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**Directing the Patient's Approach:
How Patient Characteristics Influence Physician Disclosure**

By

Jose Matthew Mata

B.S. Hope College, 1997

A thesis submitted in partial satisfaction of the requirements for the degree of

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Spring 2000

Directing the Patient's Approach:
How Patient Characteristics Influence Physician Disclosure

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By

Jose Matthew Mata

Table of Contents

Chapter 1: Overview	1
<i>The purpose of this study is to examine how patient characteristics influence information disclosure by physicians. The first research question seeks to identify the types of information that physicians try to obtain from patients. The second research question investigates how physicians use this information to talk to the patients about their illness. The last question seeks to characterize the nature of the physician-patient relationship from the perspective of the physician.</i>	
Aims of the Study	1
Research Goals	2
Summary of Contents	3
Major Findings	4
Chapter 2: Background, Literature Review, and Introduction	5
<i>There are many models that can be used to describe the physician-patient relationship, and information disclosure is an important component of many of these models. Patient characteristics have been shown to influence information disclosure, with certain groups of patients tending to receive less information. These situations may contribute to patient dissatisfaction with their physicians and discrimination in medicine.</i>	
Models for the Physician-Patient Relationship	5
The Issues of Information Disclosure and Informed Consent	11
Effect of Patient Characteristics on the Physician-Patient Relationship	16
Discordance Among Physicians and Patients	20
Discrimination in Medicine	23
Impact of the Physician-Patient Relationship on Health Outcomes	26
Chapter Summary	30
Chapter 3: Methodology	33
<i>Interviews were conducted with Family Practice physicians in Alameda County, California, and clinical vignettes were used as an interview tool. The vignettes described two different patients and two different clinical situations. The physicians were asked to read the vignettes and then asked of a series of questions to ascertain how they would talk to each patient about their medical condition. The interviews were analyzed using the Grounded Theory method, a systematic and inductive process by which theories are abstracted from data.</i>	
Research Questions	33
Study Design	34
Development of the Study Design	36
Recruitment Process	37
Interview Process	38
Data Analysis	39
Preconceptions Going into the Study	44

Chapter 4: Overview of Results	47
<i>Recruitment letters were sent to 100 physicians, resulting in a sample of 24 physicians. Four of the physicians were minorities, and 7 of them were women. There was an average age of 52 years, and an average of 21 years in clinical practice. Nineteen of the physicians were in private practice, 2 worked in community clinics, and 3 worked at Kaiser Permanente. The physicians reported spending an average of 20 minutes with each patient and typically saw about 24 patients each day.</i>	
Response Rate	47
Description of the Physicians Interviewed	47
Overview of the Results	48
 Chapter 5: Owing the Disease	 50
<i>This is the first theory that arose from the Grounded Theory analysis, and it describes the process that physicians engage in when they gain information from their patients. Physicians make judgments as to whether patients are owning their disease by evaluating whether the patient has accepted the diagnosis and is willing and able to take the steps necessary to manage their illness. Physicians evaluate things such as motivation, stressors, and the patient's knowledge of the disease to make these judgments.</i>	
Assessing understanding	50
Finding out what the disease means to the patient	54
Assessing motivation	56
Making inferences based on past experience	60
Assessing stressors	63
Assessing willingness to accept the plan	65
Assessing the patient's resources	66
Chapter Summary	68
 Chapter 6: Presenting the Illness	 69
<i>This is the second theory that arose from the Grounded Theory analysis, and it describes the process by which physicians talk to the patients about their medical conditions. During this process, the physicians attempt to narrow the differences in understanding between them and the patients. The physicians also make decisions as to whether they must motivate or console the patients based on whether they feel the patients are approaching their disease appropriately. Throughout this process, there is an underlying tone of the physician trying to convince the patient to see things their way.</i>	
Approaching the patient	70
Softening the blow	72
Educating the patient	74
Tailoring the explanation to the patient	77
Motivating the patient	79
Enlisting the family	81
Having faith in their ability to communicate	82
Chapter Summary	84

Chapter 7: Directing the Patient's Approach	86
<i>This is the third theory that arose, and it describes the nature of the physician-patient relationship from the perspective of the physician. A concept that arose often in the interviews was that of the physician as the leader. The physicians felt that they had the knowledge and the ability to process medical information and it was their job to pass their knowledge to the patient. The physicians often talked about having to persuade patients to do what was best for them, and they talked about ways that they try to control the information that the patient is exposed to from outside sources.</i>	
Negotiating the agendas	86
Deciding if the relationship will work	88
Controlling the outside influence	90
Persuading the patient	92
Chapter Summary	93
Chapter 8: Discussion and Conclusions	95
<i>The physicians in this study displayed a strong psychosocial approach to patients, and they were genuinely concerned with helping their patients improve their health. However, physicians appeared to believe that it was more important to help their patients get well than to grant them the opportunity to make decisions for themselves. The physicians used the power imbalance in the relationship to persuade the patients to adopt a particular approach. Physicians make decisions as to how well patients can make their own medical decisions, and assumptions play a significant in these decisions.</i>	
The Role of Assumptions and Preconceptions	96
The Psychosocial Approach	100
The Role of Personality	105
The Patient's Decision-Making Authority	107
The Issue of Power Imbalance	108
The Problem of Time Constraints	110
The Issue of Emotional Reactions to Patients	111
Clinical Implications of This Study	112
Limitations of the Study	115
References	118
Appendix A: Clinical Vignette Set #1	125
Appendix B: Clinical Vignette Set #2	127
Appendix C: Recruitment Letter	129
Appendix D: Consent Form	130
Appendix E: Physician Background Information Form	132

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Chapter 1: Overview

Aims of the Study

Throughout my medical education so far, I have been taught how to make clinical decisions regarding specific disease states. On rare occasions have these teachings considered the point of view of the patient, the person who is to live with the consequences of those decisions. For this reason, it was important for me to consider ways by which I could actively involve them in the process of developing both the diagnosis and the treatment plan. One aim of this thesis sought to investigate the ways in which physicians involve patients in the clinical decision-making process.

I have also had the opportunity to observe many interactions between patients and physicians throughout my education. I have seen physicians approach and interact with individual patients quite differently, even when the patients shared similar clinical conditions. This spurred my interest in examining the assessments that physicians make regarding certain patient characteristics (race, socioeconomic status, gender, etc.) and how those assessments affect the physician's interactions with patients.

Finally, I have found that there is an imbalance of power in the physician-patient relationship, with physicians holding most of the power. I wanted to look how the issue of power impacts the physician-patient relationship and investigate the effects that it has on the health outcomes of patients.

Research Goals

My first research goal was to examine the process of information gathering by the physician. I wanted to try to understand what information physicians were looking for from their patients during the medical interview. In particular, I was interested in how the patients' characteristics influenced the physicians' processes of making meaning from the information gained from the patients.

The second research goal deals with the process of physicians relaying information to their patients. This typically occurs after physicians have gained information from their patients and have processed that information. The physicians then use the information that they've gained to decide the best manner to approach this particular patient. I was interested in looking at how the physicians alter the manner in which they talk to patients based on the characteristics of the patients.

The final research goal was an attempt to characterize the nature of the physician-patient interaction from the perspective of the physician. I wanted to see if physicians felt that they were equal partners with patients in the decision-making process, or if they felt that one person should hold more of the decision-making power. I tried to determine what the physicians felt their role should be in the relationship with the patient. It was my belief that physicians feel a particular responsibility to the patient within the physician-patient relationship, and I was interested in finding out if physicians subscribe to this idea of responsibility. So, I wanted to understand how that sense of responsibility influences the amount and manner in which they give information.

Summary of Contents

Chapter 2 presents the literature reviewed and background information for this study. It includes a discussion of the various models used to describe the physician-patient interaction along with a discussion of the rationale behind information disclosure. It also includes a discussion of past research investigating the effects of patient characteristics on information disclosure. The chapter concludes with discussions of discordance between the physician and patient, allegations of discrimination in medicine, and the effect that the physician-patient relationship has on health outcomes.

Chapter 3 addresses the methodology used in this study. The study was carried out through one-on-one interviews with Family Practice physicians in Alameda County in California. The data were analyzed using the Grounded Theory method.

Chapter 4 describes the characteristics of the physician sample that was interviewed. Chapters 5, 6, and 7 describe the results from this study. Each chapter corresponds to a different research question, describing the answer to the research question and supporting the results by including quotes taken directly from the physician interviews. Chapter 5 addresses the issue of what physicians are looking for when they talk to their patients. Chapter 6 looks at the process of how physicians talk to patients after they have gathered information from them. Chapter 7 characterizes the nature of the physician-patient relationship.

Chapter 8 provides the conclusions from the study and a discussion of the results. The clinical implications of the results as well as the limitations of the study are also discussed.

Major Findings from this Study

1. Physicians rely on their assumptions about particular patient characteristics to a significant degree when deciding how the patient's illness should be managed.
2. Physicians make judgments as to whether particular patients have the ability to make good decisions regarding the management of their illness.
3. Physicians appear to believe that helping the patient to get well is more important than the patient's right to make decisions for themselves.
4. Physicians in this study took a strong psychosocial and compassionate approach to the care of their patients.
5. There is a power imbalance within the physician-patient relationship and physicians sometimes use this to their advantage to persuade patients to take a particular approach to their illness.

Chapter 2: Background, Literature Review, and Introduction

This chapter begins with a discussion of the various models that can be used to describe the physician-patient relationship. This is followed by a discussion of the virtues of information disclosure and informed consent as well as the role that these two topics play in the physician-patient relationship. The next topic to be covered is the effect of patient characteristics on the physician-patient relationship. Following this discussion, the issue of discordance between physicians and patients will be addressed. This chapter will conclude with a discussion of the allegations of discrimination within the field of medicine and a presentation of various reports discussing the health outcomes of the physician-patient relationship.

Models for the Physician-Patient Relationship

The nature of the physician-patient relationship experienced a major change in the 1960's. Prior to this time, physicians regarded the principle of beneficence as being dominant to the principle of patient autonomy (Brody, 1997). In other words, physicians felt that it was more important to act in ways that benefit the patient than to respect the patient's right to make decisions for themselves. This prioritization lead to what can be the called the paternalistic model of the physician-patient relationship. Paternalism can be defined as refusing to yield to the wishes or desires of another person for that person's own benefit (Beauchamp, 1994). Under a paternalistic model, the physician takes in the information, processes the information for the patient, and then tells the patients what they should do to manage their illness.

The role of the patient under this model is to provide information to physician and then passively accept the advice of the physician. It is important to note that the patient's wishes and desires are not ignored under the paternalistic model, they are just not considered to be the highest priority. The physician's highest priority is to tell the patient what they should do to try to help themselves get better.

The model at the other end of the spectrum is the patient autonomy model. Autonomy can be defined as personal self-rule, free from the controlling influence of others and from limitations that prevent the making of a meaningful choice by the individual (Beauchamp, 1994). Under this model, the physician gives the patient's wishes and desires priority over his or her own thoughts on what the patient should do to manage their illness. The physician's role is one of serving as an expert who provides the patient with the information that they need to make an informed decision on how best to manage their illness. The patient's role is that of the dominant decision-making agent. The patient listens to the recommendations of the physician, but under this model, his or her desires and wishes can override the recommendations of the physician.

The paternalistic and patient autonomy models are at the extremes of possible models for the physician-patient relationship, and there are many other types of models that fall in between these two extremes. For example, the contractual model is a social contract approach to the physician-patient relationship that treats both physician and patient as free moral agents with their own goals and interests (Brody, 1997). Under this model, the physician makes the more technical decisions, while the patient makes decisions regarding his or her own moral values and life preferences.

There can be some cross-over in terms of decision-making, but each side tends to make decisions within their own spheres. It is important to note that part of the contractual nature of this model is that both parties must adequately inform each other of their decisions and their rationale for those decisions.

There have been many criticisms made of the contractual approach, and they are communicated quite well by May (May, 1998). The first criticism is that in order for patients to carry out a contract effectively, they must have an intimate understanding of the goods for which they are contracting, in this case their health. The argument is that it is the physician, not the patient, who is able to understand the nature of health. Therefore, patients really don't have the ability to execute the contract sufficiently. May also argues that under the contractual model, the physician's role is too constrained. The physician is reduced to a contractor and that position is not rewarding for the physician and it does not realize the physician's full potential. May proposes the covenant model for the physician-patient relationship (May, 1998). Under this arrangement, the physician promises to look out for the patient's best interests and the patient promises to trust the physician and take his advice. May supports this model because it allows both people to accept roles that suit them and it gives physicians a role that they can find rewarding and meaningful. May also feels that the covenant model promotes devotion and commitment to the patient on the part of the physician.

Another model that falls in the middle of the spectrum is the model of mutuality. Mutuality contains the concept of therapeutic reciprocity which is defined as a mutual exchange of meaningful thoughts, feelings and behaviors between the

physician and the patient (Henson, 1997). Under this model, the physician and the patient contribute to the relationship equally, and both are allowed to enter both the spheres of medical decision-making and that of lifestyle decision-making. The physician can disclose his or her own personal experiences with the illness, while the patient can share the technical knowledge that they have regarding the illness. The benefits of this model is that it gets both physician and patient invested in the process of managing the illness and both participants are held accountable for the outcome of the management plan. Another aspect of the mutuality model is that it views the relationship as being dynamic in nature. For example, at the beginning of the relationship, the physician knows little of the patient's lifestyle while the patient presumably knows little about the disease state. As the relationship progresses over time, both become more competent in all respects and can work more collaboratively with one another.

The last model to be discussed is the negotiation model which is heavily focused on the power dynamics within the physician-patient relationship. Power can be defined as the capacity of one person to influence another. The negotiation model assumes that both patient and physician have power and that they exercise this power in the course of the medical encounter (Botelho, 1992). The patient can exercise his or her power in ways such as demanding specific treatments or tests, and the physician can exercise his or her power by refusing to provide information to the patient or discouraging them from asking questions during the interview. Under the negotiation model, there is a separation of decision-making spheres, in which the physician serves as the expert on the medical information and the patient serves as the

expert on their lifestyle preferences. This model proposes that both participants are working within their respective spheres, but toward a common purpose. They work toward that purpose by exercising their power when they feel the need to do so, creating a dynamic relationship that doesn't necessarily converge as the mutuality model suggests, but one that is dynamic and suited to the particular situation.

Many other models have been proposed for the physician-patient relationship, but those that have been presented here illustrate some of the major components that should be addressed when looking at the physician-patient relationship. There are positive and negative aspects to each model and an ideal physician-patient relationship would likely be a mixture of all of these models. The paternalistic model is useful because it stresses the fact that the physician is focused on what will be beneficial to the patient as opposed to things such as cost. The value of the patient autonomy model is that the patient is the chief decision-making agent. The contractual model is good in that it limits the power of the physician for the benefit of the patient. The covenant model has the advantage in that both parties agree to be involved in the process, and the mutuality model insures that both people are invested in the process and accountable for the outcome. Lastly, the negotiation model's strength is that it views the relationship as dynamic and dependent on the particular situation at hand.

A discussion of the models of the physician-patient relationship should also include the fact that the appropriate model often depends on the patient and their particular situation. A patient who is extremely ill or who is deemed incompetent to make an informed decision, cannot fulfill the patient autonomy model and a more

paternalistic model may be appropriate. It should also be emphasized that the physician and the patient each have their own sets of beliefs and morals. It must be acknowledged that even though a physician is committed to doing what is best for the patient, the patient's request may be at odds with the physician's moral values (Tsukamoto, 1996). It should also be noted that cultural preferences must be considered. A study done with Korean Americans and Mexican Americans found that the western ideal of patient autonomy is not universal, in that a significant number of people in these two groups did not want to be the ultimate decision-making agent in their care (BlackHall, 1995).

The discussion of these different models for the physician-patient relationship raises the question as to which of these models is most prevalent in medical practice. In 1956, Szasz and Hollender published one of the first discussions of the different models of the physician-patient relationship. Their conclusions were that the dominant model in clinical practice was more paternalistic in nature, with the physician playing the role of a parent and the patient serving the role of a child (Szasz, 1956). They went on to say that a relationship in which both physician and patient played the equal role of adults was rare. A more recent study, published in 1996, found that the dominant model in clinical practice is still one that is paternalistic in nature (Little, 1996). This finding is not undisputed in that another study found that paternalism is still a common model in clinical practice, but that it is not the most dominant model in use today (Roter, 1997). These studies suggest that despite the growing acceptance of patient autonomy over the last 40 years, the paternalistic model still has a significant impact on the practice of medicine today.

The Issues of Information Disclosure and Informed Consent

In order for a model that cedes some decision-making authority to the patient to work, the patient must receive sufficient information from the physician to make informed decisions on the management of their illness. The decision to provide this information rests almost solely with the physician. There are ways that the patient can try to gain more information, but the final decision to release that information rests solely with the physician.

The right to lucidity, or a right to know the truth of one's medical condition is a commonly held virtue of the practice of medicine in the western world (Brody, 1997). This right is derived from the belief that people have a right to know what is going on with their own bodies. On another level, the right of lucidity is viewed as a necessary component for the fulfillment of the right of patient autonomy (Brody, 1997). Because of the close link between lucidity and autonomy, the history of their development is quite similar. Prior to the 1960's, physicians commonly withheld the diagnosis of serious illness from patients in a belief that giving the diagnosis would be harmful to the patient (Brody, 1997). The beneficent withholding of information that may be distressful to the patient is one form of what is called therapeutic privilege. Although therapeutic privilege is currently allowed in today's practice of medicine, it is a doctrine that is strongly contested by many in the legal and ethical fields (Beauchamp, 1994). Some view therapeutic privilege as denying patient autonomy and supporting paternalism, while others view it as a necessary part of providing compassionate patient care under certain circumstances.

Truthful disclosure is regarded as a basic patient right in the western world. In a study of cancer patients in Britain, it was discovered that the vast majority of patients feel that they should be told the truth about their medical condition (Benson, 1996). Other studies have also confirmed that most patients in the western world express strong desires to receive all of the information regarding their medical conditions (Waitzkin, 1984; Beisecker, 1990; Vick, 1998). However, this desire for information is not universal. The aforementioned study of Korean Americans and Mexican Americans found that significant numbers of people from these groups did not want full disclosure of their medical conditions (BlackHall, 1995). Another study found that only a third of patients surveyed in Greece expressed an interest in being told of the diagnosis of late cancer under all circumstances (Asai, 1995). This same study found that most physicians in Japan, Southern Europe, and Eastern Europe conceal the diagnosis of late cancer from their patients (Asai, 1995).

In the western world, most patients want full disclosure from their physicians. This presents dilemma for physicians practicing medicine in the western world. Their job is not only to process all of the medical information for the patient, but they must also decide how much of that information to provide to patients. It would be impractical to cite every clinical study that they are aware of for each patient's clinical condition and all reported side effects for each drug that they prescribe. Making the decision on what information to provide to patients can be very difficult. The physician does not want to overburden the patient with too much information, but they also don't want to fail to provide information that is important.

The decision on how much and what type of information to provide to patients often comes down to a judgment call on the part of the physician. This judgment is typically based on the physician's assessment of what they think their patients would want to know about their medical conditions. This raises the question of how well physicians are able to accurately estimate a patient's desire for information. Studies have found that physicians underestimate the amount of information that their patient's desire (Waitzkin, 1985; Street, 1991). On a similar note, a study examining the ability of physicians to estimate their patients' preferences for life-sustaining treatment found that the physicians' decisions were correlated more strongly with their own preferences rather than those of their patients (Schneiderman, 1997).

The idea of informed consent is closely tied to the idea of disclosure. Informed consent must be viewed as a legal construction to ensure that patients have been fully informed of the nature of the procedures that they agree to undertake along with the risks and benefits of those procedures (Beachamp, 1997). Under the requirement of informed consent, a physician must inform the patients of the risks of undergoing the procedure that has been recommended. However, the physician is not required to inform the patient of all reported risks. Physicians can decide to inform the patients of the risks based on the likelihood of a particular risk occurring and its severity (Brody, 1992). For example, a physician would be required to tell a patient of a risk that commonly occurs regardless of the severity, and they would be required to inform the patient of a risk that is very severe regardless of the likelihood of it occurring. A physician may not be required to tell a patient of a minor risk that rarely occurs.

It can be said that ensuring informed consent often depends upon the judgment of the physician. Therefore, it may be difficult to decide (in a legal case for example) whether or not a physician obtained sufficient informed consent for a particular procedure. For this reason, there are a variety of standards used to decide whether sufficient information has been provided by physicians. The first is the “professional practice standard.” This standard is based on the typical practices of other physicians in the community who are in a similar practice as the physician in question (Beauchamp, 1994). Inherent in this standard is the assumption that most of the physicians in a community are acting in the patient’s best interest, and that the actions of the physician in question can be judged according to the typical practices of other physicians in the community. The next standard is the “reasonable person standard” in which sufficiency of informed consent is judged according to what a hypothetical “reasonable person” would want to be informed of under similar circumstances (Beauchamp, 1994). The last standard is the “subjective standard” in which a physician considers the individual patient considering the procedure and attempts to decide what this particular person would want to know based on what they know of the patient (Beauchamp, 1994).

The purpose of informed consent is to enable the patient to evaluate a procedure before they consent to that procedure (Pape, 1997). The main goal of informed consent is to respect the autonomy of the patient, or the patient’s right to self-determination. A major aspect of informed consent is the process of the physician providing information to the patient. However, the requirement of informed consent also requires comprehension, voluntariness, competency, and the

consenter's permission to undergo the procedure (Little, 1996). Comprehension means that the patient must actually understand what they have been told rather than just hearing the physician talk about the procedure. One's consent must be completely voluntary without coercion, manipulation, or persuasion. The patient must be mentally fit, or competent, to make the decision, and must clearly give their consent to the procedure. All five of these requirements (disclosure, comprehension, voluntariness, competence, and consent) must all be satisfied before informed consent has been obtained.

The next issue to consider under the topic of information disclosure is how much time physicians actually spend providing information to their patients. One study reported that physicians in the United States spent an average of 1.3 minutes of a 16.5-minute interview providing information to patients. When the same physicians were asked to estimate how much time they spent providing their patients with information, an average estimate of 8.9 minutes was given (6.8 times greater than the actual mean) (Waitzkin, 1996). This study raises the issue of whether either full disclosure or informed consent can be obtained when physicians spend so little time providing their patients with information. It also suggests that physicians are not aware of the paucity of time dedicated to educating their patients. These findings are compounded by another study that suggests that physicians overestimate the extent to which their patients understand what they have been told about their conditions (Kee, 1996).

The Effect of Patient Characteristics on the Physician-Patient Relationship

Physicians must make many decisions during the medical encounter with their patients. They must decide the role that they will take during the interaction with the patient, thereby affecting the role that the patient will take during the interaction. In addition, they must decide how much and what type of information to provide to their patients. In order to make these decisions, the physician must process a lot of information. One type of information that physicians consider when making the decision on how to approach each patient is the demographic and personality characteristics of that patient. Many studies have found that patient characteristics have a large effect on the way that physicians approach their patients. An analysis on how physicians process patient characteristics is a major part of gaining a better understanding of the physician-patient relationship.

Many studies have shown that patients' demographic characteristics affect the amount of information that physicians give to patients. Physicians have been found to provide less information to patients from a lower class and those who are minorities based on the belief that people from these groups are less able to process medical information (Lipkin, 1996). Physicians have also been found to spend more time with and provide more explanations to patients who are of upper- to upper-middle class when compared to patients from a lower class (Waitzkin, 1984). The same study found that there was no difference between these groups in terms of a desire for information. Physicians in the United States tend to provide more information to highly educated patients, but a very similar study in Mexico revealed no effect of educational status on information disclosure (Waitzkin, 1996). Ironically,

physicians have been found to provide less information to patients whom the physician perceived as knowing little about their medical conditions (Kee, 1996).

It has been reported that gender has an impact on the physician-patient relationship, but it is difficult to make conclusions from the published findings. One study in Mexico found that women receive less information from physicians when compared to men (Waitzkin, 1996). However, studies in the United States have found that women tend to get more information when compared to men (Waitzkin, 1984; Street, 1991; Cooper-Patrick, 1999). The findings in the United States may be confounded by personality characteristics that tend to predominate in women. Women have been found to be more likely to ask questions during the medical encounter and to actively participate in the physician-patient relationship (Waitzkin, 1984; Street, 1991). Many studies have suggested that patients who are more active during the medical encounter receive more information from physicians (Waitzkin, 1984; Beisecker, 1990; Meeuwesen, 1991; Street, 1991; Waitzkin, 1996). Thus in the United States, it appears that women tend to get more information from physicians than men, but this may be largely due to their assumption of a more active role during the medical encounter.

The taking of a more active role during the medical encounter is an important determinant of the amount of information that a patient receives. Studies have found that patients who are more highly educated display more interactive behavior during the medical encounter. The same studies found that minorities were less likely to display this type of behavior (Street, 1991; Kaplan, 1995). Studies have also shown that elderly patients are less likely to display more active behavior during the medical

encounter (Street, 1991; Irish, 1997). Physicians also tended to not enjoy interacting with elderly patients because they perceived them as not wanting to take part in the therapeutic relationship (Irish, 1997). Some studies have suggested that physicians send cues to their patients to either discourage or encourage patients to be more active during the medical encounter, and that the discouraging cues tend to be directed toward patient groups who were perceived as displaying more passive behavior during the medical encounter (Street, 1991; Ong, 1995).

It has been suggested that patients follow the physician's lead when making decisions about how involved they should be in the decision-making process (Ong, 1995). In this regard, female physicians are more interactionally oriented as compared to male physicians (Meeuwesen, 1991). Another study found that male patients were more likely to display active behavior with female physicians (Kaplan, 1995). It has been reported that female physicians are more commonly interrupted than men physicians, and female patients are more commonly interrupted than male patients (Waitzkin, 1984). This is important because interruptions are a common means of taking control of a relationship as well as a way of discouraging others to participate.

A patient's health status was also found to have an impact on their level of participation. Patients who were in good health wanted more information, but preferred to have the physicians make decisions for them, when compared to patients who were in poor health (Vick, 1998). Another study found that patients who were sicker were less likely to report having participatory visits with physicians (Kaplan, 1995). The length of the relationship and the length of time of the medical encounter

also influences the degree to which patients were involved in making decisions about their care. A longer standing relationship as well as a longer office visit was found to have a positive effect on participatory decision-making by the patient (Kaplan, 1995). Similarly, physicians who saw more patients per week and spent less time with each patient were less likely to be rated as “participatory” by their patients (Kaplan, 1996).

One goal of the physician, during the physician-patient interaction, is to predict the likelihood of obtaining a successful outcome with the patient. This prediction is often influenced by patient characteristics. One study found that the physician’s assessments of the amount of information that a patient needs to learn, the quality of the interaction with the patient, and the patient’s motivation all affected the physician’s judgment regarding the likelihood of patient compliance (Ascione, 1985). However, the same study reported that these factors do not actually correlate with compliance behavior and that physicians may be making inaccurate assessments of the likelihood of compliance (Ascione, 1985).

Assessment of marital status was also found to influence the provider-patient relationship. One study found that nursing students asked different questions to and had different assessments of young mothers who were presented as being unmarried as compared to those who were married. The study reported that the nursing students’ assessments were consistent with cultural stereotypes regarding unmarried and married women with children, but that the differing perceptions of the patients did not lead to differences in empathy and warmth during the encounter (Ganong, 1992). Another study found that patients who were unmarried were less likely to receive definitive therapy for breast carcinoma. This study also found that older

women were less likely to receive definitive therapy for this illness (Silliman, 1997). These studies suggest that physicians and nurses are influenced by cultural stereotypes and that these perceptions influence the ways that physicians approach their patients.

Discordance Among Physicians and Patients

There is evidence to suggest that physicians typically have difficulty interacting with particular groups of people. In this section, the issue of discordance between physicians and patients and its possible consequences is addressed. In the previous section we touched upon the issue of gender differences in communication patterns among physicians. It has been reported that female physicians are more likely to encourage their patients to participate in the decision-making process (Cooper-Patrick, 1999). However, this same study failed to show that gender concordance had any effect on the participatory decision-making style of the physicians (Cooper-Patrick, 1999). This study suggests that physicians are relatively consistent with their approach to patients regardless of their gender, but the results could be confounded by the possibility that patients who prefer a more participatory approach by the physician choose female physicians. It has also been reported that female physicians are more likely to discuss psychosocial issues with their patients as compared to male physicians (van den Brink-Muinen, 1998).

The issue of the effect of gender concordance on the participatory decision-making style of the physician is uncertain, but there is other evidence to suggest that gender discordance has an impact on other aspects of the physician-patient

relationship. It has been reported that verbal communication during the medical interview is shorter when there are gender discordant dyads. This same study also reported that female patients felt more comfortable with female physicians and that women visiting male physicians were also found to be more nervous, less kind, and more irritated during the interaction (van den Brink-Muinen, 1998).

Evidence also suggests that racial discordance has a significant effect on the physician-patient relationship. One study found that African-American patients were more likely to report having less participatory relationships with their physicians, regardless of the physician's race (Cooper-Patrick, 1999). In addition, racial concordant relationships were shown to lead to higher rates of participatory decision-making between the physician and the patient (Cooper-Patrick, 1999). The same study did not find a difference between minority and non-minority physicians in terms of participatory decision-making style. In terms of patient satisfaction, African-American patients were more likely to be satisfied with African-American physicians, and white patients were more pleased with the ability of white physicians to listen to their concerns (Saha, 1999).

Another study looked at the possibility that a physician's interpersonal style has an effect on the way that they approach their patients (Stewart, 1999). This study identified courtesy, respect, discrimination, cultural sensitivity, and emotional support as five elements of interpersonal style. It has been suggested that all five of these elements are influenced by ethnicity and culture and when physicians and patients of different ethnicities and cultures interact, the dyad may not achieve concordance on

all of these elements. This discordance could strain the relationship and lead to problematic interactions between patients and physicians.

Very little research has been done looking at the effect of a patient's or a physician's personality on the physician-patient relationship. These studies would be important because the physician's perceived success of the relationship often depends on whether or not the physician views the patient as being difficult to work with (Reifsteck, 1998). Patients may be labeled as "difficult" because the physician perceives them as being non-compliant, not being engaged in the process, or have some other type of deficiency. There is also the possibility that the patient and physician have differing value systems or approaches to health. The issue of how physicians deal with "difficult" patients is important since it has been estimated that "difficult" patients comprise 10 to 15% of the typical physician's patient population (Reifsteck, 1998).

The problem with discordance in the physician-patient relationship is that it can lead to dissatisfaction among both patients and physicians. When physicians are dissatisfied with particular groups of patients, they may no longer wish to work with those particular patient populations. When patients are dissatisfied with physicians, they may try to seek care from other physicians, alternative therapies, or refrain from seeking any care at all. For example, the racial discordance that was discussed earlier may contribute to the fact that mortality from cardiovascular disease is higher among African-Americans as compared to whites in the United States (Dries, 1999). However, this correlation is clearly multifactorial and is likely to be confounded by issues such as socioeconomic status and access to health care. For example, it has

been reported that there is an inverse relationship between socioeconomic class and mortality in the United States (Pappas, 1993).

The possibility exists that discordance in the physician-patient relationship could be creating medically underserved populations. In light of the reports that patients are more satisfied with physicians of the same race and gender, it seems that racial and gender concordance would be an effective method to address the problem of underserved medical populations. However, minorities are markedly underrepresented among physicians. In 1990, African-Americans comprised 4% of physicians, yet comprised 12% of the general population (Komaromy, 1996). During that same period, Hispanics comprised 5% of physicians, yet they comprised 9% of the general population (Komaromy, 1996). It has been reported that minority physicians tend to locate their practices within minority populations, suggesting that the training of minority physicians could be an effective method of addressing the problem of underserved populations by increasing racial concordance among physicians and patients (Komaromy, 1996).

Discrimination in Medicine

There have been recent reports in the media suggesting that discrimination exists within the medical field. Most of these reports involved discrimination against minorities, but there have also been reports of discrimination against women. None of the reports have concluded that there is any overt racism or sexism within the medical field. As a matter of fact, these reports fail to offer any conclusions to

explain why discrimination exists within the field of medicine. In the following section, the various reports of medical discrimination will be presented and discussed.

Last fall, a study in the *New England Journal of Medicine* reported that African-American lung cancer patients are less likely to receive surgical treatment for lung cancer, and as a result died sooner from this disease as compared to white patients (Bach, 1999). While the authors of this study acknowledged the fact that they did not control for socioeconomic status, they still suggested that patients with the same disease are treated differently by physicians. A similar study found that African-Americans were less likely to undergo coronary revascularization when compared to whites even when displaying identical clinical features (Peterson, 1997). As a result, African-Americans had worse long-term outcomes when compared to white patients. Similarly, a study reported that African-American patients are less likely to receive recommendations for cardiac catheterizations when compared to whites patients with a very similar clinical presentation (Schulman, 1999).

The studies described above are not the only reports of racial discrimination in medicine. African-American patients with psychosis have been found to be diagnosed with schizophrenia at higher rates when compared to whites with similar clinical presentations (Strakowski, 1993). Another study found that African-American patients with HIV were less likely to receive prophylactic therapy for *Pneumocystis carinii* when compared to white patients with the same stage of HIV disease (Moore, 1994). Race was found to be the factor most strongly associated with receiving these treatments, while age, sex, mode of transmission, type of insurance, income, education level, and place of residence were not correlated (Moore, 1994).

Another study found that African-Americans in the United States were less likely to undergo kidney transplantation and to survive end-stage kidney disease when compared to whites (Kasiske, 1991). However, both biologic and socioeconomic reasons were identified for the results above (Kasiske, 1991). All of the studies mentioned above provide evidence that racial discrimination does exist within the field of medicine.

Beside race, it has been suggested that there is also an age bias within the medical field. One study reported that elderly patients are less likely to receive appropriate clinical investigation for cardiac problems, more likely to be treated medically rather than surgically for cardiac problems, and less likely to receive thrombolytic treatment even in the absence of contraindications (Bowling, 1999). Many physicians would defend these situations as providing appropriate care, claiming that these interventions are less successful in elderly patients. However, it has been suggested that there is a paucity of clinical evidence supporting these claims. The elderly have been largely excluded from many clinical trials, and it is suggested that ageism is widespread in medicine (Bowling, 1999). It has also been said that medical students are exposed to ageism early in their clinical training (McCray, 1998).

Lastly, there have been reports of sexism in the field of medicine. The same study that reported lower rates of recommendations for cardiac catheterization for African-American patients also found that women were less likely to receive these recommendations as well (Schulman, 1999). Another study found that women were more likely to receive mammography from female physicians when compared to

male physicians (Andersen, 1997). In this study, there were found to be no differences in the level of assertiveness of the patients of female physicians when compared to male physicians.

All of the studies cited above provide evidence that discrimination plays a significant role in the practice of medicine today. These findings are disturbing and they clearly warrant an explanation. However, obtaining an explanation for these results will probably prove difficult, if not impossible. While it is impossible to demonstrate unequivocally, it is highly unlikely that these findings result from overt racism, sexism, or ageism among physicians. The more likely explanation is probably something along the lines of discordance between physician and patient. Physicians and patients often come from very different backgrounds and it may be difficult for physicians to interpret the presentations of some of their patients. Physicians also carry certain stereotypes that they learn in the greater society into the medical encounter and those stereotypes may color a physician's interpretations of certain patient presentations. Lastly, medical education promotes its own stereotypes. For example, medical students are taught that overweight, white men are the people who typically die from heart disease. It is likely that this situation contributed to the findings of discrimination in cardiology presented earlier.

The Impact of the Physician-Patient Relationship on Health Outcomes

The purpose of this section is to consider the effects that the physician-patient relationship has on the health outcomes of patients. The first measure of health outcomes to be discussed is patient satisfaction, and numerous studies have shown

that specific aspects of the physician-patient relationship have an effect on patient satisfaction. One study reported that during the medical interview, physicians are more directive, less attentive, and more presumptuous when compared to patients, and patients were less satisfied with physicians who were more directive (Anderson, 1998). Patients also appear to be more satisfied with physicians who display strong psychosocial focus during the interview, while being less satisfied with physicians who exhibit a strongly biomedical focus (Bensing, 1991; Roter, 1997). In contrast, another study found that a physician's socioemotional skills were not correlated with higher levels of patient satisfaction (Koss, 1997). Finally, a correlation has been made between the level of patient satisfaction and the number of times a physician discusses health education topics with the patient (Schauffler, 1996). These studies seem to support the idea that patients want to feel as though they are actively involved in the relationship and that the physician is focused more on the person as opposed to the illness.

Physician behavior has also been shown to be influenced by the physician's assessment of patient satisfaction. One study reported that physicians tended to act more personally toward patients during the medical interview when they felt that their patients were satisfied (Bensing, 1991). This same study found that the physician's assessment of patient satisfaction was not at all correlated with the patient's reported level of satisfaction (Bensing, 1991). This study returns to the idea that physicians aren't always accurate when assessing patient satisfaction, and suggests that physicians modify their behavior during the interview in response to this often inaccurate perception. This finding suggests that physicians may act more

impersonally to patients with whom they do not interact well. The concept of the “difficult” patient may be the result of a physician’s strained interactions with particular types of patients.

It seems as though patient satisfaction is influenced by the physician-patient interaction, and it is questionable as to whether blame can be placed on the physician. One study looked at multiple factors that influence patient satisfaction with the physician-patient relationship. The result was that 90 to 95% of the variance in patient satisfaction levels was explained by the patient as opposed to the physician (Sixma, 1998). Similarly, it was shown that patient satisfaction is strongly influenced by how well patients are feeling (Kane, 1997). These studies suggest that there is little that the physician’s can do to improve patient satisfaction, and provides potential reinforcement to the importance of physician-patient concordance.

In addition to the affects on patient satisfaction, many studies have suggested that the physician-patient relationship can influence patient compliance. It has been found that increased physician directiveness and less patient involvement decrease patient compliance (Heszen-Klemens, 1984). Patients also seem to appreciate a physician’s expression of both positive and negative emotions during the medical encounter. Patients who felt that the physician displayed more affective behavior, experienced continuity with the physician, and received humane interpersonal treatment from the physician rated their relationships with the physician as being stronger and reported increased rates of compliance (Safran, 1998). It was also found that the expression of more positive feelings by the physician was correlated with higher levels of compliance. One study concluded that patient non-compliance is an

attempt by patients to gain control over the management of their health. The conclusion of this study was that the paternalistic model of the physician-patient relationship is ineffective and even detrimental to patient care (DiMatteo, 1994).

Many of the results above were confirmed when biologic measurements were used to estimate the effect of the physician-patient relationship on a patient's health status. Greater patient control, more affect displayed by the physician, and increased information disclosure by physicians has been correlated with better health status among patients (Kaplan, 1989). Again, these results support the notion that patients want to feel as though they are taking an active role in the management of their illness.

The next measures of health outcomes that will be addressed are a patient's desire to switch physicians, malpractice claims against physicians, and the development of trust. All of these measures can be viewed as extreme cases of patient satisfaction or dissatisfaction. It has been reported that in recent years, patients are more likely to express dissatisfaction with and even switch physicians than they have been in the past (Gandhi, 1997). Studies have shown that patient dissatisfaction with physicians is a potent predictor of disenrollment from a physician or a health plan (Gandhi, 1997; Safran, 1998).

In terms of malpractice claims, there are significant differences in the physician-patient interactions of physicians who have been the subject of malpractice litigation when compared to physicians who have not had malpractice litigation taken against them. Physicians with a malpractice claims status had shorter office visits and their patients expressed feeling rushed during the interview (Levinson, 1997).

Physicians with no-claims status oriented patients to the process of the medical encounter more and asked the patients for their own opinions more frequently (Levinson, 1997). Physicians with no-claims status were also reported to laugh more during the interview and used humor more often when compared to physicians with claims status (Levinson, 1997).

Patient trust in their physician is strongly correlated with patient satisfaction. Patients evaluate many aspects of the physician-patient relationship in order to decide if they trust their physician. According to Thom, the three main elements of trust are dependability, confidence in the physician's knowledge or skill, and the confidentiality and reliability of information exchange with the physician (Thom, 1997). Trust is more likely in situations where communication is greater and there is an explicit shared goal between the physician and the patient (Thom, 1997). Once trust is established between a physician and a patient, the patient is more willing to accept mistakes by the physician and extremely reluctant to leave that physician's care (Montaglione, 1999). Both interpersonal and technical skills are important for the development of patient trust, and it should be made clear that patients know the difference. However, patients seem to be willing to overlook some degree of lack of technical skill in favor of good interpersonal skills (Montaglione, 1999).

Chapter Summary

There is a wide spectrum of models that can be used to describe the physician-patient relationship. On one end is paternalism in which the physician is the agent who ultimately decides the course of action that is to be taken to manage the patient's

illness. On the other end of the spectrum, is the model of patient autonomy in which the patient acts as the ultimate decision-making agent. In between these two extremes, there are a number of models, all of which involve an aspect of shared decision-making between the physician and the patient. All of the models, with the exclusion of the paternalistic model, require that the physician provides the patient with information so that they can make an informed decision on the course of action needed to manage their illness. The principle of patient autonomy requires the physician to provide unbiased information so that patients have the ability to self-govern themselves in the absence of a controlling influence by the physician.

Many studies have shown that physician interpretation of patient characteristics have an impact on the physician-patient relationship. The amount of information provided to the patient and the degree of control that the physician gives the patient have been shown to be influenced by patient characteristics. Many instances of discordance between physicians and particular patient populations have been reported. It has been hypothesized that these instances of discordance are due to physician perceptions regarding specific patient characteristics. It is thought that these perceptions make it difficult for physicians to interact with groups of patients in whom specific characteristics are prevalent.

There have been numerous published reports that have made allegations of discrimination in medicine. The discrimination is most often racial in nature, but examples of age and sex discrimination have been reported as well. The issue of discrimination may also be caused by discordance between physicians and patients. Finally, many studies have demonstrated that the physician-patient relationship has an

impact on the health outcomes of patients. Patient satisfaction is higher when patients are pleased with their interactions with physicians. Patient satisfaction is thought to promote greater compliance and it has been observed that good physician-patient interactions lead to higher rates of patient compliance. In addition, better health status, as measured with biologic markers, has been correlated with good physician-patient interactions. These studies provide strong evidence that the physician-patient relationship has an impact on the health status of patients.

Chapter 3: Methodology

Research Questions

The purpose of this study is to investigate how patient characteristics influence information disclosure by physicians. Each of the research questions addresses a different step in this process. The first research question is: What are physicians looking for when they gather information from patients? This question assumes that the physicians have a goal in mind when they listen to and ask questions of their patients. It assumes that they are looking for particular types of information concerning the patient's medical condition. This question seeks to describe the types of information that physicians are trying to gain.

The second research question is: How do physicians use the information that they obtain to talk to the patient about their condition? This question addresses both the goals that the physician has when talking to the patient and the manner in which he or she talks to the patient. It is my belief that physicians talk to individual patients quite differently. This difference in communication may be due to the physician's perception of what they have to say to the patient to get them to address their medical condition.

The third and final research question is: What do physicians think is their role within the physician-patient relationship? This question seeks to address the nature of the physician-patient relationship from the point of view of the physician. It is my belief that physicians feel that they have a particular responsibility within the context of physician-patient relationship, and that this sense of responsibility leads physicians

to assume a particular role within the relationship. I believe that this perceived role influences the process by which physicians gather information from patients and the manner in which they talk to their patients.

Study Design

The subjects for this study were physicians who were board-certified in Family Practice, and practicing in Alameda County in the San Francisco Bay Area of California. One-on-one interviews with these physicians were conducted at their practice locations, using clinical vignettes as an interview tool. Clinical vignettes were chosen as an interview tool because they provided a means by which the presentation of a patient could be done in a controlled manner and introduce a range of patient characteristics. This allowed me to obtain a very focused set of data and allowed for comparisons to be made among the different physicians' responses. Because this study is concerned with how physicians approach patients, it was important to have a study design that allowed comparisons to be made between the responses from the different physicians. The vignettes allowed us to see how a group of physicians would respond to the same two patients. The vignettes made it possible to obtain a large amount of information within a short period of time, thereby minimizing demands on the physicians' time.

Each participating physician received one of two clinical vignette sets (see Table 1.) Clinical vignette set #1 consisted of Mr. Chelito Villaflor with diabetes and Mr. James Watson with coronary artery disease. For clinical vignette set #2, the patients and the clinical conditions were switched. The reason for this switch was

because the clinical condition has an affect the perception that the physician has of the patient.

Table 1. Organization of the clinical vignettes	
Vignette Set #1	Vignette Set #2
Mr. Villaflor with diabetes	Mr. Villaflor with coronary artery disease
Mr. Watson with coronary artery disease	Mr. Watson with diabetes

Both clinical situations were described so that they would be perceived as a stage at which it was important to begin intervention with the patient. The symptoms, family history, physical exam findings, and laboratory values all remained with the clinical condition. The social history, patient description, and scenario for presenting to the office were always associated with each patient. Both demographic and personality characteristics comprised the description of the patient, giving the physician an overall description. The two patients differed in terms of their socioeconomic status, education level, ethnicity, and immigrant status. The clinical vignettes in their entirety are included in Appendices A and B. The methods used to collect and analyze the data are described later in this chapter.

This study was reviewed and approved by the Committee for the Protection of Human Subjects at the University of California, Berkeley (Approval #99-5-45; expiration date November 4, 2000). The study was funded with a \$2000 grant from the Department of Health and Medical Sciences at the University of California, Berkeley.

Development of the Study Design

The development of this study design began with a focus group with physicians that discussed issues regarding the types of information that they took into account when talking to their patients. These physicians were either clinical faculty members from the Joint Medical Program or physicians from the East Bay medical community who are guest lecturers or preceptors in the Joint Medical Program. There were five physicians from a variety of medical specialties. The group was given the task of compiling a list of patient characteristics that they take into account when talking to their patients.

In the course of compiling this list, the physicians discussed why each characteristic was important and how they would use that characteristic to decide how to approach a particular patient. During the focus group discussion, the physicians typically presented the information in clinical vignette form. For example, they would start by describing the patient and a clinical situation followed by a discussion on why they should or shouldn't provide certain pieces of information to the patient based on the patient's characteristics. This focus group provided evidence that physicians were willing to discuss this topic and that a clinical vignette format may be the best route to investigate it.

Once the vignettes were constructed, the next step was to do a pilot study with the vignettes on physicians in general practice in the East Bay. The subjects for the piloting process were also members of the Joint Medical Program clinical faculty along with preceptors and guest lecturers for the Joint Medical Program. The

vignettes were piloted on five physicians and resulted in some minor changes to the patients' descriptions and the clinical presentation. During this process, it was discovered that the clinical situation had an affect on how the physicians perceived the patient. For example, if the physician felt that the situation was very severe and that the patient had waited too long to come in, the patient was more likely to be described as being in denial. There was also variation in how severe a particular clinical situation was perceived by the physicians. For this reason, it was decided that the clinical conditions and the patients would be switched for half of the interviews in an attempt to control for the affect of the clinical situation on the physician's perception of the patient.

Recruitment Process

A list of physicians was obtained from the 1999 directory of the American Board of Medical Specialties (ABMS). The names of physicians certified in Family Practice in Alameda County were compiled, and a list of 169 physicians was obtained. Three of the physicians were excluded because I knew them personally, and one physician was no longer in practice, resulting in a sampling frame of 165 physicians. The addresses and phone numbers of about 40% of the physicians was included in the ABMS directory. The Yellow Pages, the directory of the Alameda-Contra Costa Medical Association, and the American Medical Association physician directory on the internet was used to obtain the phone numbers for 100 (about 60%) of the 165 physicians.

Once the addresses and phone numbers for most of the sampling frame was obtained, the physicians were randomly ranked in numerical order. The physicians were then recruited in numerical order provided that their addresses and phone numbers were available. A letter was sent to the physicians' offices informing of them of the study and a description of what their participation in the study would include (Appendix C). Upon receiving the letter, some of the physicians called me themselves and a time was arranged to conduct the interview. If the physicians did not call me back, I would call their offices within a week of mailing the letter. At that time, many physicians said that they were too busy or that they did not want to participate for various reasons. If they were willing to participate, we set up a time to conduct the interview. A total of 100 letters was mailed out, resulting in a sample of 24 physicians.

Interview Process

The clinical vignette set (see Table 1) that was used in each interview was selected randomly. The interviews were conducted in the offices of the physicians at their practice locations. The interview began with an explanation of the study and the interview process along with the presentation and signing of the consent form (Appendix D). Once the consent form had been signed, the physicians were given the first clinical vignette and asked to read it out loud. When they were finished reading, they were asked a standard set of questions (see Table 2), and additional probing questions if necessary. The process was repeated for the second vignette. If time permitted, additional questions were asked (see Table 3). After the interview was

complete, the physicians filled out an information form providing me with their background information (Appendix E). The entire process was recorded on audio-tape.

Table 2. Structured Questions that were asked at each interview for each vignette

1. Is there any additional information that you would like?
2. Are there any additional diagnostic tests that you would order?
3. What are your thoughts on this patient's medical situation?
4. How would you go about telling the patient of their medical situation?
5. What would you say was your biggest concern in managing this patient?

Table 3. Additional questions that were asked if time permitted.

1. What would you say is the likelihood of obtaining what you would call a successful outcome with this patient?
2. Keeping in mind that the purpose of my study is to learn about how physicians reason about and explain medical problems to patients, is there anything that you feel needs to be said which wasn't addressed in this interview?

Data Analysis

The Grounded Theory method is oriented toward elucidating the action and process involved in an area of human interaction (Strauss, 1998). It provides a technique by which reports of actual interpersonal interactions can be processed and interpreted. The goal of the Grounded Theory method is to inductively build theory

from data in the form of interviews or observations. It is an organized process by which the data are systematically broken down and reorganized to arrive at a theory that is substantive, rather than conceptual in nature. The theory can then be used to describe or characterize the phenomenon that was studied.

Given that this study sought to investigate the interaction between the physician and the patient, Grounded Theory was a well-suited methodology. The fact that it utilizes a systematic and reasonable process to arrive at the theories means that the theories obtained can be substantiated. This is important because the goal of this project is to educate both physicians and patients of the process that occurs during the physician-patient interaction. In addition, there is a paucity of research on the physician-patient relationship, and many of the studies that have been done are correlational in nature and do not adequately explain the process that occurs within the relationship. Grounded Theory is recognized as a method that is useful in areas where little research has been done (Chenitz, 1986).

The process of Grounded Theory begins with a process called open coding, which is done with transcriptions created from the interviews. Open coding is a process by which concepts are identified and their dimensions and properties are discovered (Strauss, 1998). For example, let's say a physician provided the following quote.

The patient has a very difficult family situation and that may be keeping her from controlling her illness.

The code that could be applied to this quote is “the family as a stressor.” This code accurately describes the dimensions and the properties of what the physician has said. It is important to note that the code is derived from a context determined by the researcher. In this case, the researcher is interested in the process by which a physician is assessing a patient’s ability to control their illness. This is not implicitly inherent in the quote, but the researcher understands the context in which the physician made the quote and can assign a code that accurately characterizes it.

The next step in the process is making comparisons between codes to work toward building a theory. In the Grounded Theory method, the process of making connections between codes is called axial coding (Strauss, 1998). In order to illustrate this process, we must have at least two quotes to work with, so let us assume that another physician provides the following quote.

It doesn't seem like this patient will be able to effectively manage his illness. He seems to be lacking the financial resources that will be needed.

The code that could be applied to quote is “lack of financial resources.” The process of axial coding seeks to put codes together and make connections between the different aspects of the phenomenon being studied. For example, the two codes listed above address the issue of how stressors impact a patient’s ability to manage their disease. The label applied to this category, which consists of the two subordinate codes, depends largely on the researcher and the research question. For example, if the study were concerned with how patients manage disease, the larger category may appropriately be called “dealing with outside stressors.” If the research question was

more focused on the process that the physician is conducting, it may appropriately be called “assessing the patient’s stressors.”

Throughout the process of coding many concepts, the researcher develops many different categories that deal with different aspects of the phenomenon that was studied. The next step of the process is to make connections between all of these different categories to try to find recurrent themes. The identification and characterization of these different themes eventually leads the researcher to the development of a theory that seeks to describe the phenomenon that was studied. Provided the researcher carefully develops their codes, categories, and themes and insures that they can be supported directly by the data, they will develop theories that are descriptive and substantive and clearly grounded in and developed from the data.

One of the strengths of the Grounded Theory method is that its systematic nature allows the researcher to retrace their steps and re-evaluate their theories. It also encourages the development of theory that is derived from the data. This process reduces the influence that the researcher’s own judgments and preconceptions has on the data and promotes the development of theories that accurately describe the phenomenon. Another benefit of the methodology is that it allows for the analysis and interpretation of human interaction. This allows for the characterization and description of phenomena that is difficult to do using more quantitative methodology.

One of the limitations of Grounded Theory is that it is not predictive. For example, one could not take the results of this study and predict how an interaction between a particular physician and a particular patient will proceed. However, it would be possible to identify some of the issues that may arise within the

relationship. Another limitation of this method is that it can only describe a phenomenon at a particular location and at a particular point in time. Those who have developed this method readily acknowledge this limitation (Strauss, 1998). The generalizability of the results must be considered in the context of the time and place under which the study was conducted.

The Grounded Theory method can be evaluated for rigor in a variety of ways. One measure of rigor is auditability and it is concerned with whether the theory was derived from a decision trail that can be evaluated and defended (Sandelowski, 1986). The systematic approach of the Grounded Theory method fulfills the requirement of auditability. Another measure of rigor is the idea of saturation, which simply means that the same concepts occur frequently across many of the subjects in the study. The belief is that a concept that is found in many of the interviews is likely to be accurate. The current study also fulfills the requirement for saturation on many of the concepts presented.

One measure of rigor that was not fulfilled by this study was the idea of credibility. Credibility involves evaluating the faithfulness of the results by subjecting the findings to the scrutiny of the subjects (Sandelowski, 1986). I feel that the idea of credibility as a measure of rigor is debatable. The subjects of a study may be reluctant to accept certain characterizations of their behavior, particularly if those characterizations are perceived as being negative. Although I question the validity of credibility as a measure of rigor, it is an accepted method of measurement. Another measure of rigor that was not satisfied by this study is what is called member checks. Member checks is a process by which the researcher provides another person with

their analytic strategy and allows that person to critique the validity of the strategy (Lincoln, 1985). Preferably, the other person is someone who has knowledge of the process being studied and can give adequate feedback. This measure of rigor was also not satisfied by this study.

In this study, transcripts were obtained for twelve of the twenty-four interviews. Each of the twelve transcripts were read and codes were assigned to statements made by the physicians. Once all of the twelve transcripts had been coded, I began creating a codebook consisting of all of the codes identified from the first twelve interviews. Similar codes were then organized into categories and themes were then created. The remaining twelve interviews were not transcribed. The tapes from these interviews were listened to and coded. New codes that arose were added to the codebook under the appropriate themes and concepts. The final codebook consisted of codes from all of the interviews along with information as to which interview each code could be found. The information contained in the codebook was then used to build the theories.

Preconceptions Going into the Study

The Grounded Theory method requires the researcher to limit their preconceptions as much as possible before going into the study. The rationale behind this requirement is that the goal of the Grounded Theory method is to let the theory arise from the data. If the researcher has prior knowledge of the topic to be studied, that knowledge may hinder the process and the theory that evolves will be one colored by the researcher's own preconceptions. Needless to say, it is impossible to

go into a research project with no preconceptions, so I thought that I would report my preconceptions going into the study.

First, I have my own clinical experiences. Throughout medical school, I have observed many interactions between physicians and patients and I have often observed physicians talking to their patients. I have observed instances in which patients with very similar clinical conditions were treated and talked to very differently by physicians. I also have my own views of how the physician-patient relationship should function. I highly value patient autonomy, or the view that the patient should be the ultimate decision-making agent in the relationship. In addition, I feel that the physician-patient relationship has an inherent power imbalance and I believe that physicians should be conscious of this and not use it to their advantage during the interaction with the patient. Although I tried to be unbiased, all of these factors may have had an impact on the data analysis.

Prior to going into this study, I was familiar with some of the reports of discrimination in medicine. I put these reports together with my own observations from my clinical experiences and felt that discrimination is a problem in medicine. This conclusion is one of the main reasons why I chose this research topic. Lastly, I had developed a theory prior to starting this research topic. I thought that physicians would have an easier time interacting with patients who share many of their own characteristics. For example, I felt that a highly-educated, white male physician would have an easy time relating to a highly-educated, white male patient. This theory was one of the reasons that I chose Mr. Watson as one of the patients. This

theory was not actually addressed by the physicians, nor did it come up in the data analysis, but it may have had some effect on the analysis of the data.

Chapter 4: Overview of Results

Response rate

In the course of this study, recruitment letters were sent to 100 physicians, and a sample of 24 physicians was obtained. With each mailing, approximately 10% of the physicians called me to indicate that they wanted to be in the study. The remaining 14 physicians agreed to participate after they had been called. All of the interviews were conducted in the physicians' offices and the interviews were 25 to 45 minutes in length with an average of about 35 minutes. Clinical vignette set #1 was given to 13 physicians and clinical vignette set #2 was given to 11 physicians.

Descriptions of the physicians that were interviewed

Of the 24 physicians interviews, 20 were European-American, 2 were African-American, and 2 were Asian-American. There were 7 women and 17 men. The average age was 52 years, with a range from 33 to 72 years. Seven of the physicians were from the West Coast, 7 were from the Midwest, 5 were from the East Coast, 1 was from the Southwest, 1 was from the West, and 3 were from foreign countries.

All of the physicians were board-certified in Family Practice, but one physician had retrained as an orthopedic surgeon after working as a Family Practice physician in Alameda County for 7 years. There was an average length of 21 years in clinical practice with a range from 3 to 47 years. Eleven of the physicians attended medical school on the West Coast, 6 attended medical school in the Midwest, 6

attended medical school in the East, and one physician was a foreign medical graduate.

Nineteen of the physicians were in private practice, 2 were at community clinics, and 3 worked at Kaiser Permanente, a large health maintenance organization. Seven of the physicians were in solo practice, 13 were in small group practices, and 4 were in large group practices. The physicians reported spending an average time of 20 minutes with each patient with a range of 5 minutes to an hour. The physicians saw an average of 24 patients per day with a range from 10 to 35. Eight of the physicians worked with patients of low income, 9 worked predominantly with patients of middle income, 3 worked predominantly with patients of high income, one physician saw a bimodal distribution, and the physicians at Kaiser Permanente reported seeing an extremely variable income level in their patient populations.

Overview of the results

The Grounded Theory analysis yielded three theories. The first is called “owning the disease” and it addresses the first research question. The process of “owning the disease” describes what physicians are looking for when they gather information from patients. During this process, the physician ascertains whether the patient has the ability and the desire to do what needs to be done to address their medical condition. The second theory is called “presenting the illness” and it is the answer to the second research question. This theory addresses the process by which the physicians begin talking to the patients about their medical conditions. The process of “presenting the illness” depends largely on the information that the

physician has gained from the patient. During this process, the physician tries to communicate their perception of the patient's medical condition in a manner that will be both convincing and meaningful to the patient.

The third theory is "directing the patient's approach" and it addresses the third research question. It describes the nature of the physician-patient relationship from the perspective of the physician. A concept that was prevalent throughout this study was that the physicians viewed their role as being that of the leader. They felt that they were the ones that had the medical knowledge and the ability to process medical information. The physicians felt it was in the patient's best interest to see things their way. They accomplished this goal by regulating the information that the patient's were exposed to and presenting information in a particular way. As the next three chapters are read, the theory of "directing the patient's approach" should be kept in mind.

Each of the next three chapters addresses one of the three theories presented here. The chapters are broken up into subordinate concepts that comprise a larger theory. These concepts will be illustrated using quotes taken directly from the interviews with the physicians. The quotes that are presented were chosen because they are representative of what the group of physicians discussed regarding these particular concepts.

Chapter 5: Owing the Disease

The first research question seeks to identify what physicians are looking for when they gain information from patients. It was found that physicians have specific objectives in mind when they seek information from patients, and the physicians are attempting to determine if the patients are owing their disease. A patient can be said to be owing their disease if they have accepted the diagnosis and have displayed a willingness and an ability to carry out a plan to address the disease. The theory of owing the disease was taken directly from one of the physicians interviewed in this study. She used this phrase often and it was adopted because it seemed to describe the process very well.

A physician's assessment as to whether a patient is owing the disease does not depend entirely on the patient. A physician draws from her past experience with similar patients and from her experiences with other patients who share this patient's disease to decide if the patient before her is owing the disease. In addition, the physician has her own ideas of what it takes for a patient to own this particular disease. It must be kept in mind that both the physician and the patient contribute to this assessment. The physician's assessment as to whether the patient is owing the disease affects the subsequent interaction between the physician and the patient.

Assessing understanding

Physicians typically felt that the patient's ability to own their disease was influenced by whether or not the patient understood the disease. Almost all of the

physicians felt that the patient had to be able to understand what was happening to them in order for them to truly own the disease. Many physicians also felt that the greater the understanding of the disease, the greater the compliance with the treatment plan.

One way in which the physicians assessed the patient's understanding of the disease was by seeing if the patient had correlated their disease state with the symptoms, family history, and father's death from the disease. In this first quote, the physician has determined that the patient understands his disease because he has started to see the connection between his father's death and his own situation. In addition, the physician has observed that the patient also seems to know that his chest pain is associated with the disease state. In short, the patient is starting to put things together, meaning that he is at least starting to understand his disease. This quote occurred after the physician had been asked if the patient understood his medical situation.

Yeah, I think so. I think he turned 60 years old and realized that he was real close to his dad's age of death and that he ought to get checked out, especially when he started getting chest pain. He probably denied it for a while and now he realizes he really does have, he probably hears the keys rattling.

The patient's understanding of their disease was also assessed by whether or not the patient realized the severity of the disease and the need to take action on it. In this next quote, the physician thinks that the patient does not really understand the disease because he chose not to do anything about it for such a long time. This

physician felt that in light of the strong family history and the fact that he had already been told that he has the disease, the patient should have done something to address it. This physician felt that he did not do anything because he had a poor understanding of the disease and didn't realize the importance of early management. This next quote occurred after the physician had just been asked if the patient had a good understanding of his medical situation.

I don't think so. If he let it go a year, probably not. Just by his strong, very strong family history for diabetes and the fact that he was told it was elevated a year ago and yet he didn't think it was important enough to do anything about it.

Many assumptions were made about the patient's understanding of the disease based on the description of the patient. The physicians often assumed that a patient with a low level of education probably didn't understand the disease well. They also assumed that if the patient hadn't had much contact with the medical community, they were less likely to understand the disease well. In this next quote, we see that the physician thinks that it is unlikely that the patient has an understanding of the disease because he hasn't been to a physician in a long time. This next quote occurred after the physician had said that the patient probably does not understand his medical situation very well. When asked why he thought that, the following response was obtained.

Just the fact that he hasn't gone to a doctor in a while, so he may not be much up on it...

This physician felt that the medical community itself is a major source of health education. While this may be a reasonable assumption, it ignores the possibility that the patient has other sources of information. In this case, the physician probably felt that the patient did not have access to other forms of health education.

The physicians also looked at occupation and socioeconomic status in terms of how likely it would be for the patient to understand the disease. In this next quote, the physician feels that it is unlikely that a construction worker would have a good understanding of the sciences, and this physician feels that an understanding of the sciences is necessary to understand the disease.

Probably a bias, but I don't think that construction workers necessarily have as an attuned understanding of the sciences.

The physician acknowledges that this may be a bias, but she also ignores the possibility that the patient has other sources of gaining health information. It is not known if this statement was based on actual experience with construction workers or just an assumption made about them.

The physicians sometimes took into the account the possibility that the patient had been exposed to information on their disease. For example, if family members or friends had diabetes, then it was likely that the patient knew something about it. In the next quote, the physician directly asks the patient to tell her what he knows in an attempt to assess the patient's understanding of the disease.

I would ask him what he knows of diabetes and have him tell me what he knows first, because his dad died from it and he has, what, two of his sisters also have diabetes, so he has to have some clue. So I'd want to find out what clues he has, see where he is in that knowledge base.

Several physicians asked the patient directly what they knew about the disease, but many just assumed a particular level of understanding and starting talking to the patient about his disease based on their assumptions of the patient's understanding.

Finding out what the disease means to the patient

Another typical assumption made by physicians was that if a patient who had been given a particular disease diagnosis had family members or friends who also had it, then it was likely that the patient had thought about the disease and that the disease held meaning for the patient. This was important to the physicians because it was thought to be likely that the experiences of people who were close to the patient had an impact on the patient's conceptualization of the disease. If the patient had a negative conceptualization of the disease, many physicians felt that it would make it difficult for the patient to accept the diagnosis and that it would make them less likely to follow through with the treatment plan.

Several physicians alluded to an "emotional history" with the disease, and one physician stated this idea directly. The emotional history was brought up in the context of the death of the patient's father and the emotional issues tied to that. The physicians were concerned that the patient had a lot of fear of diabetes because it was the disease that contributed to the death of his father. In this next quote, the physician

talks about the importance of the emotional history in finding out what the disease means to the patient.

I would actually go back and talk to him a little bit about his father's death from diabetes. I'd want a little bit more of the emotional history...

Many physicians also assumed that since the patient knew people who had the disease, then they saw at least a little bit about how the disease is managed. In the case of diabetes, one physician mentioned that the management wasn't great years ago and the patient may have known people who had diabetes during this time. If this was the case, the patient may have seen people who were blind, people who had amputations, or people who had to take multiple insulin injections. The consequence of these experiences may be that the patient has a very negative view of the effectiveness of the management of diabetes and that may make them reluctant to accept the fact that they have the disease. This next quote illustrates this idea very well.

People think diabetes means shots and then they have, they tend to die from diabetes or diabetic complications. 'So it means I'm going to lose weight, I'm going to lose this, and I'm constantly taking my blood sugar four or five times a day'...

All of the physicians who mentioned the possibility that the patient had been exposed to these diabetes "horror stories" talked about the importance of telling the patient that there had been vast improvements in the management of diabetes and that their disease course would be much different than those that they had seen in the past.

A few physicians mentioned the possibility that diseases can take on a non-clinical meaning to patients. In this next quote, one physician is talking about her experiences with a patient for whom this has occurred. The physician described this patient as someone who lived alone, worked at a job that she didn't like, and didn't have much of a social network. It was the physician's view that the patient saw her disease as a way in which she could seek social support from the physician.

I have a patient in particular who has asthma who, very interesting case actually, but she uses her asthma for frequent visits and she'll say that she's short of breath and can't move, yet she has no signs or symptoms whatsoever. She just likes the contact...

In this physician's opinion, the disease was being used by the patient to fulfill something that was missing in her life. This same physician then said that some patients are so focused on their diseases that she didn't know if they would have anything to talk about if they didn't have their disease.

Assessing motivation

Another major factor in determining a patient's owning of the disease was the assessment of the patient's motivation. Assessing motivation involves two components, the first is determining why the patient chose a particular time to see the physician, and the second is estimating whether they will be motivated throughout the process of disease management.

The circumstances under which the patient presented himself was an important indicator as to whether they were motivated. Assessing motivation was

strongly associated with assessing the patient's priorities and this is illustrated in this next quote. Here the physician was told that the patient had decided to come into the office after experiencing symptoms for a couple of months. This caused the physician to question the patient's priorities because in her opinion, this was a long time to delay the visit.

Clearly six months of symptoms didn't seem to get through his priority system.

This physician is using the delay in seeking treatment as a barometer to gauge or predict the level at which the patient will be motivated in other aspects during the course of the disease.

Physicians also looked at whether the patient had taken a directed action to address their disease. If the patient had already begun taking steps to address their disease then the physicians viewed this as evidence that the patient was presently motivated and would likely continue to be motivated throughout the process. In the quote that follows, the physician feels that the patient has displayed a directed action.

He's gone to the health fair. Your average 53 year old Filipino worker doesn't go to a health fair just in the course of their daily life. I mean something probably urged, you know, in his mind or his wife's mind urged him to go to the health fair to begin with. He stopped at the booth that measures cholesterol. That tells me he's on the right track.

This physician has a positive view of this patient's motivation because he has acted independently to seek out information on his health status. We also see that the

physician is trying to assess what it was that urged the patient to take the directed action. This physician feels that his wife may have had some influence. This process of trying to find what urged the patient to move forward will be addressed again shortly.

Many of the physicians felt that if a patient was concerned, worried, and even scared of their disease that they would be more likely to be motivated to act on the disease. Being concerned was viewed as desirable behavior because it meant that the patient would follow through with the treatment plan. In the next quote, the physician feels that the patient will definitely follow through with the management plan because he is worried about his heart.

Oh, he's going to be fine. He'll come back. He's concerned about his heart ... he came in because of that...

It was previously mentioned that the physicians tried to guess at what motivated the patient to come in for the check-up. A second level of assessing motivation, beyond assessing the degree of motivation, is for the physician to decide if the patient was properly motivated. This next quote is an example of an instance in which the physician feels that the patient is not properly motivated.

He's about to retire and all of a sudden he thinks 'Well, this is something else that maybe I better check on.'

This physician expressed his idea that this particular patient created a check-list of things that he had to do prior to his retirement. The physician felt that the patient was

treating this visit as if it is just another item on his check-list. It was this physician's view that this is not a good source of motivation and that the patient will probably not be committed to the process of managing his disease as his health is not a major priority. The physicians often felt that genuine desire for good health and greater longevity, as well as wanting to be around for their families were good sources of patient motivation.

Another tool utilized for assessing patient motivation involved an examination of the patient's experiences and the estimation of whether they should have been motivated by something and weren't. A few physicians felt that the family history of disease, the symptoms, and the father's death should motivate the patient to take action against their disease. In this next quote, the physician feels that the patient should have been motivated by his father's death, but wasn't. The physician viewed this as a bad sign for the likelihood that the patient would follow through with the management plan.

His dad died prematurely of a heart attack. The worst thing that ever happened to this guy in his life. His dad died. His dad up and died when he was 25 years old, you know, and now he's 61. He's now thinking about it. I don't have a good feeling about this guy. Maybe he's getting scared straight of his angina now, but it's kind of late now. He should have had his cholesterol checked 30 years ago...

Again we see that this physician thinks that it is good that the patient is concerned about his condition. However, he feels that the patient's concern is long overdue and he doubts the patient's willingness to effectively manage his disease.

During the interviews, most of the physicians tried to guess what was urging the patient to see the physician and many assumptions were made about the patient's motivations. Only a few physicians said that they would ask the patient directly what brought them in. The physician who made the statement to follow felt that it was very important to know exactly why a patient came in to see them. His belief was that it helps him to know where the patients are coming from.

Usually what I ask when people come in is, 'What got them to come in now?' They usually say 'Oh, I'm feeling fine.' Well, what prompted them to come in now? Because usually something happened. The friend died or they have more chest pain, or whatever it is. That sort of tells me where people are.

Making inferences based on past experience

The process of deciding whether a patient owns their disease did not depend solely on that patient. The physicians often drew from past experience with similar patients and sometimes with similar disease states to put the patient in front them into context. The physicians would recall past experiences with patients and decide if this patient was behaving as other similar patients had.

Physician often drew from their past experiences with patients of similar occupations and similar interests to decide if this patient was acting appropriately. The physician who gave this next quote has treated patients who work in computer science fields and decided that the patient described in the vignette was not behaving as a typical person with a similar background would.

Computer people in general love numbers. Okay? So with a diabetic in computer fields, I get faxes of every blood sugar. They have the home glucose monitors that connect to their home computers, and they bring me print-outs of, you know, with graphs of that. Incredibly elaborate stuff. He is not behaving true to form.

In this physician's experience, this patient is not behaving as he should. This physician described this as a red flag that something is going on with this patient.

A few physicians drew on experiences with other patients of a similar culture to put the patient before them into perspective. This next quote was provided by a physician who has often worked with Filipino patients and has a particular characterization of them.

Filipino people are experts in passive aggression with authority...

While this characterization may sound harsh and judgmental, I don't believe that the physician meant this in a negative way. What she was trying to convey were her past experiences with Filipino patients in which they told her that they would follow the treatment course she suggested, but then failed to do so. She felt that, in general, Filipinos were less likely to say that they disagreed with her or that they were not happy with her. Another physician also mentioned that Filipinos are reluctant to discuss negativity or conflict. Whether you agree with the statements of these physicians or not, it is likely that many, if not all, physicians use both negative and positive stereotypes in their practices. The point to be made here is that physicians should be aware of the stereotypes and not rely solely on them when assessing the individual patient.

The physician's past experience with similar patients not only affected the assessment of the patient's personality, but it also affected their processing of the physical characteristics of the patient. In the next quote, the physician has said that the physical characteristics of the patient as described in the vignette are very unlikely for this particular ethnic group.

I don't see many Filipinos, by the way, who are 30 pounds overweight.

This physician used his past experiences with similar patients to question the description of the Filipino patient given in the vignette. In a sense, he was questioning the plausibility of the description. This raises the interesting point of what this physician would think of an overweight, Filipino patient who did come into his office.

Finally, a physician's past experience with people of the same gender affected the ways in which they viewed the patient in front of them. In this next quote, the physician draws on his past experience with other men to make an assessment of the male patient before him.

Most males tend to wait a couple of months before coming in, that's pretty typical.

In this physician's experience, men often delay the visit to the physician until after experiencing symptoms, so this patient is behaving as expected. No red flags were raised. Many physicians discussed gender differences during the interviews. The physicians felt that men were more likely to deny disease and delay or refuse to come

in to see the physician. It was also said that men are less likely to follow through with a management plan. Many physicians felt that women were more oriented to preventative care and that they came in to see the physician earlier when they experienced symptoms. Physicians were much more optimistic on the likelihood of women following through with the management plan.

Assessing stressors

The physicians often considered outside factors that affected the patient's ability to own their disease. For example, physicians looked at occupation, family, and financial status as issues that could affect a patient's ability to own their disease. In this regard, even a patient who accepts their disease and is motivated to move forward and manage it, may be kept from doing so by outside factors. Many of the physicians tried to identify these factors.

Several physicians were concerned with or discussed the overall level of stress experienced by the patient. These physicians felt that if the patient has a lot of other things to deal with, they will get distracted from their health management. This next quote clearly illustrates this concept. This physician spent a good portion of her interview trying to find out what stressors the patient had to deal with besides their disease.

The more life stresses that they have, often the less people will take care of themselves...

One physician spoke specifically of an instance in which she felt that stress had a profound impact on the health of one of her patients. She describes a woman

who suffered two heart attacks that lacked medical explanation. The physician attributed the heart attacks to a difficult situation at home.

There was a woman this morning, you know, she's had two heart attacks, but her coronary arteries are clean. She's had coronary angiograms. It's because of her husband yelling at her. She's a nervous woman. It just goes like that [gestures with clenched fist], spasm. She's already had two of them. She's been admitted twice with heart attack, but her coronary arteries are totally clean. Because the moral stress she observes, you know, that guy's a jerk. He drinks and smokes and he bothers her.

This physician feels that the patient's husband is a source of substantial stress for the patient. She supported her hypothesis by saying that there have been other instances in which a neurogenic cause of heart attack was suspected and that they were thought to be due to stress.

Several physicians considered the financial status of the patient and whether that would allow them to manage their disease. One physician raised the possibility that a patient could not financially afford the things necessary to manage the disease or that he couldn't risk being less productive at work. This next quote illustrates this idea.

He might think 'Not me, I can't afford to be sick.' You know, he has to keep working, or he doesn't want to baby himself, you know, something like that.

It can also be seen in this quote that an assumption has been made about males in general. This assumption talked about the possibility that the man did not want to be

viewed as “babying” himself. A couple of other physicians talked about this and attributed it to perceived societal roles. All of the physicians who discussed this topic seemed to think that the concern over babying themselves contributed to the fact that men were less likely to visit the physician and that they were less likely to follow through with the management plan.

Assessing willingness to accept the plan

Another feature of owning the disease identified by the physicians was whether the patient was willing to accept their plan. The physicians felt that just accepting the diagnosis wasn't sufficient and that the patient must be willing to engage in a plan to address the disease in order to truly own their disease.

A couple of physicians felt that the patient's ethnicity contributed to whether or not they accepted the plan. These physicians felt that Filipino patients were eager to accept their management plan and follow through on it. One physician put this idea into words in the following quote.

Filipinos, they, culturally there is a tremendous amount of respect for the doctor, and they are very easy to deal with. They come in with meticulous notes. They generally do 100% of what you ask, to the minute of when you ask them to do it.

This physician felt that Filipino patients in general are extremely compliant and he looked forward to working with them. The fact that the patient in the vignette was Filipino made this physician very optimistic that a good outcome would be obtained.

Many of the physicians felt that the European-American patient (Mr. Watson) would be unwilling to accept a treatment plan. They cited the fact that he ignored a previous diagnosis and that he appeared to be in denial about the disease state as evidence that he might not accept the management plan. A few physicians were also concerned with the manner in which he presented himself. Mr. Watson said that he was interested in obtaining a general assessment of his health and that he was also concerned about his condition. In the next quote, the physician wants the patient to understand that he is going to have to accept more than just an assessment. She feels that the assessment will lead to a plan and the patient has to accept the plan.

I want him to do something about it. It's not just an assessment that we have to do. An assessment, by its nature, is going to generate a plan and you're going to want to move on the plan.

This physician doubted the patient's interest in accepting the management plan.

Assessing the patient's resources

In addition to stressors, the physicians also looked at resources available for the patient to manage their disease. Some physicians felt that access to information was an important determinant of compliance. It was widely believed that patients who had access to information were more likely to be compliant. The treatment of both diseases in the vignettes involved diet and exercise modification, and the physicians felt that the patients needed to have the time to concentrate on their lifestyles and make the necessary changes. Many of the physicians tried to assess the patient's resources as they felt that it affected their ability to manage their diseases.

In this first quote, the physician feels that patient's have an easier time managing their disease if they have the ability to gain and process information on it. The physician in the next quote was saying that it was good that Mr. Watson was so highly educated and had access to the internet because he could gain and process a lot of information on his disease. The physician then contrasted Mr. Watson's situation to that of Mr. Villaflor. The physician felt that Mr. Villaflor would have a more difficult time managing his disease because he lacked the resources of Mr. Watson.

The construction worker has not got the same kind of options in his life...

Several physicians mentioned the family as an important resource. A stable family was thought to be positive not only because it decreased the stress that the patient was exposed to, but was also a source of encouragement and support throughout the process of disease management. These physicians felt that Mr. Villaflor had a stable family that would help him to effectively manage his disease. These physicians talked about the wife and children as cheerleaders in keeping him focused on the management plan.

The good thing about his history is he seems to be in a stable family, has a good relationship with his family.

Lastly, time was viewed as an important resource. Both patients were viewed as people who spend a lot of time at work, and many physicians felt that this would be a constant source of distraction from managing their disease. Several physicians

perceived the fact that Mr. Watson was retiring as being positive because he would have more time to focus on managing his illness. This thought is demonstrated in this next quote.

He will be retiring, he has more free time, he can exercise according to his needs.

Chapter Summary

Owning the disease is a complex, but very important aspect of the physician-patient relationship. When a physician is trying to decide if a patient is owning their disease, they are trying to find out what the patients know of the disease, what impact the diagnosis of the disease will have on the patient, and if the patient is willing and able to take the steps necessary to manage the disease. It is also important to note that the individual patient is not the only source of information, but that the physicians draw from their own past experience to put this particular patient into context. The main goal of deciding whether the patient owns the disease is for the physician to find out where the patient is in terms of both their understanding of the disease and the likelihood that they can effectively manage the disease. The physician processes all of this information and then decides what areas they should address when they talk to the patient about the disease. In the next chapter, we will look at the process by which the physicians talk to the patient about their disease.

Chapter 6: Presenting the Illness

The previous chapter was concerned with what physicians were looking for when they obtain information from patients. This chapter addresses another process within the physician-patient relationship, namely how physicians use the information that they gain to talk to the patient about their condition. It can be said that the process of owning the disease is a process by which physician's assess whether the patient is appropriately approaching their disease and its management. Based on that assessment, the physician then decides how they will talk to the patient. Within the process of presenting the illness, there is an underlying theme of the physicians trying to get the patients to come around to their way of thinking. The physicians feel that the patient should see things their way and they look for ways to make this happen.

The process of presenting the illness begins with the physician deciding how she will approach the patient. Approaching the patient involves both the initial introduction to the disease and the underlying tone that the physician adopts throughout the process of presenting the illness. Typically the decision to be made is whether she should take on a more motivating or consoling tone. After the initial approach, the physician tries to educate the patient about their condition. In order to do this the physician attempts to explain the disease and tie the family history, symptoms, and management plan to the pathophysiology. The physicians proposed a wide variety of methods by which to accomplish this, always tailoring the education to the specific patient. In the process of presenting the illness, the physician makes attempts to motivate the patient to accept the management plan, if it is felt that this is

necessary. From the physician's perspective, the success of presenting the illness is determined by whether or not the patient accepts the physician's view of the situation.

Approaching the patient

A good place to begin the discussion of how physicians present the illness to the patient is by looking at how physicians make decisions on how to approach each particular patient. Physicians often consider education level and occupation when deciding how to begin talking to the patient about their illness. The physicians also consider the patient's past exposure to the illness as well as how often they have visited a physician. Another important part of deciding how to approach each patient was reading the patient's non-verbal communication. The physicians often described looking for signs of nervousness or disinterest as they began talking to their patients. The physicians also considered that the patient's personality and approach to health, in general, when deciding how to approach the patient.

In this first quote, the physician is concerned about Mr. Watson's approach to his illness. In the opinion of the physician, Mr. Watson is not taking his illness seriously enough and the physician is concerned that he will continue to ignore it. This physician decided to address this issue directly and this quote is the first thing that the physician would say to Mr. Watson.

Well Mr. Watson, I think that you have diabetes. I don't think that's any surprise to you. And I need to say that it is not dreadful at this point. You don't have any signs of any particular organ damage, but there are a few things that begin to worry me. Your blood pressure is too high. Your sugars are too high. You have symptoms. And you have a very strong family history for it. So the time has arrived when you must begin to take it seriously.

The physician decided to address the issue of denial head-on and clearly tells Mr. Watson that he has been in denial about this condition. He does tell Mr. Watson that the situation is not that serious, but he tempers that with information that the disease has already started to progress and that he must do something about it now. There was a split among the interviews as to how the physicians would address the issue of denial. Many physicians stated that they would address it directly, while others felt that belaboring the denial would strain the relationship while not solving the problem.

Many physicians said that their approach varied depending on the patients themselves. The idea that every patient is different and that each patient must be treated differently was mentioned often, and this next quote gives an example of that.

It depends so much on the individual how you approach things. You know. If they're a scientist, or an engineer, I would just like, boom, boom, hit the facts. You know. Everything with numbers. But with someone like him, it would be more circumspect, more of the big picture, more gentle, more, you know, take into account his culture and, um, just his emotional reaction.

It can also be seen that this physician considered the patient's occupation and culture as well when deciding how to approach each patient. The physician also acknowledged that even within a group of people with the same occupation or

culture, there is a huge range in personality and she tries to read the patient's non-verbal communication when deciding how to approach them.

Softening the blow

The physicians often voiced a concern that giving the patient a diagnosis of disease was a large burden for patients. Some physicians addressed this by moving very slowly and being mindful of not bombarding the patient with too much information. Several physicians tried to ease the patient's tension by putting a positive spin on the diagnosis or by communicating to the patient that they did not bring the disease on themselves.

Many physicians said that people don't want to hear bad news, and when diagnosed with a lifelong illness, some patients pull away from the process and try to distance themselves from the disease. The physician responsible for this next quote felt that patients often had a difficult time accepting a diagnosis of disease and were reluctant to take the steps necessary to manage the illness. He tried to address this issue by conveying his optimism that they will be able to control their disease immediately after he gave the diagnosis.

We're ahead of the game here, you know. Let's just go get these pounds off, and maybe that's all we'll need.

The physician wanted to convey optimism that the disease could be controlled. In addition, he tries to downplay the course of action necessary to manage the disease by telling the patient that perhaps all that is necessary is some weight loss. Lastly, he

includes himself as being a part of the plan, letting the patient know that he is not going to have to manage the disease alone.

One physician felt that it was important to convey the message that a patient wasn't the only person in the world who suffered from the disease. One of the first things that he would mention when talking to the patient about their diabetes, was that there were millions of people in the U.S. who had the disease. When he was asked why he gave the patient those numbers, the following response was obtained.

Well, I find that misery loves company. That sums it up. That people don't like to be the only ones, see. And it helps them, you know. Sometimes it may not be necessary, but the people I see many times they think 'I'm not all by myself. They're doing it, maybe I can do it too.'

This physician felt that when patients knew that other people suffered from the same disease, it was easier for them to accept the diagnosis. In addition, he felt that people were more likely to follow through with treatments if they knew that other people were successfully managing the disease.

Several of the physicians were concerned that the first line of treatment in managing both diabetes and coronary artery disease was diet and exercise modification. The concern was that the message being sent to the patient was that they brought the disease on themselves. A few physicians addressed this issue by telling the patient that there is a genetic component to the disease as well as a lifestyle component, and the following quote illustrates this type of communication.

Both of these conditions, just to some extent, they are due to lifestyles. What you eat and your level of activity and your weight, etc., etc. But there's a big genetic component. Both of them have family histories about it and those are things that we can't do anything about and you just have to accept that. It's not your fault that you got this. That it's just the genes that you are and there are... we can't correct the genes, but we tend to focus on the things that we can correct.

This physician tried to tell the patient that it was not their fault that they got the disease. He informs them of the genetic component to let them know that this was not entirely something that they brought on themselves. This physician felt that communicating this information made the patients more accepting of the diagnosis and the management plan.

Educating the patient

A major part of presenting the illness was trying to educate the patient about their condition. The major reason given for the importance of educating the patient was that it improves compliance. Physicians tried to correlate the symptoms, family history, and laboratory values with the disease state for the patient if the patient hadn't done that themselves. In addition, the physician tried to explain the relationship between the treatment plan and the pathophysiology of the disease. The amount of time which the physician spent educating the patient depended on the amount of information that the patient already possessed and what the physician felt that they should know.

This first quote addresses why physicians feel that it is important to educate patients. Many physicians felt that if the patient understood the disease process and

the reason for the treatment, then they would be more compliant with the management plan. This was actually the only reason given for educating the patient. In this next quote, the physician feels that patient is more compliant if they understand both the disease process and the reasoning behind the treatments.

I find that patients are more compliant if they understand their disease and understand what I am trying to do to treat their disease...

Many of the physicians were mindful of the amount of information that Mr. Watson may have already obtained about his disease, and this is shown in the first part of the next quote. They were concerned with telling him things that he already knew. No similar concerns were ever mentioned with Mr. Villaflor. In the second part of this quote, we see that the physician is trying to explain the pathophysiology of the patient's condition and tie the pathophysiology to the patient's symptoms and their family history.

Well, I would say that, um, that he is, that he may know this but, that we are concerned about the blood circulation to his heart. This is a consideration. Arteriosclerosis, or cholesterol problems in the heart there, in the blood vessels and specifically cholesterol build up in the coronary arteries. We think that this is the underlying condition that leads to heart attacks and probably what his father died of, and it can lead to angina. Angina may be a sign of this, so that the, and that with his pain when he pushes it on the tennis court, with his family history, the probability is that he has some partial blockage of the arteries of the heart.

Almost all of the physicians talked about the importance of making sure that the patient understood their risk factors for the disease. The reasoning behind this was that the major part of managing each of these diseases was to control the risk factors. Therefore the risk factors were always addressed in the context of explaining the management plan to the patient. This next quote gives a typical example of how the physicians educated the patient about their risk factors.

I'd explain to him about being overweight is a risk, because he has several risk factors for early heart disease, so, his family history is a fairly positive, although 68 isn't real early, but it's early enough. His weight is an issue, his non-exercise is an issue, his cholesterol is a huge issue, and so I'd talk to him about reducing those risk factors and changing his lifestyle. And probably, Filipino food tend to be high in fat, so I would talk to him about altering his food choices...

Several of the physicians talked about spreading the process of educating the patient over an extended period of time. The major reason for this strategy was that the physician was concerned with overwhelming the patient with too much information. The next quote is an example of this concern. In addition, the physician discusses the use of a diabetes nurse educator and his reasons for not sending patients to them.

I go very slowly with these folks. I do very, very little for a long time, because I want them to get used to the idea of being diabetic. That's a very scary idea to some people, not everybody, but since you don't know. I don't send them to see a nurse, diabetes nurse educator right away because they tend to scare patients. They feel that it is necessary to be complete, so they talk about everything from amputations to dialysis to blindness and it just scares the bajeebers out of people.

We see that this physician is very concerned about overwhelming the patient with too much information. His preference is to let the patient ease into the process of accepting the diagnosis, and he is very protective of his patients. He chooses not to use diabetes nurse educators because he feels that they scare patients. It must be said that this was the only physician in the study who mentioned this view of diabetes nurse educators. Most physicians said that a diabetes nurse educator would be a big part of managing the patient with diabetes.

Tailoring the explanation to the patient

A few of the physicians mentioned the use of analogies as a method of presenting the illness. Analogies were used as a way in which the physician could tailor the education of the disease state to the experiences that the patient was likely to have had in others aspects of their life. The physicians felt that analogies helped them to explain confusing topics to patients to or emphasize important points.

A couple of physicians mentioned tailoring the analogy to the occupation of the patient. For example, these physicians said that they would use computer or electronic analogies as a way to get through to Mr. Watson, who was described as

being a computer science professor. This next quote gives an example of a physician using a computer analogy with Mr. Watson.

I mean he's a computer science professor. I might try to work from that analogy... Obviously there's certain maintenance programs and virus detection programs which you gotta, you know, plug in and make sure that they're working regularly and maybe I could try to make some analogy for his own life. That he's not going to be able to just go on as he's been going on. He's going to have to make some changes or else the whole thing's gonna crash.

This physician is using this analogy as a way of telling Mr. Watson that the way that he has been handling his disease is not going to work. She was hoping to impress upon him the importance of taking better care of himself and she thought that the analogy would make this point more vivid for him.

One physician mentioned that she frequently uses the following analogy with her patients. She uses it to make a point that is often difficult for her patients to understand, namely the difference between aerobic and anaerobic exercise. In this next quote, the physician is acknowledging that the patient exercises, but she is trying to tell him that he has to do a different type of exercise in order to control his disease.

I am sure that he would tell me that because he's a construction worker that he works really hard. He's tired at the end of the day, but that's not aerobic. So I think I would, um, that my scenario would be the difference between a football player and a basketball player. One's aerobic and one's non-aerobic, but they are both tired at the end of the day.

This physician felt that this was a great analogy and almost all of her patients, including women, understood this analogy well.

Motivating the patient

An important part of the process of owning the disease was to assess the patient's level of motivation. In cases in which the physician feels that the patient is not motivated, they felt that motivating the patient became an important part of how they presented the illness. The motivation was often carried out by scaring the patient by telling them all of the bad things that would happen if they didn't follow through with the management plan. On the other hand, several physicians mentioned that they would motivate the patient by talking about things such the benefits of good control, or how effectively managing the disease would change their life for the better and help them to live longer.

Many of the physicians chose to motivate patients by telling them of the negative consequences of not adhering to the management plan. However, most of these physicians also mentioned being afraid of going too far and scaring the patient away. This tension is illustrated very well in the following quote.

He's got a little bonfire of concern going, and if I add a lot of stuff to the fire, he may back off from the doctor because it just gets too dark and scary. On the other hand, if I started to feel from him that he, I mean if I, since I would start to talk to him about, you know, there are some further tests I want to get, if he starts to say 'Oh, I didn't know about that,' or 'I'm worried about my insurance,' or 'I don't want to take time off from work,' or 'Do I have to see another doctor?' you know, if I think that he started to give me vibes like he was backing off, then I might throw some more things on the fire.

In this quote, the physician first mentions that it is good that the patient is concerned, but she is worried that giving him too much information on complications may scare him away. However, if she thought that he was trying to pull away, she would emphasize the negative consequences of that decision and push him to accept the management plan.

Another method by which several physicians would try to motivate the patient was to use the family as a source of guilt. These physicians talked about leaving the sons fatherless, or setting a good example for the children. This next quote is a good example of this.

Maybe get some emotional link there to where he won't leave his 32 and 29 year old sons fatherless. Maybe work on his guilt a little bit.

It should be said that a few of the physicians expressed guilt with for using this method. However, they felt that they had to do whatever it took to get the patient to accept the treatment.

Enlisting the family

Almost all of the physicians mentioned including the family as a part of the management plan. Some physicians chose to involve the wife because she does the cooking, and diet modification would be a part of the management plan. Some physicians talked about the family as being a source of support or motivation for the patient. A few physicians talked about enlisting the family as a way of keeping the patient on track, almost playing a watchdog role.

In this next quote, the physician said that he would make frequent references to the patient's family. The reason for this was that this physician felt that men were often very motivated by their family and he wanted to draw on this to keep the patient on track. The physician has also chosen to directly involve the wife in the management plan. The physician tells the wife that it is important for the patient to adhere to the management plan and suggests that she must make sure that he does not forget to do what he needs to do manage the disease.

I can draw his family in, frequent references to his family, hopefully, even if his, try to get his wife to come in with him sometime so that I can say to her too, 'So he can't forget, you know.'

Many physicians talked about using the family as a source of motivation for the patient. They felt that involving the family would allow the patient to draw from their family as a source of support and make it easier for the patient to accept and manage the disease. The physician responsible for this next quote mentioned that he would bring the wife in to talk about changing the diet. When he was asked if this was the only role that the wife should play, the following response was obtained.

I'd want her to be a cheerleader here. You know, depending on how they interact with each other. I think that being together that long, they probably have some interest in each other. And it would work to get her involved.

A few physicians displayed selectivity in which family members they would involve in the process. In this next quote, the physician feels that certain members of the family will be more helpful than others. This physician felt that people with a higher level of education were more likely to manage disease effectively. In addition, he felt that women were usually better than men at managing disease. These views are evident in this next quote.

His daughter is probably a higher education level than he is, so I would try to bring her into it if possible. Again it's a female-male thing. I mean both of the other, younger males are working in construction, so they may, I mean, they're not going to as much help.

This physician felt that the daughter would be a good ally because of her education and the fact that she is a woman. This physician also felt that it was important to involve the wife as well. In the opinion of this physician, the sons would not be very helpful because they had a similar level of education as the patient and they were also male.

Having faith in their ability to communicate

A large part of presenting the illness is whether or not the physician feels that she can communicate effectively with the patient. Overwhelmingly, the physicians

felt confident in their abilities to communicate with their patients. However, some physicians expressed frustration with the ability of some of their patients to communicate effectively. For the most part, the physicians were optimistic that they could make the patient understand the disease and the management.

In the next quote, this physician is very confident in her ability to communicate. However, she is clearly frustrated with the ability of some of her patients to understand her explanations.

I think that I give good explanations, simple and clear explanations, but some of my patients literally have an IQ of 62, and I mean how clear an explanation can you give to someone who is one neuron short of a synapse? I mean it's hard.

At another level, it can be assumed that physicians and patients often find it difficult to find a common level of communication.

Some physicians mentioned that they have difficulty communicating with particular populations of patients. The physician in this next quote had been talking about the differences between her male and female patients. She had said that women were better about follow up and I asked her if she had greater difficulty with male patients. Her response is as follows.

I don't. Once they're here, I don't think so. Um, being as I generally have explained things. I mean, I take time to explain things, so I think that they have a better understanding of why.

This physician feels that she gives good explanations to all of her patients and her good explanations keep the patients involved in the process. This physician discussed

her belief that her ability to communicate well helps her to work with more difficult patient populations effectively. Along the same lines, several physicians mentioned cultural or certain personality characteristics as barriers to effective communication.

Chapter Summary

The process of presenting the illness can be understood as a process by which the physician tries to narrow the differences in understanding between them and the patient. There were instances in which the physician felt that the patient had been denying their disease. Some of the physicians chose to address this issue head-on and force the patient to accept their illness. On the other hand, the physicians sometimes perceived the patient as being too worried or too concerned about their condition. In these cases, the physicians tried to provide optimism and soften the impact of the diagnosis. A large part of presenting the illness is trying to change the patient's view of the disease if the physician feels that the current view will hinder the ability to effectively manage the disease.

Educating the patient was a concept that appeared often in the interviews. Many physicians felt that educating the patient was important and the only reason given for its importance was the fact that it increased the likelihood of compliance. Many physicians felt that if patients understood the disease process and how the treatment addressed that process, the patients would be more likely to comply with the prescribed treatment. Educating the patient was also a method by which physicians try to get patients to view the disease in the same manner as they do. The last method by which physicians try to get patients to see things their way is by trying

to motivate the patient by various means. The physicians even enlist the help of others if they think that it will change the patient's view. Overall, physicians are overwhelmingly confident that they can successfully present their view of the illness to their patients.

Chapter 7: Directing the Patient's Approach

The theory of directing the patient's approach as a descriptor for the nature of the physician-patient relationship was taken directly from the data provided in the interviews, and it was chosen for many reasons. First, it seemed as though the role that was played by the physician was one of a leader. The physicians did not seem to be equal partners with the patient, but that they were instructing the patient on how they should be managing their disease. Secondly, the physician actively coordinated the influences on the patient as the patient was only given certain pieces of information and the outside resources that the patient was exposed to were controlled. Lastly, all of the physicians seemed to believe that it would be best for the patients to see things their way, and they tried to get the patients to accept their way of thinking.

Negotiating the agendas

Many times physicians find that their agenda is different from that of their patients. In order for the physician to direct the patient's approach to their disease, they must decide how to resolve this issue and embark on a course of action. Often this involves trying to help the patient to come around to the physician's view. Some of the physicians discussed the methods by which they negotiate the agendas with the patient, and some discussed their frustrations with this process.

Some of the physicians had an agenda which was different than that stated by the patient. In this next quote, we see that it is the physician that has the hidden agenda. He felt that preventative health or screening measures were important for the

particular group of patients to which this patient belonged. This physician saw this patient visit as an opportunity to change the patient's approach to medicine.

This may be our one big chance to get him into care...

The physician said that he would dedicate much of his time to getting the patient to accept a more preventative health care focus. He would do this by talking about all the diseases that can be prevented if proper screening tests are obtained. Similarly, the physicians often mentioned the health benefits that the patient would receive if he accepted the approach that the physician was proposing.

Some physicians talked about the frustration of negotiating the agenda with the patient. This next quote arose in the context of when a physician was discussing situations in which patients bring in information that they had looked up on their disease to review with the physician. The physician felt that this took a lot of her time and that she was not comfortable spending all of this time doing something that only the patient wanted to do. Her frustration is communicated in this next quote.

When you see 30 to 40 patients a day, I don't, sometimes I don't have time to sit down for a whole hour and say, 'Well, you know, three quarters of what you heard is wrong.'

On the other hand, this physician was not always frustrated when her patients brought in information. Many of the other physicians also discussed situations in which patients brought in information, and most felt that this was positive. However, many

physicians also felt as this physician did, namely that it is frustrating when patients bring in a lot of information and want help reviewing it.

Sometimes physicians are frustrated with the patients stated agenda because it would make them assume roles with which that they were not comfortable. This next physician is expressing frustration with Mr. Watson's stated agenda of wanting a general assessment of his health. Her concern seems to be that he is asking her to take on a role that she does not want to assume. In this next quote, the physician clearly tells Mr. Watson that she is not comfortable with his stated agenda.

He said, 'I want a general assessment of my health.' I'd say, 'You do. That is what you want. But if you're going to come to me for that, I'm not just a computer readout that can go, "Okay, click."'

In the minds of the physicians, the agenda of the patient has implications for the role that they will play in the relationship. From the physician's perspective, a large part of negotiating the agenda is considering the role that they are to assume.

Deciding if the relationship will work

In order for the physician to effectively direct the patient's approach, they must be confident that their relationship with the patient will allow them to do this. In cases in which the physician did not feel that the relationship would work, they would try to re-negotiate the relationship and if that didn't work, they often said that they would tell the patient to find a new doctor. A few physicians expressed confidence that they can always form good working relationships with all of their patients and that there was no need to re-negotiate or end the relationship. A couple

of physicians also felt that another physician wouldn't be able to do any better, so they might as well maintain the current, problematic relationship.

Several of the physicians expressed frustration with instances in which the patient desired a role for them which they did not like. In all of these cases, the physicians were concerned that the relationship would not be conducive to managing the patient' illness and many times this was because the physician was put into a subordinate role. In this next quote, the physician is expressing frustration with the role that some of her patients ascribe to her.

Sometimes I have patients that think of me as their little daughter. Well, you know, you're not going to tell your little daughter certain things.

This physician is clearly concerned that she will not be able to manage the patient effectively because she will not get all of the information that she needs. It also seems as though this physician is upset that the role of a "daughter" puts her in a somewhat subordinate position.

Many of the physicians expressed the idea that they have preferred roles for their interactions with patients. Some physicians were flexible and varied their role, depending on what the patient wanted or required. A few physicians adopted relatively rigid views of what their role should be within the relationship. If these preferred roles were not accepted by the patient, the physician often felt that it was necessary to end the relationship with the patient. This next quote provides an example of this idea.

Sometimes if the patient is very frustrating for me, then sometimes I say, 'I don't feel comfortable being your doctor.' But in general I feel that it is my job to assess a patient, give them information, encourage them, give them different ways that might help them to, you know, change their lifestyle or to improve their health. I'm not obligated to make them healthier. That's their job. I'm here, sort of, as their advisor.

This physician feels that he cannot manage the patient unless they accept his preferred role. On the other hand, some physicians acknowledged that different patients may require different roles for them, and they were comfortable switching their roles from patient to patient.

Controlling the outside influences

In the course of managing the patient, some physicians talked about the idea of controlling the influences that the patients were exposed to concerning their disease. For example, in the previous chapter, one physician mentioned that he did not use diabetes nurse educators because they scared his patients. In addition, we saw that many physicians chose to enlist the family in the process of presenting the illness, but some talked about involving some family members as opposed to others because some family members would be a better influence. The visual image of a physician as a director comes up most strongly under this concept and this will be illustrated in the next couple of examples

Some of the physicians discussed instances in which the patient decided not to accept the management plan suggested by the physician. In these cases, the physician made sure that the patient understood the situation by explaining why they felt that the prescribed plan was important. The physician usually accepted the patient's

choice, provided they felt that it was an informed decision. This process is illustrated in this next quote, but there is an additional component. This physician was talking about instances in which patients chose alternative therapies and he outlined how he deals with these situations.

I let them know that I don't agree, but that it's their right to make that decision and I make sure that they are making an educated decision. That they're not basing their decision upon some false premise or some concept that they read in Star, or something like that. But as long as I do that and they still do not do, then that's fine, and I try to work out a follow-up and, do follow-up and assessment of how their approach works.

In this situation we see that the physician first insures that the patient is making an educated decision. If the physician is satisfied that it is an informed decision and the patient decides to proceed with the alternative therapy, then the physician still tries to remain in the process. He tells the patient that they will work together to assess the efficacy of the patient's chosen course of action.

In this next quote we see that the physician is again directing the influence that the patient is exposed to. This physician felt that her patients benefited from sitting in on consultations with specialists. However, she felt that this could be overwhelming for some patients, so she talks to the specialist beforehand and lets them know how they should approach the meeting. This process is summarized in this next quote.

I think it helps the patient to at least talk to the specialist and have an idea of what's going to be done. Not to coerce them, that's not the point, um, but also I mean I've had patients who are hysterical, who don't really hear anything I'm saying and I think in a big meeting would just lose it. Um, and I would say to the specialist, "Don't use big words, and don't go into this theoretical stuff. You're going to lose the patient. They're already scared to death..."

Persuading the patient

Some of the physicians talked about having to persuade patients to accept their advice on how to manage the disease. In these cases, the physician felt confident that they knew the best method by which a patient could control their disease. However, the physicians were concerned that the patient would not see things their way. In these instances, the physician talked about putting a particular spin on information, or trying to scare the patients into the acceptance of the management plan. The concept of persuading the patient is an important part of the theory of directing the patient's approach.

In this next quote, the physician stated that he would start preparing the patient with coronary artery disease for bypass surgery. When he was asked if he would encounter difficulty getting the patient to accept this course of treatment, the following response was obtained.

Once I spin it in a way for him that lets him know that we will be preserving his functioning life...

The continuation of the quote is that the patient will accept the treatment. The idea of putting spin on information is a clear example of physicians trying to direct the approach that patients take toward their disease.

Physicians felt that they had to persuade patients in situations in which they felt that they knew what was best for the patient, but they were afraid that the patient would not accept the management plan. In the next quote, the physician clearly feels that he knows the best course of action, and he goes as far to say that the patient does as well. This physician was often concerned that patients do not effectively manage their disease because they get distracted by other aspects of their lives. This physician feels that it is sometimes necessary to persuade patients to accept certain aspects of the management plan for their own good.

The biggest problem is persuading people to do what we, and they, know they should do.

This physician talked often of his difficulties in persuading patients to do what they should do to manage their disease, and he said that a good portion of his time with patients was dedicated to persuasion.

Chapter Summary

The process of directing the patient's approach begins when the physician first starts gathering information from the patient. This process has been called owning the disease and it can be viewed a process by which the physician assesses the patient's approach to the disease. The physician then compares the patient's approach to the approach that they feel that the patient should be taking. The process

of presenting the illness is the process by which the physicians try to get the patient to accept their approach to the disease. The physician's hope is that they will be able to persuade the patient to accept the course of action that they prescribe.

One of the main components of the theory of directing the patient's approach is that of the physician as the leader. In order for the physician to effectively persuade the patient, they must have some type of leadership influence over the patient. The physician tries to secure their role as a leader by trying to negotiate the relationship with the patient. If they cannot obtain the role of a leader, the physician may choose to end the relationship. The physician tries to get the patient to see things their way by giving them certain pieces of information and even putting a spin on it. The physician's goal is to get the patient to accept their way of thinking because they feel that it is what is best for the patient. The physician hopes that the course of action taken is the one that will be the most beneficial to the patient.

Chapter 8: Discussion and Conclusions

One of the most positive findings of this study was that the vast majority of the physicians interviewed approached their patients from a psychosocial perspective and were genuinely interested in helping their patients to improve their health. They spoke of providing encouragement, giving the patient time to accept their diagnosis, and identifying barriers to management and helping the patient to remove these barriers. These physicians spoke often of the impact of the patient's family and social situation on their health and the importance of identifying these factors. All of these results were very encouraging.

However, there were some results that weren't as encouraging. In comparing the two patients from the vignettes, it was easy to see that both patients were treated differently in terms of decision-making authority. Many of the physician's felt that Mr. Watson was more capable of making medical decisions, therefore more decision-making power was ceded to him. The process of deciding how much decision-making power to give to the patient was heavily based on assumptions regarding the patient. Along the same lines, the physicians appeared to believe that helping the patient to get well was more important than ensuring that the patients were making decisions free of their influence. The physicians in this study appeared to be comfortable with the idea that they sometimes have to persuade patients to do what is best for them.

Although this study did not address this issue directly, it must be remembered that outside pressures have an impact on physicians' relationships with their patients.

Physicians are required to obtain and process information from their patients as well as provide them with information. Because of constraints on the way that medicine is practiced today, physicians are being asked to do all of this in a very short period of time. Some of the problems identified in this study, may be explained by this situation.

The Role of Assumptions and Preconceptions

The results of this study suggest that assumptions made about patients have a significant effect on how physicians perceive patients. When gaining information from the patients, the physicians commonly used assumptions to decide how well the patient understood their disease, if the patients were willing and able to manage the disease, and what the disease meant to the patient. The physicians also relied to some degree on assumptions when deciding how to talk to the patient about their disease. For example, many physicians assumed that Mr. Villaflor would need a more thorough explanation and that he would not be able to process a great deal of the medical information. On the other hand, many physicians felt that Mr. Watson already had extensive information regarding his illness and that he was eager to manage the illness somewhat autonomously. The results from this study suggest that assumptions play a very large role in the practice of medicine.

If the assumptions that the physicians make are found to be accurate, then their use really isn't problematic. However, when an assumption turns out to be inaccurate, it can have a significant impact on the relationship with the patient and on the patient's health outcome. For example, Mr. Villaflor may have wanted and been

able to play a more autonomous role in the management of his illness. Not providing Mr. Villaflor with this opportunity may lead to his dissatisfaction with the physician. Similarly, perhaps Mr. Watson did not want to take such an active role in managing his illness. His preference may be to let the physician make most of the decisions, and it could be argued that his wishes should be respected. It has been shown that physicians are often inaccurate when guessing how much information their patients want, assessing patient understanding, or even assessing whether or not the patients are satisfied with the relationship (Waitzkin, 1985; Bensing, 1991; Street, 1991; Kee, 1996). All of these findings suggest that physicians should be more reluctant to allow assumptions to play such a large role in their assessments regarding patients.

One issue that arises is how physicians should go about assessing factors such as patient understanding, motivation, and what the disease means to the patient. Perhaps, the best method that has been reported to date is to ask the patients directly (Deber, 1994). While it is often very difficult to gain information from patients, simply relying on assumptions is not an accurate method. Patients are often willing to provide the information that a physician needs, and directly asking the patient is likely to be successful. It must be said that some physicians in this study did discuss asking direct questions in order to gain information. However, this was a far less common method when compared to relying on assumptions. All of the physicians relied on assumptions to some degree, and some physicians relied heavily on them.

In fairness to the physicians, there may be very good reasons to rely on assumptions when making patient assessments. In the practice of medicine today, physicians are faced with restrictions as to how much time they can spend with

patients. During a short period of time, they must gain information from the patient, process that information, decide the best course of action to manage the patient's illness, and communicate that plan in such a way to ensure both understanding and compliance by the patient. Relying on assumptions simply takes less time than asking a patient directly. The physicians in this study indicated that their assumptions were derived from their clinical experiences. It is unlikely that all of their assumptions are derived in this manner, but many probably are. The fact that these assumptions are grounded in their experiences suggests that many may be accurate. However, physicians must be aware of instances in which they are relying on assumptions and be open to the possibility that their assumptions can be wrong.

A topic that is closely related to the issue of relying on assumptions is that physicians often held preconceptions regarding particular groups of patients. These preconceptions were determined by factors such as the patient's occupation, race, ethnicity, and education level. For example, some physicians felt that Mr. Villafior would be very compliant because Filipinos typically view physicians as authority figures. The physicians often assumed that Mr. Watson would almost enjoy managing his diabetes because "it involves a lot of numbers and computer science people love numbers." While these preconceptions were unlikely to be derived from any overt prejudice or discrimination on the part of the physician, any generalization that predicts behavior based on ethnicity or occupation seems risky. Even though these preconceptions were presented as being derived from the clinical experiences of the physicians, there exists the issue of whether a patient's characteristics and the

preconceptions that go along with those characteristics should be used as clinical information.

Physicians should be aware of their preconceptions in their clinical practices. While the use of preconceptions regarding particular groups of people can be helpful, the physician runs the risk of misunderstanding the individual patient if the preconception does not fit. This misunderstanding could lead to patient dissatisfaction with the relationship. Again the solution here may be to ask direct questions in order to assess how best to approach particular aspects of the medical encounter and the process of managing the illness. In many cases, it will be difficult to find direct questions to ask, and in these cases the physician should look for statements or actions made by the patient to determine if their preconceptions apply. It is appropriate for physicians to keep preconceptions derived from clinical practice in the back of their minds when interacting with patients, but they should give the individual patient the opportunity to dispel any and all of those preconceptions.

The physicians also held preconceptions regarding the best way to manage a particular disease. Many of these preconceptions are likely to have been gained from their clinical training and clinical experience. However, the physicians did not seem to acknowledge the subjective nature of these preconceptions. For example, it is likely that some of these preconceptions are derived from the physician's view of how they would manage their own disease. It is likely that all patients are motivated to control their disease in their own particular ways. The physicians did not seem to acknowledge this and they compared the patient's behavior to their own standards. By holding on to these preconceptions regarding illness management, the physician

may be comparing the patient to a standard with which the patient cannot comply. There is also the possibility that the patient does not need to comply with this standard to effectively manage their illness.

One problematic finding in this study was that only a few physicians mentioned methods by which they assess patient understanding. Some physicians said that they asked patients directly if they understood or asked them to repeat what they had been told. Other physicians said that they relied on a patient's non-verbal communication to assess how well the patient understood what they had been told. This finding is of concern given the literature discussed previously which suggests that physicians are not accurate when assessing patient understanding (Kee, 1996). The importance of understanding is emphasized by the correlation of compliance with patient understanding, a finding confirmed by multiple physicians in this study.

Interestingly enough, the physicians who reported a correlation between compliance and understanding were the physicians who asked their patients to repeat what they had been told. Given the role of the physician in insuring patient understanding, some have concluded that non-compliance is the fault of the physician and not the patient (Spaeth, 1995). Although this may be an extreme view, it is important to acknowledge that non-compliance is not just the fault of the patient. All too often, physicians fail to take any responsibility for non-compliance.

The Psychosocial Approach

One of the most encouraging findings in this study was that most of the physicians took a strongly psychosocial approach to the patient. This is likely to have

a beneficial effect on the physician-patient relationship given the evidence that patients are more satisfied with this type of focus during the medical encounter (Bensing 1991, Roter 1997). Many of the physicians tried to assess the patient's conception of the illness and how a diagnosis of disease would affect them. The physicians also assessed the patient's stressors in order to find things that may keep them from actively managing their disease. The physicians expressed concern over the patient's family situation and actively sought ways to involve the family in the patient's care. All of these actions tell the patient that they are being looked at as a person with an illness, not just another case of a particular illness for the physician.

Almost all of the physicians said that they would try to involve the family in the patient's care. In many instances, the physician wanted to draw the family in because they were a strong source of social support for the patient and would offer encouragement as the patient sought to make difficult lifestyle changes. This raises the question of whether patients want their family to be involved in their care. The issue here is that the patient will lose some confidentiality when the family is involved, and many of the physicians mentioned this concern. However, research suggests that most patients want their family involved in their care, even desiring more familial involvement than is allowed in the typical medical practice (Botelho, 1996).

Another aspect of the psychosocial approach that was mentioned frequently during the interviews was providing positive feedback and encouragement for the patient. Many physicians discussed calling attention to the positive aspects of the disease state, such as it being in an early and manageable stage. Some physicians

said that they would praise the patients for taking the initiative to come in to see the physician. Many physicians also talked about telling the patient that they were worried about their health and wanted the patient to get better. These displays of positive affect make the patient feel as though they are being treated as a person and that the physician is interested in their well-being. The expression of positive affect is positively correlated with patient satisfaction (Safran, 1998).

Only a few physicians talked about displaying a negative affect with their patients. For example, when patients were not adhering to the management plan, one physician said that she would tell the patients that she wanted them to get better and that she was upset that they weren't doing what they needed to do. Studies have also shown that the communication of a negative affect is positively correlated with patient satisfaction (Safran 1998). This again reflects the fact that patients want their physicians to care about their well-being and they want to feel that the physician is invested in the goal of helping them to get better. A physician communicating disappointment that a patient is not getting better tells that patient that the physician is committed to helping them deal with their illness. Physicians should not be afraid to communicate disappointment, but this display should be tempered to avoid being perceived as scolding the patient.

The psychosocial approach is typically motivated by a physician's desire to gain information on the likelihood of good disease management. Therefore, all of the information gained is focused towards the purpose of ensuring that the patient can manage the disease or finding ways to help the patient manage the disease. In contrast, some have argued that in order to truly understand the patient and how they

will manage their illness, the physician should take a broader approach which includes finding out who the patient is as a person. The argument is that understanding the life experiences of the patient will help the patient to feel that the physician really cares about and is interested in them as a person.

Social poetics is a method that has been proposed as a way to connect with patients in a more personal manner (Katz, 1996). It is a narrative approach by which a physician tries to understand the patient by listening to the patient's stories of his or her life. The physician interacts with the patient during the patient's narrative and attempts to relate to the patient's life experience. The goal of this method is to give the physician a better understanding of the way that the patient is conceptualizing their disease and an opportunity for the physician to have more meaningful and personal interactions with each patient. It is likely that many physicians will feel that this approach will take too much time and that it will yield little clinically relevant information. In all likelihood, it will be difficult to get physicians to see the value of this type of approach.

Another positive aspect of this study was that the physicians seemed willing to work with patients to overcome the barriers to managing their disease. Some physicians proposed an interpreter to overcome a language barrier with Mr. Villaflor. Several physicians talked about working with the patients to make sure that they could afford the treatments prescribed or to find treatments that the patient could afford. Many physicians discussed working with the patient to find ways to overcome the barriers to instituting the necessary dietary and exercise changes. This is another aspect of the psychosocial approach and it seems likely that patients

appreciate these measures. These measures are also likely to increase the probability of successfully managing the patient's illness.

Another positive aspect of the study was that many of the physicians displayed compassionate behavior when deciding how much information to provide to the patient. Many expressed concern with overwhelming the patient with too much information. The physicians also considered the possibility that the diagnosis of disease would be a burden in and of itself to the patients. A few physicians talked about giving the patient time to accept the diagnosis and to process the information. However, this approach was usually taken with Mr. Villaflor and not with Mr. Watson. Based on his delay in seeing the physician, the physicians often assumed that Mr. Watson was in denial or that he already had information on the disease, and thus had already begun to process it. Nonetheless, many of the physicians talked about giving the patient the time they needed to fully accept the diagnosis.

Many of the physicians also talked about tailoring the explanation of the disease and the disease process to each particular patient. A few physicians described using analogies that the patient would have an easy time relating to. They also considered the patient's education level and the patient's past experience with the disease. Some of the physicians also talked about tailoring their approach to the personality of the patient. They discussed the best ways to get through to a particular type of personality based on the ways in which that person was likely to process the information that they were given. Realizing that each patient processes information differently was a positive finding in this study.

The Role of Personality

Regarding personality, there was one issue that arose frequently during the interviews. Almost all of the physicians felt that Mr. Watson was in denial about his health status. A few physicians chose to confront Mr. Watson about this issue directly, while others chose to acknowledge the fact, but not discuss it. Those physicians who chose not to address the issue with Mr. Watson felt that it would be counterproductive, or just something that they didn't want to deal with. A few physicians said that they would avoid the denial issue until they had established rapport with Mr. Watson.

All of the physicians had a negative reaction to Mr. Watson's perceived denial and some were even upset by it. In short, Mr. Watson did not seem to inspire compassionate behavior in the physicians. This negative reaction may have contributed to the fact that some physicians would not address the issue of denial even though they felt that it was very important. This may be attributed to the physicians' past experiences which suggested that there is little that they can do when a patient is in denial. Physicians may also feel that bringing a patient out of denial isn't a part of their job.

A few physicians acknowledged the fact that they cannot have good interactions with every patient. These physicians said that their personality occasionally fails to mesh with a patient's personality. In these cases, the physician would suggest to the patient that they find a new physician. The goal of the physician was to help the patient get well, a goal which they felt was unlikely to be obtained given a patient with whom they did not have positive interactions. These physicians

felt that the patient would be able to find another physician who could work with them.

The idea of physician-patient fit is interesting and it has been addressed in the literature. One proposed model for physician-patient match is based on the patient's ability to process medical information and the patient's desired level of control of the interaction with the physician (Peters, 1994). The model assumes that some patients are better equipped to understand medical information when compared to others. It also assumes that some patients prefer more control over their relationships with physicians and that other patients prefer less. The model results in four different groups of patients. The strategy would be to decide the group to which each patient belongs and then match them with a physician who is best suited to interact with patients of that particular group.

The idea of matching physicians to patients is intriguing, but implementation of this model may prove to be difficult in clinical practice. First, it requires that patients have a choice of physicians, a situation that does not always exist. It also requires the development of methods to assess the groups to which a patient belongs. Lastly, it may be difficult for patients to accept a labels such as "low ability to process medical information" or "more control over interaction with physician." Although the proposal described above is problematic in many ways, the idea of matching patients and physicians has the potential to improve some relationships between physicians and patients.

It has been suggested that considering the personality of each particular patient will be of value to physicians, particularly physicians in general practice. The

idea of using implicit personality theory in general practice has been proposed by Bower (Bower, 1998). Implicit personality theory is the idea that specific traits are correlated with particular patterns of behavior. For example, implementation of this theory would help physicians to predict how a particular patient might respond in a given situation. It is important to note that this theory is heavily based on assumptions regarding specific traits and that these assumptions are sometimes inaccurate. However, a few physicians in the study mentioned having specific training in personality theory and that it has helped them in their practices. It can be argued that most physicians use at least some intuitive personality theory in their practices even though they do not have any specific training in this area.

The Patient's Decision-Making Authority

Almost all of the physicians expressed a willingness to involve patients as active partners in the relationship. A few physicians preferred to play the role of an advisor or a resource, believing that the patient should be the ultimate decision-maker. This suggests that physicians are willing to grant the right of patient autonomy. However, the right to patient autonomy was not granted consistently. Mr. Watson was almost always granted the opportunity to make decisions for himself, while Mr. Villaflor was not offered this opportunity as frequently. The physicians who discussed this issue felt that Mr. Watson was more capable of making decisions because, based on his education level, he would have the ability to process medical information. Some of the physicians said that as Mr. Villaflor learned more about his disease, they would give him more opportunity to make his own decisions.

These results provide evidence that the physicians in this study did not apply the same model for the physician-patient relationship with all of their patients. With some patients, the physician decided to take a more paternalistic approach while other patients are granted a higher degree of autonomy. These results also show that the physicians allow the relationship to change over time. The physicians in this study modify the relationship with the patient to suit the situation. However, the decisions on the part of the physician often relied heavily on initial assumptions made regarding specific patients characteristics, assumptions that may not be accurate.

The Issue of Power Imbalance

The physicians in this study seemed to be aware of the inherent power imbalance in the physician-patient relationship. Some physicians stated this explicitly when they said that Filipinos typically offer physicians a great deal of respect and tend to view them as authority figures. As a consequence, these physicians felt that it would be easy to ensure that Mr. Villaflor to complied with the management plan. Along the same lines, some of the physicians discussed the use of persuasion, and even manipulation, to convince the patients to comply. Interestingly, it did not seem as though the physicians viewed these methods as an abuse of power. The physicians justified their actions through claims of helping the patient to do what was best for them. The physicians felt that they knew what was best for the patient, but that the patient sometimes did not realize what was in their best interests. For these reasons, the use of power was not seen as an abuse because it was for the benefit of the patient.

It can be argued that regardless of the intent, the use of persuasion and manipulation is an abuse of power. The right to patient autonomy includes the idea that patient has a right to self-government without the controlling influence of others. The use of persuasion or manipulation by the physicians is a source of controlling influence and is not compatible with granting the right of patient autonomy. However, the physicians are using persuasion and manipulation for the benefit of the patient, so their motivations are beneficent. Some physicians felt that the end justifies the means, but this view is certainly debatable.

Some have argued that the physician's use of power during the physician-patient relationship stems from, and is reinforced by, their medical training (Brody, 1992). Physicians are routinely exposed to the idea that they must help their patients even when the patients don't want to help themselves. The idea is that the physician knows what is best and that they should do whatever is necessary to help the patient get well. This idea is distinctly paternalistic and is a common aspect of the practice of medicine today. Physicians should be aware that this action infringes upon the patient's right to autonomy.

It has been suggested that physician's fail to see their use of power as an infringement on the patient's rights because they are not exposed to the patient's point of view when they consider the process of making medical decisions (Luban-Plozza, 1995). Physicians are taught to make medical decisions by other physicians and to rely on clinical data. Rarely are they exposed to the ethical aspects of making clinical decisions or the patient's point of view. A possible solution to this disparity is to conduct focus groups on medical decision-making with both physicians and

patients (Luban-Plozza, 1995). Such a method would be expected to help physicians consider the patient's point of view when making clinical decisions. Perhaps an even better method would be to make medical ethics and the patient's perspective larger components of medical school curricula.

The Problem of Time Constraints

Some physicians expressed frustration with having to address certain aspects of the patient's agenda. It wasn't a matter of the physician feeling that what the patient wanted was not important, rather physicians felt they often did not have enough time to do everything that the patients desired. When time was limited, the physicians felt that their own agenda should receive priority. The issues of time and time management are major factors determining the quality of medical care and the situation seems to be deteriorating. Physicians are being asked to do more during the clinical visit while being given less time with the patient. Many physicians reported that cost containment measures affect their relationships with patients.

One physician discussed his view of managed care as being immoral and that it was destructive to the physician-patient relationship. He felt that his patients could not trust him because they realized he was working for the HMO as well as them. This issue was touched upon by a few other physicians. However, the study was not designed to address this issue, but it is likely to be of concern to many physicians. Recent attention has been given to the often conflicting interests of patients and managed health care organizations, and some proposals have been made to address such issues. One proposal includes carrying out open discussions with patients about

cost containment and its impact on patient care (Levinson, 1999). The goal behind initiating these discussions is that it will help patients understand the nature and rationale of cost containment. It has been recommended that physicians not openly attack health care plans when meeting with patients because it reinforces antagonism between the patient and the health care plan and places the physician in the middle. It has been argued that both the physician and the patient must consider and accept the social and economic context for changes in the delivery of health care and that the two groups should seek to define a new model for the physician-patient relationship that incorporates these changes (Balint, 1996).

There are others who feel that managed care is an immoral system and that it has no place in the field of medicine. It has been argued that managed care dehumanizes both the physician and the patient by reducing the physician to a provider of services, and the patient to nothing more than a disease state. It is argued that this dehumanization destroys the covenant between physician and patient (Fitzgerald, 1998). The debate of the morality of managed care is not the focus of this study, but the impact that managed care has had on the physician-patient relationship must be considered. This is an issue that today's physicians must confront when working with patients.

The Issue of Emotional Reactions to Patients

Another issue that can make the physician-patient relationship difficult for physicians is that they will have their own emotional reactions to the interaction. Physicians are often expected to keep their emotions to themselves during encounters

with patients. However, all forms of human interaction contain an emotional component and patients often stir up emotional responses from physicians (Zinn, 1988). Deciding the appropriate time and manner to express their emotions is a difficult issue for physicians. Many of the physicians in this study talked about having to hide their dislike of, or frustrations with, some of their patients. Controlling their emotional reactions to patients is a challenging aspect of the physician-patient relationship for physicians.

Physicians must also deal with the emotional reactions to decisions made by patients. Some of the physicians discussed instances in which the patient chose not to take their advice. In most cases, this situation is likely to only stir up minor emotional reactions within the physician. However, in certain cases, it is likely to have a huge impact on the physician. Such a situation is described quite well in a story by Gawande in which he talks about his experience with a patient who was facing the end of his life (Gawande, 1999). The patient had elected to undergo a surgical procedure that would only slightly prolong his life while the risks of the surgery were severe. While respecting the patient's right to make a decision, the physician had to endure the strong emotional reaction of letting the patient make what he thought was the wrong decision.

Clinical Implications of This Study

Patient Autonomy and the abuse of power. This study raises doubt as to the role of patient autonomy in today's practice of medicine. One of the requirements for the right of patient autonomy is that the patient has the ability to make decisions

regarding their health in the absence of the controlling influence of the physician. In this study, it was found that physicians often feel the need to persuade or manipulate patients to accept the course of action that the physician feels is best. Some physicians have little faith in the ability of patients to make the right decisions regarding their health. The physicians in this study did not see anything wrong with trying to influence that patient's decision. They felt that it was a part of their job to make sure that patients took a course of action that would be most beneficial to their health.

Although the intentions were beneficent in nature, this can still lead to an abuse of power. The physicians realize that they are the experts on the medical information and they used this advantage to persuade their patients to take the course of action that they felt was best. It is still necessary to define the role that patient autonomy should play in medical care. It can be argued that persuading the patient to take medical advice is beneficial. However, the message is then that beneficence is more valued than patient autonomy. Over the last 40 years, patient autonomy has been gaining support as the dominant principle of the practice of medicine. This study suggests that aspects of paternalism still infringe on the rights of patient autonomy.

Sacrificing the patient's agenda. Related to the question of autonomy, is the issue of respect for the patient's agenda. Throughout this study, many physicians chose to ignore or avoid the patient's agenda. Most often, the reason given for this action was physicians felt that time limitations frequently required the patients agenda be sacrificed in lieu of the physician's agenda. The physicians felt that their agenda

was a better use of time and would be more beneficial to the patient. None of the physicians expressed the belief that carrying out the patient's agenda would be unfruitful, only that their time could be used better.

This situation raises the possibility that the patient's agenda is ignored. One reason this situation is of concern is that it could lead to patient dissatisfaction with the relationship with the physician. The negative consequences of patient dissatisfaction have been reported to be non-compliance, disenrollment from the physician's practice, or malpractice litigation. This situation can be addressed by teaching patients how to ensure that the physician either addresses their agenda, or gives them other avenues to carry out their agendas. For example, if a patient wants to evaluate information that they have found through personal investigation, the physician can direct the patient to the appropriate resources to evaluate that information. Physicians can also help address this situation by trying to keep the patient's agenda in mind during the medical encounter. Ideally, the physician should address the patient's agenda, or at a minimum, inform the patient of their reasons for not doing so.

The dangers of assumptions. The final clinical implication of this study is that assumptions play too large a role in the practice of medicine. All of the physicians in this study relied on assumptions regarding specific characteristics. The problem with this method is that many studies have demonstrated that the assumptions made by physicians about patients are often inaccurate. Relying on inaccurate assumptions creates the possibility that the physician will interact in a manner that is inappropriate. As a result, the interaction may not address the issues that are relevant to helping that

patient control their disease. This could lead to ineffective control of the illness or patient dissatisfaction with the relationship.

Another possible outcome is that the patient could feel discriminated against. There have been many cases of reported discrimination in medicine and physician assumptions could play a significant role in these cases. It can be argued that discrimination may lead to disenrollment from the physician's patient population, and even reluctance to seek medical care at all. In this regard, the possibility exists that discrimination in medicine creates underserved populations. This situation can be addressed by making physicians aware of the biases that they may hold toward particular groups of patients. It can also be addressed by making patients aware of how some of their own characteristics and how the manner in which they present themselves to the physician may be interpreted by the physician. The goal is not to change the patient, just to make them aware of what may be going on and give them opportunities to address this issue.

Limitations of the Study

The first limitation of this study was that it was confined to the physician's perspective on the physician-patient relationship. We gained information on the thought processes that the physicians engage in and revealed the goals of physicians with regard to patient interaction. We also heard the difficulties that physicians experienced when dealing with particular patient characteristics. It would be useful to obtain the patient's perspective in order to truly have a view of the physician-

patient relationship. Similar studies should be done to gain the patient's perspective on the physician-patient relationship.

Another limitation of this study was that we obtained information only on how the physicians wanted to be perceived in the physician-patient relationship. Under this study design, there is no method by which we can evaluate if the patients actually perceive the physicians as they want to be perceived. The findings of this study may not reflect what actually goes on in the physicians' offices. The value of this study was that it provided us with information on how the physicians approach the physician-patient relationship, and it was successful in that regard. An area of further research would be to see how well the physician's approach is carried out in the actual clinical encounter. It would also be interesting to see if physicians are perceived as they would like to be by their patients.

The last limitation of this study is that the physicians were trying to simulate an interaction with a patient based on a written description of that patient. A few physicians mentioned that this was extremely difficult. It must be acknowledged that the study design may have forced physicians to make more assumptions regarding patient characteristics than they normally would. However, the design did appear to elicit the physician's approach to patients well. A more realistic simulation may be to use a videotape recording of a patient presenting to the physician's office. Actors could also be used to provide a more realistic simulation. Either the videos or the patient actors could replace the vignettes in this study.

A limitation that may be mentioned by others is that the sample included only 24 physicians. This is a frequent critique of qualitative methodology and it

demonstrates a common misunderstanding of the nature of and rationale behind qualitative methodology. The purpose of the Grounded Theory method is to attempt to characterize an interpersonal process that occurs in society. In this case, my goal was to characterize the nature of the physician-patient relationship from the perspective of the physician. The results of this study are generalizable to the nature of the physician-patient relationship but they are not predictive of what will happen during an interaction between a particular physician and a particular patient. The results might give us phenomena that we can look for during the interaction, but it provides no guarantee that we can predict the outcome of that particular physician-patient interaction.

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Appendix A: Clinical Vignette Set #1

Clinical Vignette #1

Chelito Villaflor is a 53 year old, Filipino male who came to your office because he thinks that he may have diabetes. Mr. Villaflor went to a community health fair two weeks ago and was told that he had high blood sugar at one of the screening booths. Mr. Villaflor says that he is very worried because his father died from diabetes. Mr. Villaflor has been working as a construction worker since he came to this country 11 years ago. He has health insurance, but he doesn't know what it covers, since he has not had to visit a doctor in a long time. When asked, Mr. Villaflor acknowledges urinating more often, having to go to the bathroom at night, and excessive thirst.

Mr. Villaflor has no history of major medical illnesses, and he reports no other current medical problems. He has two sisters who have diabetes, but everyone else in his family is healthy. Mr. Villaflor has a heart rate of 77 and a blood pressure of 144/86. Aside from the fact that Mr. Villaflor is about 30 pounds overweight, nothing significant is found on physical exam, including a normal funduscopic exam, a normal sensory exam of the feet, and full peripheral pulses. All lab values are normal except for a plasma glucose of 143 mg/dL and an HgbA_{1c} of 8.1%.

Mr. Villaflor has never smoked and he rarely drinks alcohol. He has two sons, ages 27 and 25, and a daughter who is 20. Both of his sons live in the area, and his daughter goes to college in Southern California. His oldest son is also in construction work and the younger son works in a factory. Mr. Villaflor owns a small home in Oakland and lives with his wife of 32 years.

Appendix A cont.

Clinical Vignette #2

James Watson is a 61 year old European-American male who comes to your office looking for a “general assessment of his health.” He is particularly concerned about his cholesterol since he was found to have elevated cholesterol 10 years ago, but didn’t have the time to do anything about it. Mr. Watson is a computer science professor at the University and he is considering retirement. Before he decides to give up his current health coverage, Mr. Watson would like to get an assessment of his current state of health. The only complaint that Mr. Watson has is that he sometimes gets chest pain when he “really pushes it on the tennis court.”

Mr. Watson has no other significant history of medical illness and he describes himself as being pretty healthy. His father died of a heart attack at age 68 and he thinks that his older brother may suffer from angina. You find a heart rate of 81 and a blood pressure of 138/86. The physical exam is unremarkable except for the fact that Mr. Watson appears to be about 25 pounds overweight. Laboratory values are all within normal limits except for a total cholesterol of 326 , an HDL of 36, and a triglyceride of 289.

Mr. Watson has never smoked and he drinks about 3 to 4 drinks per week. He has two sons, ages 32 and 29, who are in good health and live with their own families in San Diego and Detroit, respectively. Mr. Watson lives with his wife of 36 years in a house which they own in the Oakland Hills.

Appendix B: Clinical Vignette Set #2

Clinical Vignette #1

Chelito Villaflor is a 53 year old, Filipino male who came to your office because he thinks that he may be having “heart trouble.” Mr. Villaflor went to a community health fair two weeks ago and was told that he had high blood cholesterol at one of the screening booths. Mr. Villaflor says that he is very worried because his father died from a heart attack at age 68. Mr. Villaflor has been working as a construction worker since he came to this country 11 years ago. He has health insurance, but he doesn’t know what it covers, since he has not had to visit a physician in a long time. When asked, Mr. Villaflor says that his chest “gets tight and hurts” at work sometimes when he is lifting very heavy things and walking up lots of stairs.

Mr. Villaflor has no history of major medical illnesses, and he reports no other current medical problems. He has a brother who has heart problems, but everyone else in his family is healthy. Mr. Villaflor has a heart rate of 81 and a blood pressure of 138/86. The physical exam is unremarkable except for the fact that Mr. Villaflor appears to be about 25 pounds overweight. Laboratory values are all within normal limits except for a total cholesterol of 326, an HDL of 36, and a triglyceride of 289.

Mr. Villaflor has never smoked and he rarely drinks alcohol. He has two sons, ages 27 and 25, and a daughter who is 20. Both of his sons live in the area, and his daughter goes to college in Southern California. His oldest son is also in construction work and the younger son works in a factory. Mr. Villaflor owns a small home in Oakland and lives with his wife of 32 years.

Appendix B cont.

Clinical Vignette #2

James Watson is a 61 year old European-American male who comes to your office looking for a “general assessment of his health.” He is particularly concerned about his blood glucose since a fasting blood glucose was elevated about a year ago, but he didn’t have the time to do anything about it. Mr. Watson is a computer science professor at the University and he is considering retirement. Before he decides to give up his current health coverage, Mr. Watson would like to get an assessment of his current state of health. When asked, Mr. acknowledges frequent urination, going to the bathroom more often at night, and excessive thirst.

Mr. Watson has no other significant history of medical illness and he describes himself as being pretty healthy. His father died of diabetic complications and his two sisters also have diabetes. You find a heart rate of 77 and a blood pressure of 144/86. Aside from the fact that Mr. Watson is about 30 pounds overweight, nothing significant is found on physical exam, including a normal funduscopic exam, a normal sensory exam of the feet, and full peripheral pulses. All lab values are normal except for a plasma glucose of 143 mg/dL and a HgbA_{1c} of 8.1%.

Mr. Watson has never smoked and he drinks about 3 to 4 drinks per week. He has two sons, ages 32 and 29, who are in good health and live with their own families in San Diego and Detroit, respectively. Mr. Watson lives with his wife of 36 years in a house which they own in the Oakland Hills.

Appendix C: Recruitment Letter

570 University Hall #1190

Berkeley, CA 94720-1190

September 29, 1999

John Smith, MD

5678 Main Street

Berkeley, CA 94700

Dear Dr. Smith,

My name is Jose Mata and I am a medical student in the Joint Medical Program administered by the University of California at Berkeley and the University of California at San Francisco. As a part of my education at Berkeley, I will be completing a thesis resulting in a Master's degree in Health and Medical Sciences. For my thesis project, I am conducting a study investigating how physicians reason about and explain medical problems to their patients.

I would be grateful if you would participate in my study. Your participation would consist of completing a half-hour interview with me. In the interview, I will give you two clinical vignettes describing two different patients with two different clinical problems. After you read through each vignette, I will ask you a few questions related to the case. The interview can take place in your office, or any other location that you choose, and it will be recorded on audiotape. Your participation in this study will be completely confidential. Only I will know your identity, and only my faculty advisors, a paid transcriptionist, and I will have access to the taped interviews. I will be able to compensate you \$50 for spending your time with me.

I will be calling your office about a week after you receive this letter. If you would like to participate in my study, please alert your office staff that I will be calling. When we speak on the phone, we can try to find a time to conduct the interview. If you would like to contact me yourself, please call me at (510) 527-8875. Thank you for your time and consideration.

Respectfully yours,

Jose M. Mata



DIVISION OF HEALTH AND MEDICAL SCIENCES
SCHOOL OF PUBLIC HEALTH

570 UNIVERSITY HALL
BERKELEY, CALIFORNIA 94720-1190
TELEPHONE: (510) 642-5479
FAX: (510) 643-8771

Consent to be a research participant

Background and Purpose:

Jose Mata is a medical student in the Joint Medical Program, administered jointly through the University of California at San Francisco and the University of California at Berkeley. This is a five-year program in which the first three years are completed at UC-Berkeley, and the remaining two years are completed at UCSF. In addition to completing the pre-clinical training at UC-Berkeley, Jose will complete a health-related master's thesis for a master's degree in Health and Medical Sciences. The project in which I will be participating will assist Jose in completing his project for his master's thesis.

The purpose of this study is to learn about how physicians reason about and explain medical problems to their patients.

Research Procedure:

If I agree to participate, I will agree to be interviewed by Jose Mata concerning the issue of how I reason about and explain medical problems to my patients. During the interview, I will read through two clinical vignettes, each describing a different patient and a different clinical situation. After I have read through a vignette, Jose and I will talk about how I would go about explaining the medical problem to the patient. The interviews will take place in my office, or at any other location of my choice, and they will last one half hour. The interviews will take place during my normal business hours, or at any other time of my choice. The interviews will be audiotaped if I agree to allow them to be taped.

Jose Mata may call me back to clarify any unclear statements, or to share his preliminary results with me. Jose will provide me with either a summary of information from my interview, a summary of information from all of his interviews, or with his completed thesis if I would like a copy.

Possible Risks:

I may feel uncomfortable talking about the thought processes that I engage in when trying to decide how to explain medical problems to my patients. I have the right to refuse to answer any questions that I am uncomfortable with. In addition, I may stop the interview at any point, and withdraw from the study.

Participation in any research project carries the possibility of a loss of some degree of confidentiality. My name will not be mentioned on the audiotape, nor will my name appear in any oral or written communication of Jose's research project. Only Jose will know my identity. Jose's thesis advisors and a transcriptionist may listen to the taped interview, but they will not know my identity.

C.P.H.S.
99-5-45
EXPIRES:
11/4/2000
89

Potential Benefits:

I may enjoy discussing and thinking about how I go about explaining medical problems to patients. I may enjoy contributing to the pool of knowledge regarding the physician-patient relationship, and sharing my thinking process with other physicians and physicians-in-training, such as Jose. In addition, I may enjoy contributing to the education of a medical student

Alternatives to participation:

The alternative to participation in this study is to not participate. I have the right to refuse participation in the project.

Whom to contact if I have any questions:

If I have any questions, I may ask Jose Mata, the student researcher, or his thesis advisor, Jeff Burack, MD, at the Department of Health and Medical Sciences, in the School of Public Health, at UC-Berkeley. Dr. Burack can be reached at (510) 642-5527.

I have been given a copy of this consent form and I have read this document and hereby give my consent to participate in this study.

Print Name

Signature

Date

Appendix E: Physician Background Information Form

1. What is your specialty? _____
2. What is your sub-specialty? (if applicable) _____
3. What is your age? _____
4. How would you describe your race? _____
5. How would you describe your ethnicity? _____
6. From what region of the country or foreign country were you raised?

7. What year did you graduate from medical school? _____
8. In what state or country was your medical school located? _____
9. How many patients do you see in a typical day? _____
10. On average, how much time do you spend with each patient? _____
11. How would you describe the average annual income of your patients?
 - a. Low
 - b. Low to middle
 - c. Middle
 - d. Middle to high
 - e. High
12. Do you belong to any physician's organizations? If so, which ones?

13. How would you describe the organizational structure in which you practice?
 - a. private practice
 - b. closed panel HMO (eg. Kaiser)
 - c. institution-based practice
 - d. academic setting
 - e. hospital-owned practice
 - f. other. Please specify.

14.
 - a. solo
 - b. small group (less than 8 physicians)
 - c. large group (more than 8 physicians)