelligent young man despite his condition.

The exchange of information emphasized in the patient-centered clinical model, as described by both Jack and Beth is expanded to include a way of communicating. The focus is not the end result—the transfer of information—but what that transferral accomplishes, which is a level of engagement and negotiation that allows Beth and Jack to feel comfortable enough to express what they need to express, without fear of judgment, and enact the amount of power in decision-making they wished to enact for their own sense of well-being.

Emotional Negotiation

The last level of tension and negotiation is the emotional level. Emotional engagement was most often connected to a demonstration of care and concern on the part of the physician. It

is the level that holds the most power in its ability to address the sense of vulnerability and the power imbalance in the doctor-patient relationship. The story and sentiments raised by Diana will illustrate the significance as well as the demonstration of this emotional point of tension and level of negotiation essential to a trusting and open doctor-patient relationship. But first, some of her social context, history, and relationships with her providers will be described briefly. As it will soon be shown, this kind of background detail is necessary to understand the nature and importance of the emotional tension and negotiation in the doctor-patient relationship for it is through the life context of the individual that these interactions are viewed, dealt with and felt.

Diana has had a traumatic childhood and young adulthood. Her mother suffered from a mental illness that destabilized and her family considerably. Diana really liked the first pediatrician she had during this time. She remembered this doctor as quite capable of diffusing awkward or uncomfortable situations, such as getting a prescription for a birth control pill at a very young age, through humor. Then, because of a change in insurance providers, Diana had to switch to another pediatrician right around the end of middle school, beginning of high school. She was quite unhappy with the relationship she had with this second pediatrician. Meanwhile, the situation with her mother was worsening and so she was also made to see a psychiatrist. While seeing these two providers, Diana's mother left the family and then committed suicide. Although stuck with the pediatrician she disliked, luckily, the psychiatrist was very helpful and she recounts their relationship quite fondly. Unfortunately, after two or three years, cancer took the psychiatrist away from Diana. Despite this, she holds the advice and wisdom gained from this relationship very close and has taken steps to ensure the maintenance of her own mental health as a result. Her involved history with providers and the proximity of both hers and her mother's health and relational context figured prominently in each of these relationships.

The four providers and how Diana recounts each of their relationships and interactions will be discussed in turn starting with the second pediatrician. She begins her account during high school. When asked why she disliked her second pediatrician, who oversaw her general health around the time her mother died, Diana responds,

“...she was very almost like rude, and very...judgy about things, so I felt like I couldn’t tell her the truth about anything...It was kinda like...she asked if I had ever drank and I was like honest, cuz I was trying things and stuff at that point, like I was like 16 and um I was really active too cuz I was on like three sports teams so I was always playing sports but like I was still angry about stuff... like, ‘Oh, I’m gonna try a little of this and this.’ And then when I told her that, she’d be like, give me an answer that wasn’t so like, ‘Oh well maybe you shouldn’t,’ it was more like ‘Well that’s not...good.’ And it was just like awkward.”

When Diana was honest with the pediatrician in the ways she was coping and experimenting with alcohol, the way the physician responded made Diana feel uncomfortable, judged, and critiqued. For Diana, this compromised her level of openness with the pediatrician. When asked to describe this particular conversation about alcohol in more detail, she says,

“I’m trying to think of the conversation we had. I think I was like, she said, ‘Have you ever drank?’ And I was like, ‘Yes,’ and she was li--, and I was like, ‘I was just being honest,’ cuz she kinda looked at me and she’s like, ‘That’s pretty young to start drinking...’ And it was just kinda like...”

“That’s like a moral judgment,” the interviewer offers.

“Yeah, it was more of like a ok but I’m going through a lot stuff right now and I don’t—it was just judgey, that’s the way I always felt and that was like really when I started really

having sex with my boyfriend. And I was like [finishing high school], and I had her and I was very much--he was my boyfriend for like 3 years, so it wasn't just like a random person but I was like afraid to like talk about that because of, I felt like she was gonna judge me for that too or give me that rude, snidey comment, so I just kinda kept quiet about that for awhile, until I was 18, I don't think I said anything, and then I stopped seeing her. Shortly after that."

By referencing the fact that there was a lot happening in her life at that time and that she was still very active and involved in school, she is implying that the reasons for her behavior weren't as maladaptive or as simple as the pediatrician's reaction implied. The behavior could have been viewed as a way of coping as well as experimentation, however, by not allowing for the complexity of the situation to be expressed and communicated by the patient, the physician compromised the trust and openness of the relationship. By ignoring or failing to elicit the life context of the behavior or situation, the interaction came off as judgmental and uncaring. After disclosing this behavior, the sense of judgment and authority Diana felt in the relationship kept her from sharing much more about her lifestyle—she consciously withheld important information from her physician because she had lost her trust. When asked what the ideal provider would have done in the situation, Diana responds,

"In the drinking sense? Either way, I feel like accepting the person's answer as is and maybe saying, oh well why or like maybe further delving into like, 'Ok, what was your experience with that,' like...asking me to elaborate more than saying like, 'Oh that's like not good'...and then just kinda like giving like suggestions about, like in general like, 'Well, you do know it's underage drinking,' or something like that, 'So as long as you're being careful and safe about like—you don't want anyone driving or like you know you

have to stay in moderation,' or you know just like helpful like guidance rather than like, cuz like in my experience, if you tell someone not to do something, then more often than not, they're gonna be like, 'I'm gonna do what I want!' So...I mean, I dunno, and as far as the sex I feel like she, an ideal person probably would have been comforting than like, 'Are you safe? Do you feel comfortable with the person you've been with?' Those kind of questions..."

She contrasts an authoritative, directive approach where the language the physician uses is commanding, such as “don’t do,” with one in which the physician elicits more detailed information about her habits, feelings, and experiences through open-ended questions and which allowed for the individual’s circumstance to gain the complexity of a unique and layered situation. The physician also offers information and advice about her choices, consistent with the consumerist model mentioned in the previous section. All in all, Diana calls for her ideal physician to have delved into her experience with the behavior to assess risk and offer guidance to ensure safety. Both of these behaviors adhere to the patient-centered clinical method in that the patient’s experiences, knowledge, and feelings are elicited and then a common ground is negotiated where the physician incorporates his or her input. However, as Diana’s choice demonstrates, this flow of events doesn’t happen automatically. What does not correlate with the patient-centered clinical method is the establishment of an environment in which the patient feels comfortable enough to share how her behaviors are a product and are experienced through her life context. Although the second pediatrician asks all the right questions, the way she asks them definitely seems to matter to Diana. The approach matters. She says,

“I feel like, for that instance, like for example, when I was younger, she was so judgey that it didn’t make me want to answer anything, whereas if she had been like, “Oh, do

you have a boyfriend?” “Like are you sexually active” like asking like in a conversation way rather than like a survey or like, “Do you smoke. Are you drinking...’I should feel comfortable enough to [share or answer her questions].”

Approaching the questions in the consultation as a “conversation” rather than a “survey,” Diana says, would have helped make the consultation environment more relaxing for her. Also, by posing the ideal provider as offering information and advice that offers corrective action (while still “accepting the person’s answer as is”), she acknowledges that her point of view isn’t the only one that’s important in this consultation, she shows a willingness to accede the fact of risk in her decisions—she’s willing to establish that common ground and perhaps “eclipse” her own views as McWilliams suggests physicians do. Although Diana expressed a willingness to engage in such a conversation where there were ways in which her behaviors could be considered unhealthy and unsafe, she felt her pediatrician was unwilling to meet her halfway and engage in that relational process. The pediatrician refused to recognize that there were ways her behavior could be lower risk and not just inarguably bad behavior. The pediatrician did not adequately engage into her emotions and feelings in this interaction. This lack of emotional engagement is a point of tension in the relationship because it made Diana uncomfortable enough to compromise the exchange of information.

Diana emphasizes that a conversational, personal, and emotional engagement is necessary to create an environment where she felt comfortable to share the information she needed to share. Although an open-question style is advocated in the patient-centered clinical method, the individualized aspects of this relational dynamic that are neglected. For example, in addition to more open-ended questions, Diana also poses humor as a way to address the power dynamic, diffuse the situation, and make her feel comfortable enough to share. Diana’s relationship with

her psychiatrist, however, provides a more illustrative conception of emotional negotiation for her unique situation. She recounts that after her mother voluntarily went to an institution to get better, Diana began her relationship with her favorite psychiatrist.

“I had a good relationship for like two years with my psychiatrist. She was so funny and so nice and when I tho—I felt comfortable enough that I could cry there which was nice because I hated crying in front of my dad, like he doesn’t do well with that. So I kinda felt like that was my place to like, “Everything sucks! I hate my life!” But she was always very encouraging that things were gonna get better...”

Her psychiatrist also functioned as a therapist for Diana, allowing her to express feelings about her life and what was going on. That wasn’t all, however.

“...She was informative about the fact that I might be having depression bipolar etcetera cuz my mom had like very small depression when she was like a teenager but then when she had my sister, that postpartum depression made the bipolar like that much worse so it’s kinda one of those things where she’s putting in my head that if you see any of these signs, this is when you have to be careful and this is when we have to start having, you see someone. Which is [why] once I started seeing the signs when I came to college, that was the first thing I was thinking of was like you have to remember she said like these five things and like you have—these symptoms, you need to go and like talk to someone and like maybe do medication or something.”

When asked how she was able to remember these “signs,” of which there were five, Diana answers,

“It was like generally like, will you cry for like no reason, are you like having—a day where you feel like this is the best day ever and I’m like on cloud nine and then the next

day for no reason you just feel like crap or like and like anxiety-wise she—I used to have a lot of anxiety she would like give me tips on how to like calm down and she was like if any of those stops working, like the counting, or I'd go out and shoot the basketball for awhile, but if any of those things stops working then I need, I need to like go see someone cuz it might be like, I might need medication to calm me down at first, to like work on those things so once all these things started kinda happening I remembered that these are some signs and symptoms and that's when I eventually went up here and got medicine.

Knowing the details of Diana's family history, the psychiatrist tried to create a plan for Diana that would prevent flares or destructive breakdowns in the future that her mother was unable to avoid. Although they were general signs, the tips the psychiatrist was able to offer were specific to Diana, such as playing basketball to relieve her anxiety. Granted in such a relationship such as that between a psychiatrist and a patient, emotional engagement is more natural since eliciting the life context of an individual is more generally accepted to be conducive to the treatment of the individual's mental disease or illness. However, as will be seen in the next chapter, such an approach was deemed necessary by many participants. By acknowledging the life context of the patient, the physician acknowledges the feelings the patient experiences, demonstrates concern, and thereby helps establish a sense of trust between the doctor and patient, without which, important information could be withheld out of fear of judgment.

Few of the previous levels of negotiation were engaged without engaging in some level of emotional negotiation. Within the same breath of Nancy emphasizing the need for a physical negotiation, she also calls for the context of her health to be explored, eliciting emotional engagement. When Beth highlights the fact that her physician's intellectual engagement allowed for the two to "just talk," asking her about school and her college experiences, she is also eluding

to an emotional negotiation in which her concerns and overall well-being was contextualized. Because it is through the life context of the individual that these interactions are viewed, dealt with and felt, an emotional negotiation is necessary to lessen the distance and asymmetric power distribution of most doctor-patient relationships.

Applying the Model

Through these excerpts, a model has been established that addressed the physical, intellectual, and emotional levels of negotiation in the doctor-patient relationship. Evident in each of these responses were both the tensions involved related to the imbalance of power in the relational dynamic and their remedial levels of negotiation. Nancy recognized the physicality of the medical encounter and the body language of providers provide both an opportunity to accent the power imbalance of the relationship or blur it by sitting and engaging the patient at “eye-level.” Beth and Jack both emphasized ways in which they were intellectually engaged by their physician, negotiating the sense of imbalance brought about the asymmetric distribution of knowledge inherent to the relationship. And Diana emphasized ways in which her providers created an environment in which contextual factors of her disease and experience were elicited and used. This engages her on the emotional or contextual level through which she experiences mental illness in her life, and helps establish the trust necessary for such a transfer of information to take place. The next chapter will further illustrate the various ways in which these levels of negotiation were enacted in a relational process by relating and analyzing a few of the more involved narratives of the student participants. By doing this, not only will the applicability of the model be expanded, as the dimensions or levels of tension and negotiation are extracted from new situations, but the significance of this model will also be illustrated. It will be shown that these are necessary levels or aspects of the creation of a clinical environment that addresses the

levels of tension and imbalance of power. For these illustrations, these various dimensions of engaging the patient in the doctor-patient relationship that the participants advocate, are not adequately addressed in the patient-centered clinical method.

Chapter Four: Student Narratives through the New Lens

So far, a model has been proposed that acknowledges the tensions that are involved or a part of the doctor-patient relationship and offers avenues in which the various levels of tension—physical, intellectual, and emotional—can be addressed through respective levels of negotiation. However, so far only one or two case studies of participant responses have been used to support this model. In order to establish the more widespread applicability and significance of this model, several more stories and participant responses will be discussed using it. Instead of exploring and analyzing the stories and specific sentiments of a participant only as far as they illustrate a certain aspect of the model, however, each story or participant's sentiments will be discussed as a whole, connecting various phenomena and feelings reported to the model as one narrative progresses. By doing this, it is hoped that the process of engagement or negotiation will be illustrated in an individualizing way, highlighting the ways particular and unique relational dynamics addressed the tensions involved in each of the doctor-patient relationships.

The first story that will be discussed is that of Ruby, the student that was first introduced at the beginning of this paper. As mentioned, Ruby was hospitalized after collapsing at a half-

marathon. She recounts a number of tensions involved in hospital culture, such as the donning of the hospital gown; family communication; and the limited time with physicians granted patients in large hospitals as well as those tensions involved in the doctor-patient relationship. The elements of her story that relate to the latter aspect of her experience will be the focus in this analysis.

Ruby

Ruby's experience at the hospital left her angry, confused, and afraid. After collapsing near the end of a half-marathon race, she was taken to the hospital, placed in the ER, then moved to a private room in the cardiac ward because it was thought that she had a heart issue. While recounting her three or four day hospital visit, she emphasizes the feelings of uncertainty, bewilderment, anger, and not knowing that came as a result of a lack of clear communication between her and her healthcare providers.

“I was told...that I could leave [the next] morning and some intern came in [that] morning and said, ‘Hey you look great! Levels are normal! ...You’ll get to leave in a couple hours.’ And I was like, ‘Yeaaaah! Whooo! Let’s go!’ And then like a real doctor came in and was like, ‘Ok, so we’re gonna hook you up to another IV; it’ll probably be like, maybe this afternoon or something,’ I was like, ‘Oh ok, I guess I’ll sit here for another 8 hours,’ And then, that afternoon, they came in and they were like, ‘Well, your heart looks great, but we’re gonna keep you overnight just to do another test in the morning.’ And I was like, “Uh...Okay...[laughs] lovely...So, I was really angry with the hospital because they were telling me all sorts of different things...I was a little upset by this point and I was really angry about all the—every time an intern came in they asked me what happened, again, and told me a different thing was gonna happen next.”

The conflicting messages, the lack of communication, and having to repeat her story over and over without getting any answers were extremely frustrating to Ruby.

“I was really angry and I was really mad that I had the intern because I felt like I was being told a million different things...I just felt like no one was giving me a straight answer and like everyone was making up differ—I dunno I just felt like no one was listening to me and everyone was listening to my parents and what they were saying...I felt so confused, I felt like no one, I don’t know, I just felt like why couldn’t the doctors take five minutes to come talk to me...why did they have to leave 9 hours to talk to us.”

Although she voices frustration, her tone in recounting these sentiments isn’t angry, but quietly desperate. Not only did the variety of physicians give her a variety of feedback and fail to communicate with her enough to feel as if she knew what was going on, but she was forced to recount her story, feelings, and experiences repeatedly which left her feeling ignored in the end.

“...So I was getting really frustrated because I couldn’t understand why they couldn’t look at my chart and see what happened, versus me telling the story five hundred times, I don’t even know the story, I don’t remember collapsing, I don’t remember going to the hospital, I woke up in the ER and thought my feet were broken. I don’t know why, like that’s why I thought I was there.”

This can be considered a lack of intellectual negotiation for Ruby is not engaged in a discussion that allows her to understand what is happening. She is merely treated as a potential vessel of information—information which could either be used or discarded. Added to this was the discomfort of her stay. After being transferred to the cardiac ward, Ruby is asked to perform a stress test in which the patient is made to walk, jog, and finally run on a treadmill with an increasing incline in order to monitor the performance of her heart. However,

“When you’ve run 13 miles and have been sitting in a bed for 48 hours, your legs are in a lot of pain. And so like, [the male technician] is like, ‘Keep going,’ And I’m like, ‘Do you not see my calves right now? Like my legs—’ And then the cardiologist walks in and is like, ‘Holy shit, like stop! Like you can see her legs like legitimately cramping.’ And I was like limping up the hill.”

What added insult to injury for Ruby was when she went down for her stress test, “[The staff were] like, ‘They want you to wear the gown open in the front.’ And I had a male technician and a male cardiologist and I felt just like very awkward like violated sort of... Cuz like I’m a twenty year old girl and this was like a middle-aged man.” The male technician was less-than-accommodating to her discomfort. When asked if she voiced her distress she responds,

“Yeah! I was like, ‘I feel so awkward right now.’ And [the male technician] was like, ‘Well, this is the only way—well, this is what happens when you complain about chest pain.’ And I was like, ‘I never complained about chest pain.’ And that made me really angry too because I felt like no one was actually like reading what happened to me and I felt like they were all just like assuming things. Cuz like, twenty-year-olds in general aren’t doing stress tests, like it’s typically like an older overweight adult to see how their like heart functions. And like, it was just like, ‘Oh this is what happens when you complain of chest pain.’ And I’m just, ‘What? What are you talking about?’ And then he was like, ‘Let’s see if you get to running.’ Did you read my file in any way shape or form? I’m here because of running!”

The feelings of violation she felt during her stress test as a result of her exposure and discomfort highlight the presence of a physical tension in the healthcare provider-patient relationship. The technician failed to acknowledge the feelings of discomfort raised as a result of what can be

considered a conventional garb for hospital environments and the discomfort that came from the test itself. For Ruby, wearing the garb in such a way, although functional for the test, was strange, exposing and distressing. In addition, Ruby continued to feel as if her experiences and voice were being discounted and ignored. The disregard for her recent history, as a participant in the marathon, led to extreme discomfort as her legs cramped during the stress test as well as discomfort from the level of exposure to the male technician. The physical tension of the hospital environment was accented by the relationship to this healthcare provider and the oversight of her cardiologist. It did not matter to the technician how she felt or why she felt that way, she had no choice but to undergo the stress test requested by her cardiologist—a stress test she believed to be unnecessary in the first place. She was very adamant that her heart was not the issue.

“...I was insisting that I didn’t have a heart defect. I’ve been a runner for ten years, never had any problems before, I knew I was dehydrated and I knew I didn’t eat right before but I knew that it was completely my fault that I was there. And everyone was like, ‘No, you have a heart defect...’ And I was like, ‘I don’t have a heart defect.’”

Despite her insistence, she remained in the cardiology ward and underwent cardiac tests. As a result, she felt as if her own experiences and feelings were ignored. So when she was made to endure the test and the technician’s inconsideration, and then the test turned out to be fine, she was even more frustrated,

“...the technician was just so plain rude! I was like, clearly I’m in like a lot of pain but it’s not my heart! So what do you people want? It just made me really mad and he was like, ‘Well, your heart looks great.’ I was like, ‘Yeah, it looked great yesterday too and the day before and the day before and the day before.’”

Overall, Ruby's stay made her feel uncomfortable, confused, ignored, upset, and afraid. She comments that the lack of communication, the dismissal of her own lifestyle expertise as an experienced athlete, and the disregard for her feelings made her feel dehumanized.

“And I was just like, [no one] knows what’s wrong. Just like, I just felt so confused I felt like everyone was treating me like this problem like this thing that needed to be solved and they weren’t actually taking into account that like I’m human. I had no idea what was going on, little freaked out, like...[laughs] they’re coming in telling me that like my heart is like freakin’ out and I’m just like, “What?” I don’t know I just I think that being a person should be the number one thing.”

“Yeah,” the interviewer offers, “A person with a history.”

“Yeah.” Ruby agrees, adding, “and paying attention to it, not just reading it on my chart.”

By emphasizing the fact that her feelings of discomfort, experiences as an athlete, and awareness of her own situation were neglected, Ruby points to a lack of physical, emotional and contextual, and intellectual engagement.

However, there was one physician at the hospital who addressed some of these levels of tension for Ruby. When asked what made the interactions with this provider different from the rest, Ruby answers,

“Well, he would come in and just be like, so he says, ‘Good morning,’ or ‘Did you have a good night?’ like just like talking as if I was a normal person before he’s like, ‘Ok, so this is your numbers and this is what’s happening.’ Like he would like, it was like he was trying to be like my friend before he was like, give me terrible news. And like, he was like, or if he had personal questions to ask like, he would be like “Oh—“ like he would ask my

parents to step out or something just to like making me feel as if it was about me and not about like my parents, and what they wanted. And like, he would be like, 'OK, well I hope you have a great day. I don't know what's gonna happen, cuz like I haven't seen the cardiologist or anything.' And like he would check-in throughout the day and be like, 'How ya doin?' And so like he was like friendly and like cared and I felt like he wasn't coming in cuz he had an obligation, I felt like he was coming in cuz he wanted to see how I was actually doing. Whereas I felt like other people were coming in because they felt like they had to come in.”

What mattered in this interaction was the concern the doctor had for Ruby personally, demonstrated by “coming in” and asking questions about her experiences and feelings. He also consistently checked on her throughout the day. His interaction style and attempts toward an emotional negotiation helped address some of the emotional tensions Ruby was feeling as a result of being treated “like a problem...or...disease” rather than “like a person.” This made Ruby feel as if he physically came into her room because he cared and helped alleviate some of her misgivings and discomfort. Later Ruby recounts her relationship with her specialist—a relationship posed in direct contrast with a few more demonstrations of intellectual and emotional tensions.

“And I went to see [my specialist] for the first time in the beginning of October, so that's over two months of having this. And not really knowing what is happening, like basically my doctors, they're like, 'If you drink alcohol you'll die, or like your kidneys will fail... 'And if you run, you'll collapse.' And I was like, 'Oh my god, I'm gonna die!' Like, I was like convinced that I had this horrible thing happening and that I was like dying slowly, and I was just like, What?...They were more concerned with my kidneys functioning

versus my levels coming back down whereas I was more concerned with my levels coming back down because I couldn't do any physical activity.”

These sentiments reflect both a lack of intellectual and emotional negotiation. She did not understand the importance of her “levels” to her kidney function—it was not explained to her. What she did understand was that her “levels” were keeping her from doing her favorite hobby—running. The lack of intellectual negotiation while at the hospital haunted her and her lifestyle for months. But no one approached the problem in this way until her specialist.

“But then I went to see him and he’s like, ‘Ok, so, this is what’s happening, this is why, and this is like how we’re gonna like fix it.’ And I was like, ‘You’re the first person that has like step-by-step broken down what is going on in my body.’ And so, I really appreciated that because like I didn’t know. And then, he...then we kinda discussed like the factors that could’ve caused it and...he made me feel like I wasn’t gonna be doomed for the rest of my life, and it that it wasn’t gonna come back, because, like, he told me that everything that has happened, was like a reasonable reason, for that to happen. So like, it was warm, I had been outside all day but the day before, like, I wasn’t hydrated. Like, it wasn’t like I had some unknown underlying like factor, which made me feel a lot better, because I needed that like—like I could run again and not just collapse. Which I really scared of. And so, and then like, he literally sat down with me and we made like a training plan. Which I really appreciated.”

Ruby had been afraid that her condition would be a chronic illness, when in fact, it was acute—once it went away, it would be less than likely to come back as long as she behaved more responsibly. The fact that she was unaware of this fact insinuates the level of consequence the intellectual tension or the lack of intellectual negotiation can pose. Her specialist, however,

relieves her fears and empowered her in their interactions by explaining or breaking down the process “step-by-step” in an intellectual negotiation. He also acknowledges her fears in a demonstration of emotional engagement when he “sat down and...made a training plan” with Ruby so that she could continue her beloved hobby. By “literally” sitting down, Ruby also implies a physical demonstration of the relational negotiation and so all three levels of negotiation are exemplified in a single doctor-patient interaction.

Ashley

Another narrative that illustrates some ways in which physical, intellectual, and emotional negotiation can be realized or the levels of tension addressed is that of Ashley. Ashley advocates an approach or relational dynamic she believes creates a clinical environment ideal for her—where the patient feels comfortable sharing more information and asking more questions. At a basic level, this call to elicit patient involvement, knowledge and experiences adheres to the patient-centered clinical method. However, Ashley also tries to explain how to create an environment conducive to this exchange of information. Her examples and sentiments outline her conception of the process necessary to create an open, communicative, and effective partnership with her physician. By contrasting her pediatrician and current specialist with another specialist she had before coming to UNH, she tries to illustrate ideal type of engagement necessary to create such an environment in the clinical consultation.

Ashley suffers from a gastrointestinal chronic illness that makes her feel quite sick after eating certain foods. The disease was undiagnosed for seven years. During that time, her pediatrician “suspected everything but” her disease—even going as far as to prescribe Ashley very strong antidepressants thinking that she was suffering from anxiety associated with an eating disorder. Ashley recounts,

“I had like gone through the motions with my doctor, like bloodwork on bloodwork, they’re like, ‘Oh you have an eating disorder, you’re making it up,’ Like all this stuff and I’m like I know I’m th--, I just know that I’m sick.”

She felt as if her first pediatrician didn’t even believe that it was something outside of a mental illness. She tries to express understanding in regards to his oversight, saying,

“I know that oftentimes, they used to teach in med school that [her disease] wasn’t that common, that it was...rare to see it, so if he wasn’t specializing I guess I could see, he was just my pediatrician.”

However, many of her sentiments and emphases can be traced to this seven-year long failure to correctly diagnose her disease. Her frustration finally found an end when she met her specialist,

“So, he eventually referred me to her and she’s a pediatric gastroenterologist so I went into the office [and] really lucked out. She tears off a piece of sterile paper and writes down like Celiac’s, Crohn’s and something else and she’s like, ‘I think you have one of these three things.’ Because she just listened to me, like, what I was dealing with, and stuff like that. So we kind of went through the motions with all the testing and everything and figured [it] out...[my pediatrician]was like do bloodwork and repeat it and repeat it and they thought that I was anemic but they didn’t tie that into [my condition] but the specialist was able to.”

Ashley seems to trace the solution of her medical mystery, not only to the medical or scientific expertise of her specialist, who was able to tie in the anemia to her condition, but also to her interaction style. Her specialist was able to determine the cause of her sickness “because she just listened to” Ashley. After narrowing down the possibilities, from there, it was only a matter of going “through the motions with all the testing” to determine the diagnosis. It was also presented

to Ashley in a simple straightforward way, taking out a piece of paper and writing down the possibilities. This demonstration of intellectual negotiation seemed to greatly please Ashley. When asked to explain what exactly was different about the interaction style of her specialist versus her pediatrician, Ashley recounts,

“She was just...a lot easier to talk to, I think too. She realized that like—she asked me, So how do you poop? And my PCP had honestly never asked me that. But it was like, Oh! ...Well! Like, let me tell you. She clearly has like a lot of expertise on it and she was just like really easygoing, like friendly, easy to talk to. Like she actually like got to know me, like found out about what sports I was into and stuff like that....Yeah, like she really got to know me and then if like I had like something else she’s be like, ‘Oh, and how’d that end up going for you?’”

Not only did the specialist have enough expertise to ask Ashley about her bowel movements, but she engaged her and Ashley’s personal context and her experiences. She created an environment where Ashley felt at ease by asking about other interests Ashley had and following up on what was shared from previous visits. She further describes this interaction style and the way it made her feel,

“Yeah, it was like, I was, like, a real person to her and it wasn’t like, you know, the doctor shuffling in, saying blah-blah-blah-blah [rips piece of paper motion] here ya go! Like ripping off the script and handing it over to me. It was like she sat down and listened, she wasn’t always on time but even if she was running late she still spent all the time with me that I think I needed. So I never felt like rushed with her.”

Instead of running down a scripted list of questions, in what can be construed as a demonstration of physical negotiation, the physician physically settles down as if for a lengthy exchange and

created such an environment where Ashley felt heard. The interaction was thorough so that she didn't feel rushed whereas with her current physician, she feels the interactions are hasty and superficial. When asked to compare her current specialist to the one she had liked, Ashley responds,

“Um, I think it was...the time she spent with me versus him. And it's...also that...he's kinda just like, you know, an older doctor, an older gastroenterologist so he'll ask...a few questions. Like I feel as if I'm just waiting for him to ask stuff so I have to go...out of my way to tell him stuff and then I leave and I'm like, 'Ohh. I just thought of that.' Cuz it wasn't like he eked it out of me or whatever.”

Her sentiments reflect the issue mentioned in the literature review that an authoritative interaction style, where only the physician is in control of the relational dynamic, limits the exchange of information and the quality of the interaction. Ashley felt as if she were “waiting for him to ask” questions and then had to go “out of [her] way to tell him” information. As a result, she felt as if she was more likely to forget important questions or information. Also Ashley's call for a relational dynamic or clinical environment that was more conducive to a more open and through communication style is insinuated by her reference to the physician's failure to “ek[e] it” or her questions, knowledge, and feelings out of her. When asked what she meant by this, Ashley answers,

“Thorough. Just like, by how many questions she asked, the variety of questions asked, stuff like that... just really kind of like investigating every single angle, whereas he was just kinda like, 'Ok, tell me what happened,' then he's like, 'Oh alright let's try this medicine,' then he'd be like, 'Oh, well, we could always like repeat your scope,' but it...you know what I mean? It's kinda like thinking out loud, sort of not asking me how I

felt about stuff, cuz like if she wanted to put me on a medication, she'd be like, 'Well how do you feel about that?' And she'd tell me what it was. But when he would send me on my way, he wasn't very clear. So I actually had to ask, like the secretary, I'm like, 'Wait, do I actually have a prescription to pick up?' And she'd be like, 'Oh yeah!' So I didn't under--And I didn't really know what it was for. So I was really conf—and I actually did end up like, the prescription ended up messing up my system a little bit so I didn't like it. And then I had to go back in and say, 'Oh this didn't work for me. Can I have something else?'"

By not asking her “how [she] felt about” her experiences or the treatment, Ashley felt an important aspect of her prognosis, the emotional negotiation, was being neglected. She also points to a lack of intellectual negotiation when she mentions that she did not really understand or was not informed what exactly the medication was for. Her quotes and sentiments also reflect the absence of an attempt to negotiate a common understanding of the situation. The current specialist simply offers courses of action after hearing her story. The negotiation process, both emotionally and intellectually, is completely bypassed. She traces this lack of emotional, personal, and intellectual engagement to the failure of her medication. When asked to elaborate on her ideal interaction style for her physician, Ashley says,

“Just a variety of questions and just trying to find out what's there that's not on the surface, I guess. Like really working hard to find the cause of the problem and how it's making me you feel and how it's affecting your life and stuff like that.”

Again, she emphasizes the context of her disease, emotional negotiation. Without engaging her at this level, she says her current specialist just doesn't “seem too concerned.” In fact, she seems to consider switching providers because of this shortcoming. When asked why this level of

negotiation, eliciting her personal feelings and experiences was so important in the clinical interaction, she answers,

“Um, I just think that like for me personally, health problems have been interfered with my life so much, and that like a lot of my friends have like never had more than a sore throat. I mean, I’m so happy, I would not wish this upon anyone but it’s nice to know that like someone is going out of their way to ensure that like my disease is like being controlled ok. Cuz I know I can have problems with like fertility and stuff like that down the road for having it undiagnosed for so long. But like the doctor I have right now, it’s just not something I would wanna talk about with him....I don’t know if he’d be able to... really talk about it with me that well. And, I mean, that’s not a concern, like god no not right now, but down the road...”

The emotional engagement helps create a sense of thoroughness in the interaction for Ashley. Even questions such as ““Ohhh! So how’s school going?...how’s you major, what do you want to do?”” helped demonstrate to Ashley that the physician cared about her condition, helped to “eke” out the information about the patient’s experiences and feelings, and also facilitated a “meeting of minds” in deciding the course of treatment. There is certainly a process or procedure necessary to create an environment in which Ashley felt as if she could be open and communicative and helped make the doctor-patient partnership more effective.

Jean

Although both the narratives of Ashley and Ruby heavily emphasize the emotional and intellectual levels of negotiation in similar ways, one interview that at first seemed to challenge the model proposed in this paper was that of Jean. Jean’s account did not follow a chronological order, and so her accounts will be related considering the important providers in her life. The

narrative of Jean emphasizes the need for a fluid relational dynamic that allows the doctor-patient relationship to be co-constructed in a unique and flexible way that allowed for the compartmentalization of both her disease and her care. This compartmentalization also adhered to the levels of negotiation proposed by the previous narratives.

Jean suffers from a variety of mental and other chronic illnesses. She laughs, “Oh gosh, there have been so many doctors...” Although she has only seen two pediatricians, “I’ve seen...like fifty psychiatrists.” At the time of the interview, she had finally found a psychiatrist, psychologist, and primary care physician who she really liked, however, she likes each of them, for very different reasons. When recounting her relationship with her psychiatrist, Jean says,

“Um...I see her like once a month, cuz she...kinda pisses me off a little. But she does her job really well and I’ve had so many bad experiences with psychiatrists that it’s just like...she does her job right, so I’m sticking with her.”

When asked why the relationship sometimes frustrated her, Jean responds,

*“She’s really...anal retentive and it’s kinda like her way or the highway...and it really should be my way like, she should be working to accommodate **me**.”*

Because the psychiatrist is very authoritative, Jean can sometimes feel un-accommodated.

Despite this, Jean feels she is still able to say that her psychiatrist performs her job correctly and does not seek to replace her. As a patient with mental illness, this certainly seems to go against much of what has been discussed so far—the fact that emotional engagement and the transfer of power is necessary to create an effective doctor-patient partnership. However, Jean goes on to explain why she has stuck with this particular physician despite her shortcomings in her ability to engage in an emotional negotiation,

“Like she’s good, she’s good at medications, which is her job. So it’s good that she’s good at that. She’s not so good at, at like...”

“Talking?” the interview offers.

“Yeah, like she’ll ask me questions, and I almost...don’t wanna answer them...Like questions about mental health and stuff. Like that stuff that I’m comfortable talking about with my psychologist because she’s like a real person [Laughs] Whereas [my psychiatrist] is just a doctor. I think sometimes she tries to think that like she has the mind of a psychologist so she’ll start recommending things that a psychologist should be focusing on. And she’s usually wrong about those things, but she’s always right about medication.”

For her psychiatrist, Jean almost consciously rejects her attempts toward emotional negotiation. She offers as a reason for this reaction as the lack of expertise or skill the psychiatrist has in the softer aspects of mental health. Where her expertise does lie is in the more “hard” scientific aspects of her treatment. When asked if she felt this reaction or preference for the type of information she shared with her psychiatrist had something to do with personalities of the physicians, she agrees and goes on to say,

“Right. Some like, feel like psychiatry and psychology kind of like, meet in the middle. Like, you need to be good at one to be good at the other. Or, at least, that’s the impression that I get. And there are other ones who are just like, no, I’m here for your meds...And I like that. Like, I don’t need like another therapist, can we please just talk about medication.”

Instead of dismissing certain levels of negotiation, she compartmentalizes her needs and distributes them among her physicians. Although she rejects her psychiatrists attempts to engage

in an emotional negotiation, she still seems to fulfill that need elsewhere—with her psychologist. Jean likes that the psychiatrist is simply there to recommend and prescribe the correct medication. This is not to suggest, however, that there is a complete absence of a negotiation process in this relationship. When asked to elaborate on a comment Jean mentions, (“help like a doctor should,”) Jean explains,

“...I started having visual hallucinations which is not a side effect of my kind of bipolar...the visual [hallucinations are] a new problem. I had recently started with a second sleep medication to help with insomnia and she just like, [my psychiatrist] said, ‘Flush them down the toilet, never take them again,’ even though there’s only a 1% report of people who have visual hallucinations.”

Her psychiatrist demonstrates a capacity for negotiating the patient’s expertise in what she is going through in her personal experiences. Without questioning Jean’s account of her own experience, the psychiatrist instructs Jean to a proper course of action. Despite her tendency to be authoritative in her interaction style, Jean’s psychiatrist is still able to deal with and prescribe Jean’s numerous medications in an effective way.

Intellectual negotiation is also insinuated in her satisfaction of the medication-focused dynamic with her psychiatrist. The way she compartmentalizes her mental illness as “medication” based and “mental health” or living with the disease is congruent with this functional interaction style. The psychiatrist had to accept that Jean would not share aspects of her disease unrelated to the medications, that it was alright to compartmentalize both her disease and care. Although Jean is annoyed with her psychiatrist’s authoritative tendencies, she is not considering finding a replacement for this provider and so demonstrates her satisfaction with the

relationship because the psychiatrist's intellectual negotiation allowed her to fill only the more concrete medical needs of Jean.

To see how another level of negotiation fit into Jean's account, her descriptions of her other healthcare providers, mainly her psychologist will now be examined more closely. When relating the function of her psychologist, Jean goes as far to suggest that "everyone" should have psychological therapists,

"You vent in the appropriate friend way but you don't spill, like, and just go on and on for hours about how much you life sucks. Therapists, that's their job, they just take it! Yeah, and then they give you advice about it."

Jean finds the relating of her personal context, emotional negotiation is quite a necessary part in her healing process, especially as a patient with mental illness. However, she finds that these needs are addressed in her relationship with her psychologist. She finds these interactions so helpful that she even recommends such a relationship for "everyone." Because her psychologist engages with her on this level, she able to offer personal coping mechanisms.

"My therapist...gives me a bunch of ideas and techniques for how to handle like when I flare or if I end up being manic...[for example] if I feel a panic attack coming on, lie down...I have very, some people's panic attacks are more like...calm on the outside but like inner...Mania. Mine show on the outside as well. So I've had times where people thought I was having a seizure. And I almost always pass out at the end of them and that's how I've gotten like three of my concussions. So, if I feel it...lie down. Even if you're sitting in a chair, just lie down cuz it's gonna get bad."

In a very intimately detailed example, it is clear how this level of negotiation and engagement contributed to the personal nature of the psychologist's recommendations. Her advice on how

Jean can prepare herself feel quite personal and specific to Jean, to her previous experiences and tendencies. Jean recounts,

“I used to cut so when I feel it coming on, I have a locked box that’s like hidden in the back of my closet where I keep my medications and stuff and then I also have my pillminder which I use during the week. But if I feel that coming on, I’ll put like, the scissors, my exacto-knife, all sharp things, in the lock box because if I’m feeling really shitty, I’m not gonna have like the strength, or the energy or sometimes the consciousness to get up, go to my closet, pull all the shoes and clothes off the lockbox, punch in the code, turn the dial, and then cut. And that’s something that she told me to do.”

When asked to elucidate the sort of topics that are included and important to the way the psychologist engages with Jean, she says, in addition to the coping strategies,

“I still talk about...the medical and mental health things I’m going through, but I also just talk to her about my relationships. And my academics, stressors in my life, and that’s good to do with your psychologist because they know your medical background too, like if you’re sick. And they can identify like...this is going to make you flare. Yes, you’re going to have a flare up and be incapacitated for a week and a half. So let’s act on this now!”

By interacting her on an emotional, contextual, and intellectual level, the psychologist helps Jean handle the challenges her mind and body throw at her. Jean also insinuates how this aspect of her conditions is layered and linked with those more scientific aspects addressed by her psychiatrist,

“But [my psychologist] can link all the things together and like she converses with my psychiatrist...and they have a very good communication. Cuz psychiatry and psychology...are linked. Like therapy and the meds, especially if it’s mental illness.”

Although Jean does not require all levels of negotiation to be the focus of any one doctor-patient relationship, they are addressed in the ways and levels unique to her through a multiple relationships with her providers. She highlights her preference to compartmentalize the roles of her providers while in a tangent highlighting her call for honesty in the partnership. Although Jean still emphasizes that levels of negotiation are necessary to the doctor-patient relationship, she also acknowledges that everyone has their strengths and weaknesses,

“So I mean, like if you can’t fix it, like I don’t...just don’t do like...don’t try and be like the best friend AND this And that and do All that and say, “Oh, I’m gonna fix your problems...” if you can’t. If you can’t fix it, like I—don’t...Like if you’re a doctor, do a doctor’s job, like psychiatrists, your meds, almost always, some psychiatrists, do...some psychology things...Cuz they have both of those licenses or...whatever. But I like my therapist to do my therapy, my psychiatrist to do my meds and then just like my regular doctor for regular normal, non-chronically ill person things.”

Jean’s sentiments exemplify how the negotiation process must be fluid. For her, although required, emotional negotiation was not a necessary part of some relationships. Her relationship with her psychiatrist did not need the emotional level of negotiation because this need was fulfilled by her psychologist. Instead, her psychiatrist satisfied Jean’s need for an intellectual negotiation in which it would be appropriate to simply seek the medical expertise of this physician. This compartmentalization of her own disease was also accepted by the psychiatrist who simply worked with Jean’s therapist to ensure Jean received the care she needed.

The narratives of Ruby, Ashley, and Jean show ways in which various levels of negotiation were demonstrated in ways unique to the preferences of the students relating their experiences. Ruby’s story highlighted how each of the levels of negotiation could be

demonstrated and the importance of each to the comfort and care of a patient. Ashley emphasized emotional negotiation above all for she blamed her misdiagnoses on the lack of thoroughness or absence of such contextual engagement. And Jean highlighted the importance of fluidity and for an active negotiation process that accounts for the individual and unique wants and needs of each patient and the strengths of the providers. In each of the narratives, approaches were described that emphasized the various ways in which the patient was engaged in a relational dynamic process. This process occurred on physical, intellectual, and emotional levels in ways that were unique to each situation and preferences of the people involved.

Conclusion

Summary

In the doctor-patient relationship, there is an inherent imbalance of power that affects the effectiveness of care and communication. As the case study from San Francisco Bay illustrates, the prevalence and tendencies related to this uneven distribution of power in the relationship can leave the patients feeling uncomfortable to ask questions, clarify instructions, or voicing discomfort. To shift the concentration of power, approaches toward the development of an open and more effective a doctor-patient partnership have been described. As one of these approaches, the patient-centered clinical method advocates for a doctor-patient interaction in which the means towards a power-shift favoring the patient was mainly a more balanced exchange of information. According to the sentiments collected during this project, while this seems to be a step in the right direction, how to facilitate such an exchange becomes key—if the patients do not feel comfortable sharing more information or this information is not solicited in an encouraging and individually specific way, the interaction is less likely to be reported favorably

by patients. As Ashley puts it, this kind of open exchange of information must be “eked” out of the patient, overcoming the inherent tendencies towards a physician-centered interaction and tailoring the approach to each individual patient through a negotiative and relational process.

Although the empowering partnering approach attempted to outline an interaction process in which the development of the relationship is theoretically described, its presentation remains too vague to give meaningful illustrations of how to enact such a model in the relational process of the consultation. Participants in this study, however, were able to recount aspects of interactions in which physicians created an environment conducive to more open communication. According to their sentiments, to create this environment takes a process of negotiation that addresses the tensions in the doctor-patient relationship through the physical, intellectual, and emotional levels of negotiation directly related to these tensions.

The ways in which these levels of negotiation were demonstrated were unique to each individual and their situation. For Nancy, the nursing student, an important part of this negotiation process was a physical demonstration of engagement between the patient and provider that sought to level the interaction. Sitting at “eye-level” and having the provider not look down at the patient lessened, for her, the sense of authoritarianism. For Jack and Beth, an intellectual exchange in which Beth felt the physician was making an effort to make her understand and Jack felt free to explore his own curiosity were their favorite aspects of consultations between them and their preferred provider. Jean pointed emphasized the fact that she could compartmentalize her care of her mental diseases into both a strictly biochemical phenomenon and something she deals with on a daily basis. For many participants, especially Diana and Ashley, emotional negotiation, or the exploration into the lived experience of the patient’s condition or overall health, was a necessary part of the diagnosis, prognosis, and

healing process. This helped Diana put herself in the context of her family's mental health history and allowed her seriously consider those implications as she plans how to care for herself in the near future. And Ashley felt that a contextual exploration could have helped her physicians diagnose her illness sooner.

The narrative that best demonstrates the importance and impact of the doctor-patient relationship is that of Ruby. Ruby's narrative highlighted ways in which the physicality of the clinical environment, such as the stress test, created tension and resulted in feelings of dehumanization and violation. She also highlighted how a lack of intellectual negotiation resulted in feelings of bewilderment and misinformation during her hospital stay and upon discharge. She had thought her condition was chronic and that she would never be able to run again. And a lack of emotional engagement left Ruby feeling unheard and ignored. Her unfortunate experience at the hospital is posed in stark contrast to her interactions with her specialist, who did engage her to address these levels of tension. He helped her understand and helped get back to the things she loved doing.

Based on the results of this project, it is clear that the sentiments of the participants seem to reflect the relational process across three levels of tension and negotiation, as opposed to the transfer of power proposed by the patient-centered care model. And although practical applications of this model have rarely been suggested, the students offer ways in which aspects of this model were easily applied in their own situations. Although the physician's technical or "hard science" expertise remains to be a central concern for the patients interviewed, the communication and interpersonal skills of the physician have also become essential to the development of an effective and rewarding doctor-patient relationship. For it is through the use of these skills that the patient's unique needs in the consultation can be assessed. "I'm a person,"

not a “problem,” Ruby says, and to be treated as such is to be listened to and compassionately and appropriately accommodated. Her statement is a call to look at the multifaceted aspects of not just living with a condition but also how the illness is experienced, how it is understood, and how it feels to physically be in the consultation or clinical environment. To apply these findings, it seems the Medical College Admissions Test is taking a step in the right direction—this study adds another reason for an increased focus on these communication and “people” skill sets, as well as increased exposure to patients, in the education of the physician.

Future Directions for the Doctor-Patient Relationship

Despite the potential of this model, it has yet to be fully cross-examined and developed. In order to better understand the challenges and various approaches to an effective and satisfactory doctor-patient relationship, the perspective of the other partner in this dyad must be explored and viewed in conjunction with that of their patients. How do providers view the development of such a relationship? Do they see a relational process as well, or would they describe an interaction that adheres more to the patient-centered clinical method—as an exchange of information? Do they recognize similar levels of tension related to the inherent power dynamic in the doctor-patient relationship? And most importantly, how does this affect care and patient satisfaction? Although similar explorations have been undertaken, again, few studies have approached this topic with a narrative focus as this study has done with the patient perspective. Once personal experiences and sentiments have been received and analyzed, some direct participant observation with the participants of the study would provide an abundance of data to cross-examine these findings. Time constraints and the recruitment method prevented direct shadowing of the participants of this study while in consultation with their physicians.

However, if future studies were to recruit at a particular practice rather than on a removed university practice, this obstacle may be avoided. By both interviewing physicians in addition to patients and sitting-in on consultations, this negotiation model can be adequately challenged and critiqued into a more useful and applicable approach to the doctor-patient relationship.

Another avenue of research, somewhat removed from the study, was raised by the results. The statistics from UNH Health Services point to a wide disparity between young men and women in the use of this facility. After talking with the staff, many suspect that the different health-seeking behavior between the sexes is a cultural phenomenon, but few would venture to speculate much more. Unfortunately, this study's recruitment methods also prevented an adequate representation of what could be uniquely male sentiments concerning the doctor-patient relationship. Could their sentiments concerning the doctor-patient relationship be related to different health-seeking behaviors? Even if not, perhaps exploring it this way would begin to chip away towards the answer to this phenomenon and rightfully complicate approaches to the doctor-patient relationship further. Recruitment would have to take place in more gender-neutral areas and a screening process would be necessary to gain a wider distribution of participants. By gaining the insight from more male participants and also shadowing consultations involving the participants and the physicians they describe, the answer to these questions can begin to be explored and help the various wellness programs at the university's health facility attract a wider population and aid in the development of an effective and communicative doctor-patient relationship. Uncovering the tensions associated with being a male versus female patient may also help complicate approaches towards a more effective relationship. Unfortunately, due to recruitment methods and time constraints this study was unable to pursue this thread of inquiry.

Despite the study's shortcomings, with the information and stories collected, the development of an effective doctor-patient relationship has been further illuminated and will hopefully contribute to the improved implementation of a sound partnership model. Stepping away from the technicalities of this proposed model and looking at the implications, it seems the place to start improving patients' clinical experiences and clinical outcomes in general is with medical education. Young doctors must be taught that the medical consultation has enough of a degree of complexity to be called an art form. It cannot be simplified to a simple transfer of information between doctor and patient. The relationship is constructed around various levels of tension, some of which are unique to each individual. Without acknowledging these levels of tension and responding to them through a negotiative process, important information can be lost, patients can be left feel neglected, ignored, or dehumanized. Luckily, the patients know what they want and know what a good consultation feels like. The study goes to the source in medical education by eliciting the perspectives and preferences of the patients themselves. Although more research is needed to more fully illustrate the art of the consultation, the study's methods and analytical approach are a step in the right direction towards the construction of a partnership model that acknowledges the inherent power imbalance of the doctor-patient relationship, expounds upon the multi-leveled approaches towards bridging the power gap between the physician and patient, and leaves room for the individualization necessary to help each patient, each person, the way they wish to be helped.

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APPENDIX A
RECRUITMENT POSTER

Health Services



Participants Needed for Research in Health Provider-Patient Relationships

PARTICIPATION INCLUDES:

- A one-on-one interview about your relationships and experiences with doctors, nurses, and other healthcare providers (30-60 minutes)
- \$20 Simon Giftcard* following the interview

For more information about this study or to participate, please contact:

Monica Stewart
UNH Anthropology Department
(813) 787-2949 | mce43@wildcats.unh.edu

Confidentiality will be absolutely maintained

This study has been reviewed by, and received ethics clearance through the Institutional Review Board of the University of New Hampshire.

APPENDIX B

CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

TITLE OF RESEARCH STUDY

“The ‘Doctor’ and the ‘Patient:’ An Exploration into the Roles Assigned”

My name is Monica Stewart and I am an undergraduate pre-med student in the Department of Anthropology at the University of New Hampshire-Durham.

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this research is to explore the roles patients assign to both healthcare providers and themselves and why they are assigned these roles. I hope to gain a better understanding of the complexities and the challenges that provider and patient communication and collaboration face. The research will involve the exploration and discussion of behavior among healthcare professionals and patients. I plan to interview at least 7 individuals.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

Participation in this study will involve an approximately 30-60 minute interview. This interview will be recorded for transcription purposes only. After the recording has been transcribed, it will be destroyed. You will be asked questions pertaining to your perspectives on patient, doctor, and nurse roles in healthcare in an open-ended interview.

WHAT ARE THE POSSIBLE RISKS OF PARTICIPATING IN THIS STUDY?

I will be asking questions on the type of interactions you and your healthcare providers share. No identifying health information will be recorded or requested. Because I will be asking about personal experiences with healthcare, I must warn that emotional risk might be involved if a sensitive or embarrassing subject is discussed during the interview session. You also should understand that the researcher is required by law to report certain information to government and/or law enforcement officials (e.g., child abuse, threatened violence against self or others, communicable diseases).

WHAT ARE THE POSSIBLE BENEFITS OF PARTICIPATING IN THIS STUDY?

Possible benefits of participating in this study are those associated with a self-reflection on healthcare professional and patient communication. It may raise some insights within the participants themselves on how to better improve communication between the two. The study may also help improve communication within the current model of healthcare. Anyone who engages in the biomedical healthcare model would stand to benefit from improved communication with their doctors. Also students of the health services such as nursing and pre-medical students would stand to benefit from the different perspectives this study may offer in the roles for which they are training to attain.

IF YOU CHOOSE TO PARTICIPATE IN THIS STUDY, WILL IT COST YOU ANYTHING?

The researcher will ask for 30-60 minutes of your time. However, the time commitment is variable depending on the preferences of the participant.

WHAT OTHER OPTIONS ARE AVAILABLE IF YOU DO NOT WANT TO TAKE PART IN THIS STUDY?

You understand that your consent to participate in this research is entirely voluntary, and that your refusal to participate will involve no prejudice, penalty or loss of benefits to which you would otherwise be entitled.

CAN YOU WITHDRAW FROM THIS STUDY?

If you consent to participate in this study, you are free to stop your participation in the study at any time without prejudice, penalty, or loss of benefits to which you would otherwise be entitled.

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

The researcher seeks to maintain the confidentiality of all data and records associated with your participation in this research. You should understand, however, there are rare circumstances when the researcher is required to share personally-identifiable information (e.g., according to policy, contract, regulation). For example, in response to a complaint about the research, officials at the University of New Hampshire, designees of the sponsor(s), and/or regulatory and oversight government agencies may access research data.

My data will refer to you and any identifiable locations by either pseudonym or letters that will be chosen by participants unless you wish to be recognized for your participation. The “key” that will identify your name with this initial or pseudonym will be saved on a disk and stored under lock. Interviews will be recorded for the purposes of transcribing the conversation onto a word document. The recordings will be kept in a password enabled safe until they can be safely transcribed. After transcription, the recordings will be destroyed. These word documents will be kept under a password-enabled file of a password-enabled computer. Names and locations will be changed to protect the identity of participants. These data will later be coded for qualitative analysis, searching for recurring themes in the answers to the questions and the interactions between the health practitioners and patients. The results and quotes, if used, will be reported anonymously. The research will extend into a senior honors thesis project.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY

If you have any questions pertaining to the research you can contact me by email or phone:

Monica Stewart

Email: mce43@wildcats.unh.edu

Phone: (813) 787-2949

Or you may contact one of the research advisors:

Dr. Joe L.P. Lugalla

316 Huddleston Hall

Phone: (603)-862-1847

Fax: (603) 862-1131

Email: jlpl@unh.edu

Dr. Sara Withers

317 Huddleston Hall

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Judy Stevens, RN
Community Health Nurse
12 Ballard Street
Phone: (603)-862-3823
Fax: (603)-862-4259

If you have questions about your rights as a research subject you can contact Dr. Julie Simpson in UNH Research Integrity Services, 603-862-2003 or Julie.simpson@unh.edu to discuss them.

I, _____ CONSENT/AGREE to participate in this research study-
interview

Signature of Subject

Date

APPENDIX C

INTERVIEW GUIDING QUESTIONS

This study will seek to explore the roles assigned to healthcare providers by their patients and what roles patients assign themselves. Please feel free at any time to stop the interview or skip a question. And do not feel obligated to give more information than makes you feel comfortable.

1. What is the role of a doctor/nurse/physician assistant/healthcare provider?
2. How would you describe the ideal doctor/healthcare provider?
3. How would you describe your doctor/physician assistant/nurse practitioner? What roles do they play? (Offer terms such as teacher, coach, car mechanic, and ask to clarify).
4. How many times have you been to health services or other healthcare facility in the past 12 months?
5. At your last visit to a healthcare provider, how would you rate your doctor on helpfulness on a scale of 1-5, 5 being extremely helpful, 1 being not at all helpful.
6. Overall, how has your experience been with healthcare providers in general?
7. Do you do anything to prepare for appointments at a clinic?
8. What part do you play as a patient when you go into a health office? What is your role?
9. What power or authority do you feel you have as a patient when you go into a health clinic?
10. Tell me about your best doctor-patient experience. What about your worst?

